[2025] WACOR 26

JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	ROSALINDA VINCENZA CLORINDA FOGLIANI, STATE CORONER
HEARD	**:**	1-5 JULY 2024, 8-11 JULY 2024, 23 OCTOBER 2024
DELIVERED	**:**	9 JUNE 2025
FILE NO/S	**:**	CORC 44 of 2019
DECEASED	**:**	CLARKE, JOYCE GLADIS

Catchwords:
Nil

Legislation:
Nil

Counsel Appearing:
Ms R Young SC assisted by J Tiller assisted the State Coroner
Ms K Heath assisted by Ms C Wood (Aboriginal Legal Service of WA) appeared on behalf of Ms Bernadette Clarke
Mr A Crocker (instructed by Mr K Banks-Smith (Banks & Smith)) appeared on behalf of JC's mother and JC's son
Ms K Ellson (State Solicitor's Office) assisted by A Nowak appeared on behalf of WA Country Health Service, and North Metropolitan Health Service; and Dr Margaret Sturdy, and Dr Viki Pascu, and Dr Helen Van Gessel and Dr Salam Hussain and Dr Nathan Gibson
Ms S Smith assisted by Mr T Boyle (State Solicitor's Office) appeared on behalf of the Western Australian Police Force, and Senior Constable Lucinda Cleghorn and Senior Constable Kenneth Walker and Sergeant Antony Caracatsanis and Detective Senior Constable Edward Cooney and Senior Constable Bryan Bird and First Class Constable Dillon McLean and Mr Alan Taylor and Mr Chris Markham and Superintendent Michael Dellacosta and Deputy Commissioner Allan Adams
Mr G Yin assisted by Ms F Hugo (Tehan Legal) appearing on behalf of Mr Adrian Barker
Mr J MacLaurin SC assisted by Mr A Mossop (instructed by Ms Ariane Owen, Tindall Gask Bentley) appeared on behalf of Senior Constable Brent Wyndham

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 ***Joyce Gladis CLARKE*** *with an inquest held at Geraldton Courthouse, Courtroom 2, 15 Marine Terrace, Geraldton, on 1 – 5 July 2024 and Perth Coroner's Court, Central Law Courts, Court 51, 501 Hay Street, Perth, on 8 – 11 July 2024 and 23 October 2024 find that the identity of the deceased person was* ***Joyce Gladis CLARKE*** *and that death occurred on 17 September 2019 at Geraldton Hospital, Shenton Street, Geraldton, from a gunshot wound to the abdomen in the following circumstances:*

SUPPRESSION ORDER

That there be no reporting or publication of any details of any information in any document or evidence given that would reveal:

1. **The technical aspects of a taser or a firearm, being their effective distance and effective positioning, limitations on their effective capabilities, and the effective method of deploying (including drawing and covering) a taser or a firearm; or**

2. **The fact of any taser conducted energy weapon currently being considered for use in Western Australia and any pilot program or roll out plans in relation to that weapon, and in any other jurisdiction.**

For the avoidance of doubt, the suppression order does not, and cannot, extend to the suppression of information already in the public domain; and does not prohibit the reporting or publication of the events or the decision making processes of the individual officers on 17 September 2019.

Table of Contents

INTRODUCTION

1. Joyce Gladis Clarke was a 29 year old Aboriginal woman of Ngarlawangga Yamatji Martu descent. She was born on Yamatji country in the Murchison area on 18 March 1990. She tragically died on the evening of 17 September 2019 from a gunshot wound to the abdomen. She was shot by a police officer on a residential street of a Geraldton suburb (Petchell Street). The police officer was one of a number of officers who had responded to a call out concerning a person walking through the suburb carrying a large knife.

2. At the request of her family and community, the deceased woman is referred to as JC.

3. After JC was shot, attending police officers called an ambulance and rendered first aid. JC was conveyed to Geraldton Regional Hospital by ambulance but despite extensive resuscitative efforts, she was unable to be revived.

4. JC's premature death, in violent circumstances, deprived her of her life at a young age. It deprived her young son of a mother, caused immeasurable grief for her family, and caused distress for the Aboriginal communities in and around Geraldton, and in the wider areas. It sadly reactivated and magnified the historical mistrust and antipathy that many Aboriginal persons feel towards police officers, for reasons that are well known and deeply embedded in the unfortunate and brutal consequences of colonisation.

5. By the time of the inquest, feelings of angst and anger were reverberating through the Aboriginal communities. This shocking incident risked undoing the very many years of concerted efforts on the part of the Western Australia Police Force (WA Police) to work with Aboriginal communities to foster mutual trust and respect.

6. The focus of the inquest into JC's death was on the events leading up to the police shooting, and the question of how, looking back, the shooting could have been avoided. Ever present was the feeling that there must have been a better way of ending the incident, than shooting JC.

JC

7. JC was a Ngarlawangga Yamatji Martu woman. She was well-known around Geraldton, and loved by her family and community. She was a strong minded person and a talented artist.[1]

8. Sadly, JC's Aboriginality meant her life was influenced by harmful social factors beyond her control or that of her community. These include poor education outcomes, paucity of employment opportunities, endemic unemployment, consequential lack of income, poor access to culturally appropriate health services, poor living environments and social exclusion. Collectively, these factors are known as social determinants of ill-health. These social determinants play a critical role in health from the time of conception, through pregnancy, to the post-natal period, and beyond.[2]

9. It is suspected that JC was exposed to alcohol in utero. While it remains unconfirmed, it is likely that she had Foetal Alcohol Spectrum Disorder (FASD) and that this had adverse long-term impacts upon her mental state, contributing to her volatility. JC endured a difficult life, marred by poverty, the effects of drugs and alcohol, and instability in her familial relations, as family members underwent their own struggles. Over time these difficulties became insurmountable for JC, compromising her physical health and predisposing her to a range of serious mental health conditions. She had attempted to take her life on a number of occasions.[3]

10. JC had long standing learning and behavioural problems. She had a low threshold for discharge of aggression, a low tolerance to frustration, she was impulsive and displayed mood dysregulation. Her history of alcohol and drug abuse (including cannabis and methamphetamine) and her volatility led to numerous interactions with the criminal justice system. For significant periods she was transient as between prison (mostly for property crimes) and family in the mid-west of Western Australia. She had no employment history and lived on welfare payments.

11. By about 2010, at around the age of 20 years, JC had received a diagnosis of anti-social personality disorder and drug induced psychosis. In later years

[1] Exhibit 5, tab 8.
[2] Thirteen Children and Young Persons in the Kimberley Region Finding delivered by State Coroner Fogliani on 7 February 2019 p.13, para 33.
[3] Exhibit 1, tabs 8 and 9; Exhibit 5, tabs 3 to 5.

she was diagnosed with schizophrenia. She was admitted to Graylands Hospital on several occasions between 2010 and 2016.

12. During most of 2016 to 2019, JC was imprisoned. After serving her last custodial term of imprisonment at Bandyup Women's Prison, JC was transferred to Greenough Regional Prison on 29 August 2019 and released to freedom on that date. JC had indicated she would be living in Geraldton. After release JC proceeded to travel into Geraldton, where she hoped to meet up with family. She was looking forward to seeing her young son. A week later she was hospitalised. Just three weeks after her release from prison, most of which time was spent in hospital, JC died. It was a few days after she was discharged from hospital.

13. Amongst the turmoil that JC endured, throughout her life she was mothered with love and affection. At the request of JC's family, JC's mother is referred to in this finding as AJ. JC's much loved son CJ was born in 2012, and he was mothered with the same devotion by JC and AJ. JC had an enduring relationship with her sister, Bernadette Clarke (Ms B Clarke). In the midst of her ongoing difficulties, during her short life, JC experienced this bonding, and it was very important to her. Thoughts of her son and family were foremost on her mind.[4]

THE INQUEST

14. JC's death was a reportable death within the meaning of section 3 of the *Coroners Act* 1996 (the Coroners Act). It was reported to the coroner as required. By reason of s 19(1) of the Coroners Act I have jurisdiction to investigate the death.

15. The death occurred following a police shooting. Therefore, pursuant to s 22(1)(b) of the Coroners Act the holding of an inquest into JC's death was mandated because it appeared that the death was caused, or contributed to, by an action of a member of the WA Police.

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

[4] Exhibit 1, tab 9; Exhibit 5, tab 8.

of JC there is a direct relationship between the actions of the police and the death.

17. My primary function is to investigate the death. It is a fact-finding function. Pursuant to s 25(1)(b) and (c) of the Coroners Act, I must find, if possible, how the death occurred and the cause of the death. Pursuant to 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.

18. Immediately before death JC was not a "*person held in care*" within the meaning of s 3 of the Coroners Act. She was not at any stage under the control, care or custody of the WA Police, because the attending police officers had not gained control, she was not yet within their care, and they had not established a custodial relationship. It follows that JC was not escaping from their control, care or custody immediately before death.

19. I am therefore not required, under section 25(3) of the Coroners Act, to comment on the quality of the police's supervision, treatment and care of JC.

20. I held an inquest at Geraldton Courthouse on 1 to 5 July 2024 and Perth Coroner's Court, Central Law Courts on 8 to 11 July 2024 and 23 October 2024.

21. The primary and relevant areas of focus at the inquest were:

a) the circumstances of JC's death, in particular, the adequacy of the attempts made by police officers to de-escalate the situation, and the decision to use or not to use force by the police officers who attended the incident;

b) the adequacy of WA Police policies and training concerning de-escalation and use of force;

c) the adequacy of WA Police policies, training and approach in responding, particularly during callouts, to people in mental distress, those with complex mental health concerns, who are Aboriginal and who may have substance abuse issues;

d) the extent to which those WA Police policies and training, on de-escalation, use of force and/or mental health callouts, were adhered to from an individual and an organisational perspective;

e) the adequacy of mental health care JC received in the weeks prior to her death; and

f) the adequacy of the health care treatment JC received after being shot.

22. At the inquest I heard from 22 witnesses, and I received the following exhibits into evidence:

a) Exhibit 1, containing 31 tabs;
b) Exhibit 2, containing 13 tabs;
c) Exhibit 3, containing 11 tabs;
d) Exhibit 4, containing 23 tabs;
e) Exhibit 5, containing 8 tabs;
f) Exhibit 6, containing 14 tabs;
g) Exhibit 7;
h) Exhibits 8.1 to 8.4, comprising a series of diagrams marked by various witnesses;
i) Exhibit 9, containing 4 tabs;
j) Exhibit 10;
k) Exhibit 11;
l) Exhibit 12;
m) Exhibit 13; and
n) Exhibit 14, containing 6 tabs.

23. Investigations continued and after the close of the evidence, between 22 July 2024 and 28 August 2024, I received the following exhibits into evidence: Exhibits 15, 15.1, 15.2, 16, 16.1 and 17.

24. My role is to scrutinise the police actions leading to the shooting, and the shooting itself. I make findings and comments on those matters in furtherance of the principles of open justice and transparency, having regard to the community's concern about any exercise of a police power or function that results in a death. I also make comment in furtherance of the coroner's

death prevention role, in the hope that improved training and practices may avoid a death in similar circumstances.

25. 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.

26. Pursuant to s 44(2) of the Coroners Act, before I make any finding or comment adverse to the interests of an interested person, that person must be given the opportunity to present submissions against the making of such a finding.

27. On 2 August 2024 through my Counsel Assisting, the legal counsel for the interested persons were provided with written notifications of proposed adverse findings or comments, and recommendations that are open to me to make.

28. Between 22 and 27 August 2024, legal counsel for the interested persons responded to those notifications by making written submissions on behalf of the following persons or entities: WA Police, AJ and CJ, Ms B Clarke, Senior Constable Brent Wyndham, Mr Adrian Barker, Department of Health, North Metropolitan Health Service, WA Country Health Service, and the Office of the Chief Psychiatrist.

29. On 23 October 2024 legal counsel for the interested persons were provided with an opportunity to make submissions in open court.

30. 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. The more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.

31. I have had the opportunity to review all the evidence concerning the events leading to the shooting and the shooting itself. At the inquest there was particular focus on the evidence from the time that that the first police vehicle arrived at the scene, being approximately 6.19 pm, to the time of the shooting of JC, being approximately 6.20 pm (by which time all four police vehicles had arrived at the scene). It is approximately one minute, and it begs the question of what thought, if any, was given to de-escalating the situation before the shot was fired. Also, it leads to considering how, in a future incident, de-escalation may more appropriately be attempted.

32. In scrutinising the police actions, I have been mindful of hindsight bias. Hindsight bias is the tendency to perceive events that have occurred as being more predictable than they were at the time.[5]

33. I am mindful of the fact that on that day police were required to make rapid decisions within the context of a dynamic environment, without the time that I have had to reflect upon the circumstances. However, I am equally aware, as will be outlined in this finding, that it was some of those rapid police decisions that contributed to an escalation of the risks and truncated the amount of time available to them for considering de-escalation options.

34. I have taken these factors into account in reaching my findings in this case.

35. My findings appear below.

JC'S RELEASE FROM PRISON AND HOSPITALISATION

Release from prison on 29 August 2019

36. JC was released from Greenough Regional Prison on 29 August 2019, having been transferred there from Bandyup Women's Prison on that date. Some steps had been attempted in advance of her release. JC's medical records from the Central West Mental Health Service reflect that on 26 August 2019 the Clinical Nurse Specialist from the State Forensic Mental Health Service (SFMHS) Prison In-Reach Transition Team, wrote to the Midwest Mental Health & Community Alcohol & Drug Service based in Geraldton noting, for information, that JC was to be released and discussing where she might go. It was also noted that, with the exception of some recent anxiety in

[5] www.britannica.com/topic/hindsight-bias

relation to her pending release, JC was stable and had not been on medication or treatment for several months.[6]

37. However, the Community Mental Health Nurse from the Midwest Mental Health & Community Alcohol & Drug Service responded to the effect that JC was not an active client with them, and they were not sure why this notification had come through to them.[7]

38. It appears that JC's mental health was considered to be stable. She was therefore unlikely to be accepted as a client at one of the community mental health services, under their existing processes. However, the observation that JC was considered to be stable was a point in time observation. It was clear to JC's clinicians, and to JC herself, that if she reverted to using methamphetamine after her release, her mental state would deteriorate. JC made no secret of the fact that she proposed to use methamphetamine after her release.[8]

39. After release from prison, JC relapsed into using drugs.

40. It is at this stage that, had it been possible, a connection between JC and the local mental health service in Geraldton may have resulted in it being identified that a crisis was imminent and that JC required active support. I make further comment on this later in the finding under the heading: *Recommendation 6 – Improved communication between health service providers*.

41. I turn back to the sequence of events. JC did not initially provide details as to where she would live after her release, though it was thought she would be going back to her family in Mullewa. She declined any assistance or community linkages. A day after her release she indicated she proposed to live in Geraldton.[9]

42. Four days after her release, on 3 September 2019, JC was allegedly involved in an incident in Spalding, a suburb north of Geraldton, and police were called to attend. JC was said to have been armed with a knife and was alleged to have damaged some property. By the time police arrived, JC was said to

[6] Exhibit 4, tab 16; Exhibit 5, tab 3.
[7] Ibid.
[8] Ibid.
[9] Ibid.

have left, and the occupants informed police that JC did not threaten any person.[10]

43. JC was having difficulty adjusting to life outside the prison environment and had no evident support to assist with that transition. It was compounded by her feeling that she had nowhere to live, in Geraldton, that was stable for her.

Hospital admissions 7 to 13 September 2019

44. On Saturday, 7 September 2019, JC made two calls to police indicating that she might take her life. She gave an address in Rangeway, a suburb in Geraldton.[11]

45. It was later discovered that JC had also made a call that day to the Kids Helpline indicating her intention to self-harm.

46. At about 3.30 pm on 7 September 2019, Senior Constable Adrian Barker (Senior Constable Barker) and another officer were doing general duties in Rangeway. By the time of the inquest Senior Constable Barker was no longer a police officer. He had ceased being a police officer in November 2021. However, in this finding he is referred to as Senior Constable Barker to reflect his role at the material time.[12]

47. While they were near Levy Park, Senior Constable Barker saw a job being typed into the WA Police Computer Aided Dispatch (CAD) system by a triple 0 operator. That job identified that JC was on the phone to the triple 0 operator: "*threatening suicide*". Senior Constable Barker looked up and saw JC walking towards his police van, while she was still speaking on the phone to the triple 0 operator, intermittently yelling.[13]

48. Senior Constable Barker approached JC and spoke to her in a friendly, chastising tone, that he described at the inquest as a: "*distraction technique*". That tone did seem to distract her. JC engaged with Senior Constable Barker and said to Senior Constable Barker: "*I'm going to kill myself*". She was animated, agitated, and seemed affected by methamphetamine.[14]

[10] Exhibit 1, tab 8; Exhibit 4, tab 7.
[11] Exhibit 1, tab 8; Exhibit 2, tab 10; Exhibit 4, tab 7.
[12] ts 366.
[13] ts 373 to 374.
[14] ts 374 to 375.

49. Senior Constable Barker told JC that in light of her having said that, he would need to take her to hospital. He believed JC understood his reasons, and he was able to persuade her to enter the police van, for conveyance to Geraldton Regional Hospital, utilising the powers under the *Mental Health Act* 2014 (Mental Health Act)[15].

50. Geraldton Regional Hospital Emergency Department Notes reflect that JC was brought in by police at approximately 4.00 pm on 7 September 2019, that upon arrival she was agitated (therefore difficult to interview) and that she admitted to having used drugs. Approximately half an hour later, the hospital's continuation notes record that JC was escalated and agitated, that she was visually hallucinating, and smelled strongly of alcohol.[16]

51. Senior Constable Barker stayed with JC during that presentation, and it appears the hospital staff found his presence, and his interactions with JC to be helpful, as he was able to calm her. JC was agitated when medical treatment was attempted. Senior Constable Barker spoke to her to try and help her when medical interventions were being undertaken. He distracted her using conversation and pushing down on her shoulders, when she became agitated, to help keep her still, so that medical equipment would not become detached and hurt her. He testified that the clinical staff prefer not to "*handcuff*" agitated patients to the hospital bed.[17]

52. JC was eventually sedated, though she remained conscious. Senior Constable Barker felt he built a rapport with JC during the time he was there trying to keep her calm. Before he left, they held hands and as he left, JC gave him a wave.[18]

53. JC remained at Geraldton Regional Hospital for two days, but unfortunately her needs were not able to be met as she was physically and verbally abusive to staff, resulting in a number of "*Code Black*" incidents (being an emergency code that denotes a threat to staff).[19]

54. By the morning of 8 September 2019, JC's treating team had determined to transfer JC to, initially, Graylands Hospital for treatment and review, as there

[15] ts 376 to 377.
[16] Exhibit 5, tab 6.
[17] Exhibit 5, tab 6; ts 380 to 381.
[18] ts 379-380; Exhibit 5, tab 6.
[19] Exhibit 5, tab 6.

were no available beds in a locked ward in Geraldton. To facilitate this, referral and transport forms under the Mental Health Act were completed.[20]

55. The Form 1A referral under the Mental Health Act dated 8 September 2019, made at 9.20 am, had the effect of compelling an examination of JC at Sir Charles Gairdner Hospital by a psychiatrist. The treating doctor at Geraldton Regional Hospital felt that JC required an involuntary treatment order due to matters that included her suicidality, in the context of a history of schizophrenia and polysubstance abuse. Accordingly on 9 September 2019, JC was accompanied on a Royal Flying Doctor Service to Perth and then by ambulance to Sir Charles Gairdner Hospital.[21]

56. JC arrived at Sir Charles Gairdner Hospital at about 2.00 pm on 9 September 2019. JC had reported that she had nowhere to live after leaving prison (she had previously expressed a desire to return to prison). At the time of her arrival, there were no beds available on a locked ward. She was placed on a wait list for a bed in a locked ward at Graylands Hospital.[22]

57. It was initially noted in the Emergency Department at Sir Charles Gairdner Hospital that JC had polysubstance abuse, an antisocial personality and there was a query regarding a possible diagnosis of schizophrenia. It was also noted that she had called triple 0 expressing an intention to take her life. The assessment in the Emergency Department confirmed a working diagnosis of drug induced psychosis and suicidal ideation.[23]

58. On the evening of 10 September 2019, JC was admitted to the psychiatry division of Sir Charles Gairdner Hospital, with Consultant Psychiatrist Dr Russell Hoyle (Dr Hoyle) as the responsible clinician. Dr Hoyle reviewed her on 11 September 2019.[24]

59. JC was assessed, on the secure unit, as having mild, resolving paranoia, secondary to drug use. She did not appear to have a current psychotic illness. It was thought her suicidal ideation was related to her being homeless. She was placed on a Form 3C, meaning that her detention under the Mental Health Act was continued for a further 72 hours to enable further assessment.[25]

[20] Ibid.
[21] Exhibit 5, tab 5; Exhibit 6.
[22] Ibid.
[23] Ibid.
[24] Ibid.
[25] Ibid.

60. JC was commenced on a low dose of quetiapine. She was nursed on a "*2:1 special*" (meaning two staff for one patient) being a high level of nursing observation, due to her aggression towards staff. A client management plan was developed, and a social worker and welfare officer attempted to assist her regarding accommodation in Geraldton and Centrelink support.[26]

61. During this stay, several Code Blacks were called due to JC's aggression. On occasion she required restraint and seclusion, for management of her aggression, and minimisation of risk to herself and/or others.[27]

Discharge from SCGH on 13 September 2019

62. On Friday, 13 September 2019, JC said she wanted to be discharged from Sir Charles Gairdner Hospital, so she was reviewed by Dr Hoyle. Dr Hoyle, noting that JC was: "*demanding*" discharge, found no evidence of major mental illness. He found there was no psychotic or mood disorder present. He noted that JC's longstanding behavioural issues remained unchanged with contingent: "*suicidal threats*" made by her in response to not getting her needs met.[28]

63. As a result of his review, Dr Hoyle revoked JC's Form 3C for involuntary detention, and plans were made for her discharge. JC indicated she was happy to return to Geraldton, and bus transport for that day was arranged for her by the social worker. AJ was contacted, and she indicated that she had planned for a family member to collect JC from the bus in Geraldton that evening, and take her to her aunt and uncle, for her to stay with them over an initial period.[29]

64. Consequently, JC was Sir Charles Gairdner Hospital with follow up with Ruah Community Services in Geraldton scheduled for 16 September 2019, to assist her with her longer-term accommodation. Her discharge diagnosis was methamphetamine use complicated by antisocial personality disorder and her situational crisis (in the context of homelessness). No medications were provided to JC on discharge, and a recommendation was made that she see a GP.[30]

[26] Ibid.
[27] Ibid.
[28] Exhibit 5, tabs 4 and 5; Exhibit 6.
[29] Exhibit 5, tabs 4 and 5.
[30] Exhibit 5, tabs 4 and 5.

65. The quality of JC's medical care and treatment at Sir Charles Gairdner Hospital, including the quality of her discharge was subsequently reviewed by A/Professor Salam Hussain, Acting Head of Clinical Service at Sir Charles Gairdner Hospital Mental Health Service (A/Professor Hussain), who produced a report for the coroner and gave evidence at the inquest, based upon his review of JC's medical records.[31]

66. In connection with the revocation of JC's Form 3C, A/Professor Hussain noted it was documented that: "*further* [involuntary] *inpatient treatment would be detrimental to her wellbeing*". At the inquest he was asked how he interprets that. A/Professor Hussain posited that Dr Hoyle may have reviewed previous hospital admissions (for example to Graylands Hospital in 2016) and noted that her symptoms had resolved relatively quickly. Further, the schizophrenia was a historical diagnosis and when he reviewed JC for discharge, Dr Hoyle's mental state assessment did not suggest evidence of psychotic symptoms or other major psychiatric illness; rather what JC needed was stable accommodation.[32]

67. In A/Professor Hussain's opinion, Dr Hoyle assessed that JC had a drug induced psychosis, and that restrictive practices (such as involuntary treatment) would not be helpful to her. Given that JC did not meet the criteria for involuntary treatment, there was no basis for keeping her in hospital, and no basis for placing her on a Community Treatment Order (the latter amounting to involuntary treatment as well).[33]

68. In his report to the coroner A/Professor Hussain proffered the view that the decision to discharge JC on 13 September 2019 was sound based upon a risk benefit analysis. He took account of the need to balance her autonomy and the clinical requirements, and outlined the following aspects as some of the justifications for her discharge:

> "*The team identified that illicit substance-use and accommodation issues are main contributors to the exacerbations of longstanding impulsive behaviours with low frustration tolerance and low-grade paranoia that had not been modified by medications. These behavioural symptoms had evidently settled after long abstinence from psychoactive substances during her long incarceration.*"[34]

[31] Exhibit 6; ts 817 to 833.
[32] Exhibit 6; ts 823.
[33] Ibid.
[34] Exhibit 6.

69. I am satisfied that JC was appropriately discharged on 13 September 2019 because there was a reasonable basis for Dr Hoyle concluding that her drug induced psychosis had resolved, and that her frustrations were largely generated by a lack of suitable accommodation for her. Follow up had been arranged to assist with her accommodation.

70. In his report to the coroner A/Professor Hussain noted that, in hindsight, there was room for improvement in that a referral to Geraldton community mental health service was not documented in JC's medical notes. I have made comment regarding future improvements in the area of referrals and notifications, for continuity of support, later in this finding under the heading: *Recommendation 6 – Improved Communications between Health Service Providers*.[35]

71. After discharge from Sir Charles Gairdner Hospital on 13 September 2019, JC returned to Geraldton as planned.

EVENTS OF 17 SEPTEMBER 2019

Morning of Tuesday 17 September 2019

72. At about 8.30 am on 17 September 2019, JC went to the Northlands shopping centre in Geraldton. Due to previous incidents involving JC at this shopping centre, she was known to some of the security guards and retailers. It would appear JC was aware she may not have been welcome at the shopping centre, because shortly after she arrived, she approached a security guard to inform him that another security guard said she could remain at the shopping centre.[36]

73. There followed a conversation between the two security guards, and then the one whom JC had approached ushered her out of the shopping centre. JC was annoyed about this and became verbally aggressive. She appeared to leave but returned shortly afterwards, and the same security guard ushered her out again.[37]

74. At around this time the security guard received a call from an employee of the Liquorland Store (located within the shopping centre precinct) advising him of a theft of alcohol and describing the alleged thief. The security guard went to the Liquorland Store, viewed the CCTV footage and identified JC.

[35] Exhibit 6.
[36] Exhibit 1, tabs 12 and 13.
[37] Ibid.

It appeared that at around 10.00 am JC had gone there and taken a four pack of Smirnoff Double Black vodka drinks without paying for them.[38]

75. The store manager at the Liquorland Store described her interaction with JC, stating that her tone was: "*a little bit aggressive*", and that she appeared a little jerky, but did not smell of alcohol. JC did not return to the shopping centre after that.[39]

76. Shortly after the events at the Liquorland Store, between about 10.30 am to 11.00 am, JC went to the Wajarri Community Office in Geraldton (it is about a 10 minute walk away). With the assistance of the member services manager of the Wajarri Community Office JC called her mother, AJ, saying she wanted to come home, to Mullewa, to see her and her son. JC was upset and crying. Her mother said she did not have a car to come to Geraldton to bring her home. Unfortunately, JC reacted with frustration and ended the conversation after approximately five minutes.[40]

77. The member services manager proceeded to speak with AJ directly. AJ had told JC that her cousin was due to arrive by bus in Geraldton that day (Tuesday) and that they could both return to Mullewa together by bus in two days' time (Thursday). After spending some time with the member services manager, JC calmed down and said she would await her cousin at the bus stop that day, and then catch the bus back to Mullewa, as planned by her mother, on Thursday (being the next available bus to Mullewa). She appeared calm when she left the Wajarri Community Office.[41]

JC at Joel Court residence

78. JC then travelled to the home of some relatives, at a location in Joel Court Karloo, in Geraldton, occupied by her brother-in-law. The brother-in-law stated that for cultural reasons he refers to JC as his sister. It was before lunch when JC arrived and her brother, feeling that she was tired and grumpy, invited her to sit on the couch, to relax. JC smoked some cannabis and slept a few hours on the couch. When she awoke, she ate some food, and chatted with the people in the house, including one of her sisters, who lived nearby.[42]

[38] Exhibit 1, tabs 12 and 13.
[39] Exhibit 1, tab 13; ts 291; ts 296 to 297.
[40] Exhibit 1, tab 9; ts-318.
[41] Exhibit 1, tabs 9 and 14.
[42] Exhibit 1, tab 16.

79. At some stage JC told those present that she was going to die that day, and that she did not want them to go to her funeral. JC later left to go to the other Joel Court residence next door, where other relatives of JC's lived. Her brother did not notice her leave but had earlier told JC, that she could always have somewhere to sleep and somewhere to eat at his place.[43]

80. JC arrived at the other Joel Court residence, the house of one of her sisters, between approximately 3.00 pm and 4.00 pm. The sister's niece and nephew were there, but the sister was not there. JC was still tired and lay on the couch. At some stage, JC and the niece had an animated discussion about JC's son. JC was concerned about him and fearful that he would go into care, although there was no indication of that being planned. The nephew initially described it as a: "*friendly argument*". However, JC was volatile and shortly afterwards, in her argument with the niece, JC became verbally abusive and threatening. The niece did not want to engage with JC in this manner, and felt JC was coming down from drugs.[44]

81. JC left the other Joel Court residence abruptly, saying she felt unloved. The niece, unsure of what to do, rang her grandmother, who was AJ. AJ told her to call police, about JC's welfare. Then the sister arrived home, and as the niece had not yet called the police, the sister called them.[45]

82. The sister had been told by someone (she could not recall who) that JC had left the house, taking a knife and hammer with her, and at 5.50 pm she relayed this to police in a telephone call, along with the fact that JC had been abusive and yelling.[46]

83. Police records reflect that as a result of the sister's call, a CAD job was created at approximately 6.00 pm for Geraldton Police to attend at the relevant Joel Court residence, which read as follows:

> *"[JC] has just been at her address and has become abusive and yelling. [JC] has then grabbed a knife and hammer and has gone next door to number [deleted] Joel Court, Karloo. Police required as caller unsure if [JC] will hurt anyone*".[47]

[43] Ibid.
[44] Exhibit 1, tabs 15 and 18 to 20.
[45] Ibid.
[46] Exhibit 1, tab 8 and 20.
[47] Exhibit 1, tab 8; Exhibit 2, tabs 5 and 6; Exhibit 4, tab 5.

84. JC had not harmed any person, but her family were concerned about her. There was reason to believe that she was agitated, volatile, and potentially affected by drugs. Her behaviour was unpredictable and given that she was thought to be armed with a knife, it was appropriate to call the police. The sister who made the telephone call was not Ms B Clarke, but another sister.

JC on Assen Street

85. After JC left the other Joel Court residence, she appears to have gone back to the former Joel Court residence, her brother's home, to collect her bag, and then she walked off, towards Assan Street.[48]

86. In the meantime, her sister's call to the police referred to previously prompted a range of actions by the Geraldton police.

87. Senior Constable Bryan Bird (Senior Constable Bird) and Constable Dillon McLean (Constable McLean), in marked Police vehicle FG107 were tasked to attend. They were travelling to another job, when at 6.10 pm, a plan was arranged that they would check in on JC and if she: "*is ok*", they would head to the other job.[49]

88. The radio communications to Senior Constable Bird and Constable McLean made clear that Geraldton Base (staffed by Sergeant Adrian Geary (Sergeant Geary) of Geraldton Police station) knew that the person about whom the call had been made was JC. Her name was used in the radio communications.[50]

89. Information made available to Senior Constable Bird was to the effect that JC had taken a knife and hammer and gone to an identified Joel Court residence. Senior Constable Bird had attended previous incidents involving JC and had formed the view that JC had displayed behaviour consistent with having mental health issues and that on occasions she had appeared drug affected.[51]

90. JC was later seen on Assen Street. At about 6.15 pm a civilian made a call to triple 0. He reported he was driving up Assen Street and: "*there's a bloke walking down the street with a fairly large knife in his hands*". The caller described the knife as being about 30 centimetres and described JC's

[48] Exhibit 1, tab 16.
[49] Exhibit 2, tab 12.
[50] Exhibit 4, tab 5.
[51] Exhibit 2, tab 12.

clothing. The location described by the caller was about 600 metres from the Joel Court residence that JC had left.[52]

91. This information was being shared over the police radio communications system as police made their way to the scene.

Police continue to travel to the scene

92. At about 6.18 pm, Geraldton Base communicated with Senior Constable Bird and Constable McLean further as follows:

> *"Geraldton Base to foxtrot golf 107, ah, just an update on your job. P2 has just dropped in saying there is a dark-skinned male wearing knee length shorts, black hoody with a white square on the front. Callers says he has – is walking down Assen Street with a 30 centimetre knife."*[53]

93. In the meantime, Senior Constable Bird and Constable McLean had arrived at the other Joel Court residence and were talking with one of the residents. As they heard this update, they indicated on the radio back to Geraldton Base that they would depart shortly and sort it out.[54]

94. The resident, who heard the radio call, stated that afterwards, the taller officer (being Senior Constable Bird), tapped his gun twice and said: *"that's what we got these for*".[55]

95. When questioned at the inquest, Senior Constable Bird denied making that statement. He said that he did tap his gun, but said: "*don't worry, we will protect you*" to give the residents of the other Joel Court residence some reassurance that police were around and that they will be able to deal with any serious imminent threat to them or anyone else. His partner then present, Constable McLean, was not able to corroborate that at the inquest; he did not recall hearing that.[56]

96. This conversation, and the claim that Senior Constable Bird tapped his gun in the manner outlined by the Joel Court resident was the subject of submissions by AJ, and CJ, through their counsel Mr Crocker. They submit

[52] Exhibit 1, tab 21.
[53] Exhibit 2, tabs 11 and 12; Exhibit 4, tab 5.
[54] Exhibit 2, tabs 11 and 12; Exhibit 4, tab 5.
[55] Exhibit 1, tab 19.
[56] ts 261 to 263; ts 304.

that I ought to prefer the resident's account of the episode, and not Senior Constable Bird's account.

97. While it is unnecessary for me to resolve this question, to the extent that it relates to the inquest, it is to be borne in mind that at this stage, some of the incoming radio communications were referring to a male person. It is unclear whether the connection was made, at the material time, that all of the communications were references to JC. However, I am satisfied that in tapping his gun, Senior Constable Bird did not indicate any intention to use it in connection with JC, nor was it a reflection of any animosity towards her. Self-evidently, on a more general note, it is not desirable for police officers to tap their guns when speaking with civilians in this manner, irrespective of what is being said.

98. Turning back to the events, other police officers in the meantime continued to travel to the scene.

99. At 6.18 pm Senior Constable Edward Cooney (Senior Constable Cooney) and First Class Constable Brent Wyndham (First Class Constable Wyndham), in unmarked police vehicle FG 110 (an orange sedan), radioed that they would assist. They said: "*we're just around the corner*", and: "*we'll have a look*". In just over a minute, they arrived at the scene.[57]

100. At 6.18 pm, First Class Constable Lucinda Cleghorn (First Class Constable Cleghorn) and Senior Constable Kenneth Walker (Senior Constable Walker), in marked police vehicle FG 109, indicated over the radio: "*we're on Assen coming from Abraham now*". In under a minute, they arrived and saw JC (initially believing it was the male referred to in the police radio transmission).[58]

101. At 6.19 pm, FG107 (Senior Constable Bird and Constable McLean) communicated to the other police vehicles over the radio that were to attend saying: *"It sounds like [JC]".* Within a minute, they arrived at the scene.[59]

102. Over the police radio communications, there was reference to a male person holding a knife, and separately there was also reference to it sounding like it was JC. Not all the attending police officers heard, or recalled, all the police radio communications. They did not know, with confidence, that it was JC when they initially reached the scene.

[57] Exhibit 2, tab 13; Exhibit 3, tab 1; Exhibit 4, tab 5.
[58] Exhibit 2, tabs 7 and 8; Exhibit 4, tab 5.
[59] Exhibit 2, tabs 11 and 12; Exhibit 4, tab 5.

JC turns onto Petchell Street

103. At 6.19 pm, as recorded on CCTV of a nearby house, JC turned off Assen Street into Petchell Street. The resident was in the front yard. JC made no motion towards her, and did not react to her presence. JC was dressed in a black hooded jumper, black shorts, wearing a dark backpack, and appeared to be holding something in her right hand. JC continued walking in a westerly direction along Petchell Street, on the left hand side of the road.[60]

104. At 6.19 pm a few seconds after JC was recorded on CCTV, FG109 (with First Class Constable Cleghorn and Senior Constable Walker) were the first of the attending police officers to arrive at the scene. They saw a person that they initially thought was a male, but who was in fact JC. First Class Constable Cleghorn reported on the radio:

> "*Oh we found him and it's on Petchell and he most definitely does have a big knife*"[61]

105. First Class Constable Cleghorn and Senior Constable Walker attempted to engage JC with verbal commands. They were not successful, in that JC did not stop for them, nor drop the knife.[62]

106. During those radio calls, Senior Constable Walker was also calling out by yelling "*oi*" to JC.[63]

107. At around this time First Class Constable Cleghorn, realising it was JC reported on the radio:

> "*It is [JC] and she's ignoring us. She has a pair of scissors in her left hand. She's got a really big knife in her right hand. We're still in the vehicle. She is not acknowledging our direction.*"[64]

108. Despite attempts to engage by First Class Constable Cleghorn and Senior Constable Walker's own attempts, JC continued walking at a moderate pace along Petchell Street. At one point, JC shrugged her shoulders with both arms moving up, most likely in response to one or other of the attempts by police to get her attention.[65]

[60] Exhibit 1, tab 26; Exhibit 12; ts 11 and 12.
[61] Exhibit 2, tab 7; Exhibit 4, tab 5.
[62] Exhibit 2, tabs 7 and 8.
[63] Exhibit 2, tabs 7 and 8; Exhibit 12; ts 484.
[64] Exhibit 4, tab 5; ts 12; ts 32 to 33.
[65] Exhibit 2, tabs 7 and 8.

109. JC was aware of the presence of police, and it is likely she heard some of their commands as she continued to walk along but she did not acknowledge or respond to them.

Police converge on the scene at 6.20 pm

110. At 6.20 pm, within one minute after First Class Constable Cleghorn and Senior Constable Walker arrived at the scene in FG 109, three other police vehicles arrived at the scene, within moments of each other, converging on Petchell Street where JC was standing.[66]

111. Marked police vehicle FG 105 arrived at 6.20 pm and 9 seconds, having just notified Geraldton base that they were nearly there. FG 105 was driven in a westerly direction along Petchell Street, on the right hand side, by First Class Constable Antony Caracatsanis (First Class Constable Caracatsanis) with Senior Constable Barker as passenger.[67]

112. At 6.20 pm and 10 seconds, First Class Constable Cleghorn reported on the radio:

> "*Yeah, we've told her that if she doesn't put down she's gonna get tasered. She doesn't seem to care.*"[68]

113. At 6.20 pm and 43 seconds, First Class Constable Cleghorn reported on the radio:

> "*Geraldton, ah, Base, we need an ambulance immediately to our location. One shot fired.*"[69]

114. As will be detailed later in this finding, under the headings: *The seconds immediately prior to the gunshot*, and: *The gunshot*, in those 33 seconds between First Class Constable Cleghorn's two radio communications, there was a flurry of activity resulting in JC being fatally shot.[70]

115. I turn back to the police converging on the scene. After First Class Constable Caracatsanis and Senior Constable Barker arrived at the scene in FG 105, within seconds Senior Constable Barker exited his vehicle, walking behind JC, who was now walking in a westerly direction along the right side of

[66] Exhibit 12.
[67] Exhibit 2, tabs 9 and 10; Exhibit 4, tab 5; Exhibit 12.
[68] Exhibit 2, tab 7; Exhibit 4, tab 5.
[69] Exhibit 2, tab 7; Exhibit 4, tab 5.
[70] Exhibit 12.

Petchell Street. Senior Constable Barker was the first of the police officers to get out of a police vehicle. Senior Constable Barker did not have anything in his hands, and JC did not initially appear to notice or react to his presence. FG 105 came to a stop approximately in front of 39 Petchell Street.[71]

116. At about that time (still 6.20 pm) unmarked police vehicle FG 110 arrived, driven in a westerly direction along Petchell Street by Senior Constable Cooney with First Class Constable Wyndham as passenger. First Class Constable Wyndham, being the passenger, made a split-second decision and got out of his vehicle, moving towards JC. Just prior to that, he had not heard anyone give JC any commands, other than what he heard over the radio. When questioned at the inquest his evidence was that he had not thought about whether the other police officers already there, First Class Constable Cleghorn, Senior Constable Walker or Senior Constable Barker had had longer to appreciate the risks at the scene or to assess JC's demeanour.[72]

117. Then Police vehicle FG107 arrived on the scene, driven by Senior Constable Bird with Constable McLean as passenger.[73]

118. Within seconds, at around 6.20 pm a total of eight police officers had attended at Petchell Steet. The police vehicles were arranged around JC in the configuration depicted at Figure A below (the configuration), near 34, 37 and 39 Petchell Street, with FG 109 having done a U-Turn to approach JC from the westerly side, FG 105 (now only with First Class Constable Caracatsanis inside) having driven slowly behind Senior Constable Barker and come to a stop on the right hand side, FG 110 (now only with Senior Constable Cooney inside) having resumed driving slowly behind JC and then slowing to a stop on the left hand side, and FG 107 driving over the left hand verge and coming to a stop across the road from where JC was standing. The police vehicles came to a stand still in the configuration.[74]

[71] Exhibit 2, tab 10; Exhibit 12.
[72] Exhibit 12; ts 490 to 492.
[73] Exhibit 2, tabs 11 and 12; Exhibit 12.
[74] Exhibit 8.1; Exhibit 12.

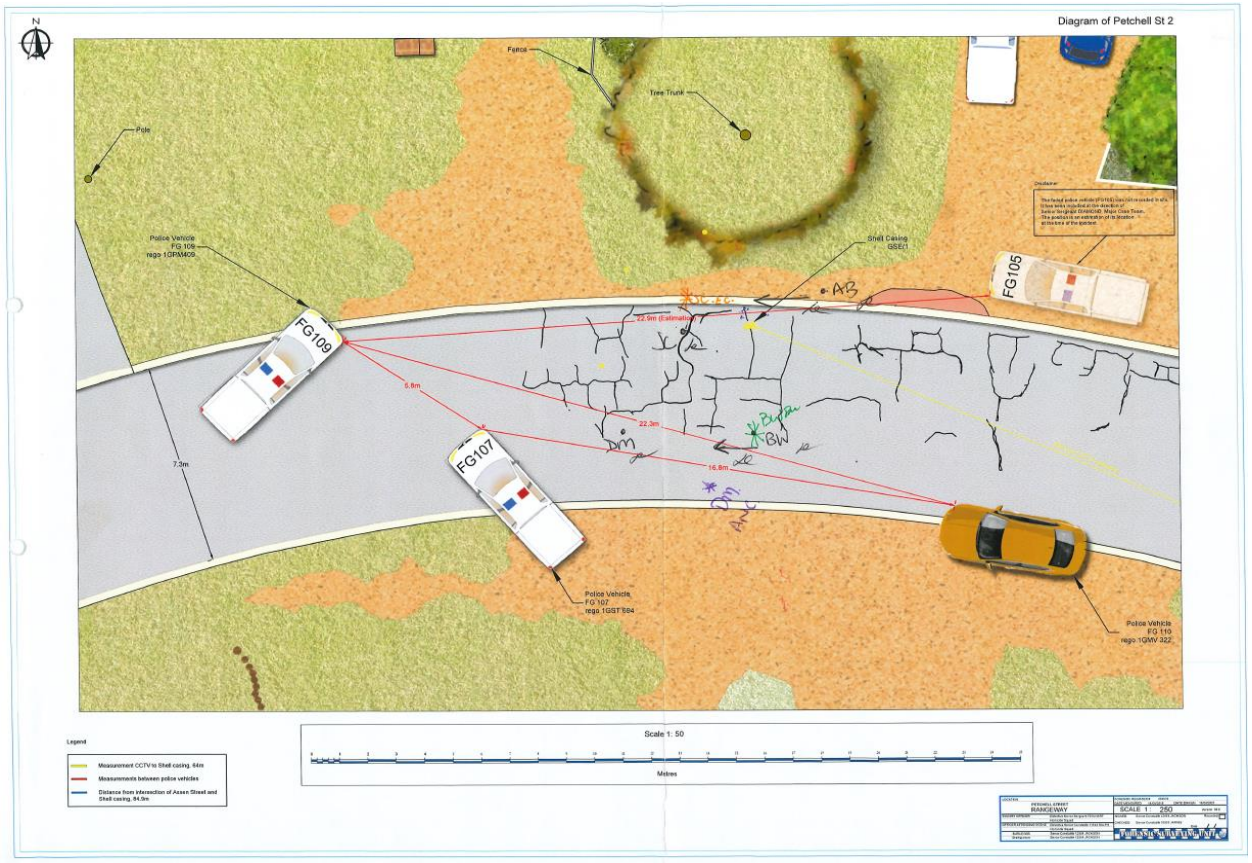

Figure A (Exhibit 8.1)

119. The configuration of the police vehicles was relevant to my consideration of the police actions that followed.

120. At the inquest I heard evidence about the configuration from Mr Alan Taylor (Mr Taylor) of the WA Police, who was attached to their Operational Safety and Tactics Training Unit, that was responsible for the development, management and use of their Use of Force policy, and training of police officers. Mr Taylor was not involved in the incident on 17 September 2019.[75]

121. Mr Taylor, who has trained police officers on cordoning and containing an individual, was asked to look at Exhibit 8.1 (Figure A, above) and he testified that in his view the configuration looks like an effective police cordoning and containment of JC, similar to what he has taught previously: "*100 per cent, no doubt at all*".[76]

122. Mr Christopher Markham (Mr Markham) of the WA Police, attached to the Operational Skills Training Faculty as a Capability Advisor – Use of Force,

[75] ts 663 to 707.
[76] ts 679.

and also attached to the Operational Safety and Tactics Training Unit prepared a report dated 11 September 2020 initially for the Homicide Squad, and subsequently provided to the coroner. He gave evidence at the inquest concerning the configuration. Mr Markham was not involved in the incident on 17 September 2019.[77]

123. In his report to the coroner Mr Markham referred to the effective positioning of the four police vehicles (namely, vehicular containment, which is effectively a mobile containment) and the three police officers approaching JC on foot, observing that as a result, JC was effectively boxed in and contained.[78]

124. At the inquest Mr Markham was also asked to look at Exhibit 8.1 (Figure A, above) and he testified that in his view he considered the configuration of the police vehicles to be an effective containment, adding: "*the fact that the drivers remained with the vehicles would enable them to make that a moving containment, if necessary*". He explained that the vehicles could be moved and adapted to prevent access and egress. He noted that although there appeared to be no radio communication between the drivers of the police vehicles, it was evident to him that they were moving and positioning their police vehicles to provide a vehicular containment of JC.[79]

125. I am satisfied that the configuration of the police vehicles as shown at Exhibit 8.1 (Figure A, above) represented an effective cordoning and containment of JC by the attending police officers.

126. The evidence of Mr Taylor and Mr Markham, to the effect that there was an effective containment of JC is relevant, because it contrasts with the tenor of the evidence of the attending police officers, who did not consider that JC had been effectively contained. This raised questions around the efficacy of their training, that find expression later in this finding under the headings: *WA Police missed opportunities to effectively train its officers* and *Recommendation 9 – Review of WA Police training*.

127. The inference to be drawn from a proposition that JC was not effectively cordoned and contained by the configuration of the police vehicles is that something more needed to be done by attending police, to contain her. Conversely, the inference to be drawn from JC being effectively cordoned

[77] Exhibit 3, tab 11; ts 709 to 731.
[78] Exhibit 3, tab 11.
[79] Exhibit 3, tab 11; ts 720.

and contained by the configuration of police vehicles is that there would have been time to consider de-escalation options.

128. It is at this stage that, had it been available and considered, the advice of an authorised mental health practitioner, working with WA Police as part of the Mental Health Co-Response, located remotely and away from apparent danger, may have been helpful.

129. For example, First Class Constable Cleghorn had already recognised her as JC. A search of JC's medical records would have shown she was recently released as an involuntary mental health patient. If hypothetically this had been conveyed to attending police over their radio, it may have put a different complexion on JC's actions and may have supported a slowing down and a consideration of de-escalation options.

130. Further comment on this is made later in this finding under the heading: *Recommendation 8 – Mental Health Co-Response*.

The seconds immediately prior to the gunshot

131. I turn back to the events of the day. JC had continued to walk along Petchell Street notwithstanding the presence of the police vehicles and the police officers shouting commands at her, to put down the knife. She was aware of their presence, and as indicated I am satisfied she heard at least some of their commands. In the seconds immediately prior to the gunshot she had crossed Petchell Street from left to right and was positioned approximately at the mid-point of the configuration of police vehicles, on the right-hand side of Petchell Street (viewed from a westerly direction), towards the verge, approximately opposite 39 Petchell Street.[80]

132. I turn back to First Class Constable Wyndham's split-second decision to get out of his police vehicle FG 110. At the inquest he testified that when he got out, despite the police radio communications having referred to JC, he was not sure it was JC as there were reports of a male person with a knife, and he did not hear First Class Constable Cleghorn's radio communication where she referred to JC by name.[81]

133. First Class Constable Wyndham was the second police officer to get out of a police vehicle. When he got out, on the passenger side, he was several metres behind JC on her left side and JC was facing away from him. First

[80] Exhibit t12.
[81] ts 546.

Class Constable Wyndham ran along the left-hand side of his police vehicle FG 110 towards JC and when he reached the bonnet of the vehicle, JC turned to face him.[82]

134. At about the time First Class Constable Wyndham was near the bonnet of FG 110 or just beyond it, he pulled out his firearm using his right hand. At the time he pulled out his firearm, JC was in the process of turning towards him.[83]

135. At the inquest First Class Constable Wyndham testified that pulling his firearm was a split second and instinctive decision.[84]

136. First Class Constable Wyndham rationalised this decision in his mind because JC was armed with a knife and scissors and had been refusing or ignoring demands to put the weapon down and she was in close proximity to Senior Constable Barker. However, both before and after exiting his car, First Class Constable Wyndham did not hear anyone else giving commands, other than the one he heard over the radio.[85]

137. Meanwhile, Senior Constable Barker, having already gotten out of his police vehicle FG 105, being the first to do so, was initially several metres behind JC to her right, standing near the kerb of 39 Petchell Street. He had not pulled out his firearm or his taser. He was attempting to see if JC would respond to him. Essentially, he was hoping to talk her down. Senior Constable Barker was, on First Class Constable Wyndham's estimates, initially about five to seven metres from JC.[86]

138. Close to this time First Class Constable Wyndham, standing approximately opposite to JC, issued his own command to her, shouting to the effect of: "*put the knife down*". He did not use her name.[87]

139. First Class Constable Wyndham's firearm was pointed at JC. JC reacted by raising her right hand which held the knife stopping about level with her chest line and waved it bending her arm from her elbow to her hand one or two times. She took two steps briskly back and then turned and started

[82] Exhibit 12; ts 493 to 495.
[83] ts 495 to 497.
[84] ts 496 to 497.
[85] ts 490 to 496.
[86] ts 391 to 391; ts 505.
[87] ts 498.

walking away from First Class Constable Wyndham, with the knife back down by her side.[88]

140. First Class Constable Wyndham said he felt scared by JC's arm motions and her two steps backwards. He explained that at the time, he did not consider that she was trying to retreat away from him, because it all happened very quickly. He did not feel safer when she moved away from him because she still had the knife in her right hand. He was also aware that she had a pair of scissors in her left hand.[89]

141. Between the time that JC took two steps briskly back and when she turned around to walk towards the kerb on the right-hand verge, First Class Constable Wyndham then yelled out four commands: *"put [a] knife down", "get on the ground", "you're under arrest. Get on the ground"*, and then: *"put the fucking knife down".* JC did not respond to any of those commands. First Class Constable Wyndham estimated that at this stage the distance between him and JC was about five metres.[90]

142. First Class Constable Wyndham tried to keep pace with JC as she was walking away, following her and leaving a five-metre distance (approximately) between them.[91]

143. Senior Constable Barker was also moving towards JC at this time. He ended up, on First Class Constable Wyndham's estimation, about three to four metres from JC.[92]

144. When JC got to the right-hand kerb of Petchell Street, she turned and started walking back to First Class Constable Wyndham. JC's turn meant she was facing towards First Class Constable Wyndham, looking directly at him. First Class Constable Wyndham began to back up and called out to JC: "*drop it. Drop it*". He took about three to four steps backwards. JC still held the knife in her right hand, at this time down by her side with the blade pointing out towards First Class Constable Wyndham. JC did not react to his commands; she did not drop the knife.[93]

145. As this was happening, First Class Constable Wyndham was aware of Senior Constable Barker's location, on his right-hand side, moving towards

[88] ts 497 to 502.
[89] ts 497 to 502; ts 507.
[90] ts 502 to 503; ts 510.
[91] ts 504.
[92] ts 504 to 505.
[93] ts 505 to 506; ts 508.

JC. He knew Senior Constable Barker did not have a weapon in his hand and he initially thought that Senior Constable Barker was going to try and communicate with JC to try and get her to drop the knife. As Senior Constable Barker closed in on JC, First Class Constable Wyndham thought Senior Constable Barker's position was dangerous. Senior Constable Barker's hands were up. It now appeared to First Class Constable Wyndham that Senior Constable Barker was going to try and take her on and try and grab her with his hands. It did not cross First Class Constable Wyndham's mind that the reason Senior Constable Barker had no use of force option in his hand was because he might be wanting to speak with JC in an open communication style, as opposed to issuing a command. At one point First Class Constable Wyndham saw JC turn to look at Senior Constable Barker.[94]

146. Meanwhile, Constable McLean was the third of the police officers who had got out of the police vehicle. He got out of police vehicle FG 107, and advanced towards JC from the verge in front of 34 Petchell Street. He had pulled out his taser, but not armed it. Constable McLean stopped when he was about four metres from JC, began the process of arming his taser and yelled out a warning to JC: *"drop the knife or you will be tased*". JC looked towards where Constable McLean was standing but did not react to his warning. At the inquest First Class Constable Wyndham testified that he was not aware of Constable McLean's presence until after the gunshot.[95]

147. At a later stage, but prior to the gunshot, Senior Constable Cooney, having parked FG 110, got out of the police vehicle (being the 4th police officer to do so) and went to stand behind First Class Constable Wyndham.[96]

148. Within seconds, less than a minute, four police officers had got out of their police vehicles and three of them were advancing towards JC from different angles, (one with a firearm pointed at her, one with a taser and one with his hands up). JC continued to hold the knife in her right hand and did not heed the police commands to drop the knife.[97]

The gunshot

149. I turn back to the point where First Class Constable Wyndham took about three to four steps backwards, as JC turned and started walking back towards him, with the knife in her right hand, down by her side with the blade pointing out towards him, and the scissors in her left hand also down by her

[94] ts 492 to 493; ts 508 to 509; ts 554.
[95] ts 286 to 287; ts 505.
[96] Exhibit 2, tab 13.
[97] Exhibit 12.

side and pointing out towards him, and she herself looking directly at him. Her arms were slightly bent, at about a 25-degree angle from her body.[98]

150. At the inquest First Class Constable Wyndham testified that he thought of taking more steps backwards to try and get away from JC, but that he saw Senior Constable Barker moving in from his right, towards JC, with his hands up. He did not believe he had the time to call out to Senior Constable Barker to tell him to stay back or retreat.[99]

151. First Class Constable Wyndham testified that JC then moved her right hand up, moving from a 25-degree angle to her body and then lifting it up, so the blade of the knife was pointing straight at him. He testified that her body then came towards him as follows: "*her body has come forward **like she's** going to come towards me*." (emphasis added).[100]

152. At the point at which JC moved her right hand up, she did not take a step towards First Class Constable Wyndham (or any other person), but he said that he observed a: "*forward momentum*" of her body (having regard to her shoulder, and her upper body). It was a quick movement on her part. First Class Constable Wyndham stated that at this point, the distance between him and JC was two to three metres.[101]

153. Senior Constable Barker remained within First Class Constable Wyndham's line of sight. First Class Constable Wyndham believed the distance between Senior Constable Barker and JC was under three metres, describing that distance as being: "*close*", but essentially not being sure of it. First Class Constable Wyndham's focus was on the knife. He was not focussed on her face, the hood of her jumper was up, and he did not know it was JC (meaning he did not know who the person holding the knife was before he fired his gun).[102]

154. First Class Constable Wyndham then fired his gun at JC. It was about 6.20 pm and 35 seconds. First Class Constable Wyndham testified that it was about 16 or 17 seconds from the time that he had exited his police vehicle, to the time that he fired his gun, based upon him having viewed the CCTV footage. His perception was that once JC turned away from the kerb and came back towards him, he felt like time slowed down.[103]

[98] ts 505 to 508; ts 531.
[99] Ibid.
[100] ts 508 to 509.
[101] ts 509 to 511.
[102] ts 512 to 513.
[103] ts 509 to 511; ts 516; ts 522.

155. JC was hit in the abdomen and immediately fell to the ground.[104]

156. At the inquest First Class Constable Wyndham described his firing of his gun as: "*instinct*" (as opposed to making an actual decision about it) and that: "*it just happened*". He also testified that it did not cross his mind that JC did not react to any of his commands because she might be feeling panicked with all that noise and shouting at her, and that it did not cross his mind that she might have been frozen, not understanding the commands or that she might be mentally ill.[105]

157. First Class Constable Wyndham's evidence was that he did not think about using any other use of force options (for example a taser). In considering the matter with the benefit of hindsight, he maintained there were no other steps he could have taken other than firing his gun. The absence of any other option was because, he said, JC was: "*too close to"* him.[106]

158. It is to be borne in mind that it was First Class Constable Wyndham's own actions, in advancing towards JC when he got out of the police vehicle, that resulted in him being within two to three metres of JC. Further comment on this aspect is made later in this finding under the heading: *First Class Constable Wyndham ran towards the threat*.

159. When he heard the gunshot, Constable McLean had begun to turn his taser on, but he had not yet activated it.[107]

160. The evidence of other witnesses immediately before the gunshot is important. It concerns the question of whether JC took a step forward towards First Class Constable Wyndham before he fired the shot. While First class Constable Wyndham did not testify that JC lunged at him, the matter was put into issue and JC's family maintain that JC did not lunge at him.

161. The civilian who made the triple 0 call from Assen Street described JC just before the gunshot as follows:

> "*I could still see the knife in the person's left hand as it was their hand closest to me.*

[104] Exhibit 1, tab 8.
[105] ts 516; ts 518 to 519.
[106] ts 517.
[107] Exhibit 2, tab 11.

The person then raised both arms out to their side at waist level slightly to the front of their body and took a step forward toward the Officers.

That was when I heard a bang." [108]

162. The other police officers were questioned at the inquest as to JC's movements immediately before the gunshot. A number of them could not recall or could not see her feet from where they were positioned. I accept that it happened very quickly. There is nothing untoward in the lack of recollection.

163. The locations of JC and First Class Constable Wyndham, Senior Constable Barker and Constable McLean at the time of the gunshot are noted on the excerpt of the map at Figure A (Exhibit 8.1) above, to the best of various police officers' recollections.

164. By that evidence, Senior Constable Barker and Constable McLean were the two that were closest to JC (other than First Class Constable Wyndham).

165. Constable McLean's evidence was he could not recall whether JC took a step forward immediately prior to the gunshot. He did recall JC's jaw moving from left to right, repeatedly.[109]

166. While Constable McLean gave evidence in a prior statement that JC: "*began to raise her right hand and the knife up by her side*", he did not have any memory of that at the time of giving evidence at the inquest.[110]

167. Senior Constable Barker's evidence was that immediately before the gunshot, he was focused on JC's face. He noticed she was grinding her jaw. He did not have a window of vision to see whether or not JC took a step forward.[111]

168. When questioned at the inquest, First Class Constable Cleghorn's evidence was that she did not see JC's right hand move immediately before the gunshot.[112]

169. Senior Constable Walker described the knife as twitching. He observed that JC's muscles were clenching causing the knife to make small movements.[113]

[108] Exhibit 1, tab 21.
[109] ts 290.
[110] Exhibit 2 tab 11; ts 293.
[111] ts 403 to 404.
[112] ts 43 to 44.
[113] ts 117 to 118.

170. First Class Constable Caracatsanis was not looking at JC at the time immediately before the gunshot, therefore could not comment on any reaction that JC had to First Class Constable Wyndham's command to her. He was in FG 105, looking through the windscreen, at First Class Constable Wyndham.[114]

171. Senior Constable Cooney, who was in the process of getting out of FG 110, observed a flicking or a rotation of JC's right hand, but did not see JC take a step forward (or in any direction).[115]

172. Overall, given the other attending police officers were unable to recall or see a lunge towards First Class Constable Wyndham, a significant factor if it occurred, involving not merely a small movement of her feet, it is less likely that JC lunged.

173. First Class Constable Wyndham made a number of split second decisions that day to get out of his police vehicle, to pull out his gun, to close within approximately three metres of JC and to fire the gun. The split second decision making is consistent with him arriving at the scene promptly getting out of his police vehicle and, about 17 seconds later, shooting JC.[116]

The aftermath of the shooting

174. At 6.20 pm and 43 seconds, being about eight seconds after the gunshot, the police radioed for an immediate ambulance, explaining: "*one shot fired*", and they promptly commenced first aid.[117]

175. The call was officially recorded on the St John Ambulance Patient Care Record at 6.24 pm and records reflect that the ambulance departed within one minute of this time, under Priority 1 conditions.[118]

176. At 6.29 pm, the St John Ambulance crew arrived at the scene. A police officer was applying pressure to her wound. Upon examination they found JC to be conscious, responsive to voice and able to maintain her own airway. She had an increased rate of breathing, with low oxygen saturations and a weak, rapid pulse. There was a single bullet wound to her umbilicus and no visible exit wound. Pressure was maintained on the wound. Her abdomen

[114] ts 168.
[115] ts 214 to 215.
[116] ts 491, 496 and 540.
[117] Exhibit 4, tab 5.
[118] Exhibit 5, tab 6.

was distended, and massive internal bleeding was suspected. JC was administered oxygen and fentanyl for pain.[119]

177. At 6.45 pm, the ambulance departed for Geraldton Regional Hospital. During that drive, JC's vital signs deteriorated.[120]

178. The Emergency Department Consultant Dr Colleen Taylor (Dr Taylor) of Geraldton Regional Hospital had been given advance notice of JC's arrival, and a trauma call had been made to gather a number of staff in readiness for her arrival.[121]

179. At 6.50 pm, the ambulance arrived at Geraldton Regional Hospital and JC was treated immediately. Four doctors, led by Dr Taylor, worked on JC. JC had sustained three significant injuries from the gunshot. Two were to her large blood vessels, that led to the uncontrolled haemorrhage that caused her death. These were a 2 millimetre size hole in her right external iliac artery, and a virtually complete transection of her right common iliac vein. The third injury from the gunshot was a partial transection of the mid transverse colon.[122]

180. Despite their best efforts, with both emergency medical and surgical interventions, JC did not survive. The loss of her cardiac output and subsequent cardiac arrest was due to the haemorrhage of her circulating blood volume, leading to the lack of oxygen delivery to her vital organs such as the heart muscle and the cardiac and respiratory control centres in the brain.[123]

181. At 7.27 pm on 17 September 2019, after there had been no cardiac output for 20 minutes, resuscitation efforts ceased, and Dr Taylor declared JC life extinct.[124]

182. I am satisfied that the clinicians at Geraldton Regional Hospital, led by Dr Taylor used all appropriate skills and efforts in their endeavours to resuscitate JC. JC's injuries were not survivable. I have taken into account the opinion of the independent expert Consultant Trauma Surgeon at Royal Perth Hospital Dr Sudhakar Rao, who subsequently reviewed JC's care at Geraldton Regional Hospital and concluded as follows:

[119] Ibid.
[120] Ibid.
[121] Exhibit 4, tab 13; ts 892 to 893.
[122] Exhibit 5, tab 6; Exhibit 14.
[123] Exhibit 5.6; Exhibit 4, tab 13; Exhibit 14; ts 916 to 917.
[124] Exhibit 5.6.

> "*…. the seriousness of the injuries to 2 major blood vessels resulted in massive haemorrhage and severe derangement of JC's physiology and biochemistry. In context of the health care and resources available in Geraldton in 2019, JC had very little chance of survival in the first few hours. JC would almost certainly have succumbed to organ failure and septicaemia in the ensuing few days even if she survived the initial cardiac arrest and blood loss to be transferred to Royal Perth Hospital*."[125]

CAUSE AND MANNER OF DEATH

Cause of death

183. Under s 25(1)(c) of the Coroners Act I must find, if possible, the cause of JC's death.

184. On 23 September 2019 the forensic pathologist Dr DM Moss (Dr Moss) made a post mortem examination at the State Mortuary on JC's body. The examination revealed a large gunshot wound to the abdomen, with associated injury to the iliac artery, iliac vein and large bowel. At the conclusion of the examination on that date, Dr Moss formed the opinion that the cause of death was gunshot wound to the abdomen. Further examinations of histology, toxicology and neuropathology were ordered.[126]

185. The results of these subsequent examinations had no bearing on the cause of death. Specifically on 6 January 2020 Dr Moss, after reviewing the further examination results, determined that his opinion on JC's cause of death remained unchanged.[127]

186. I accept and adopt Dr Moss' opinion on JC's cause of death. **I find that JC's cause of death was gunshot wound to the abdomen**.

Toxicological analysis

187. The final results of the toxicology testing, that became available on 1 November 2019, had bearing on the question of whether any of JC's actions on 17 September 2019 may have been influenced by her intoxication. The results of the toxicology testing were subsequently analysed by the consultant chemical pathologist and toxicologist Dr Jonathan Grasko (Dr Grasko) who produced a report and gave evidence at the inquest.[128]

[125] Exhibit 14; ts 906 to 923.
[126] Exhibit 1, tab 5.
[127] Ibid.
[128] Exhibit 1, tab 6; Exhibit 4, tab 15; ts 925 to 934.

188. In connection with substances referred to in JC's toxicology report, and excluding the medications used to treat her after the gunshot wound, Dr Grasko opined as follows:

a) in respect of the methylamphetamine found at a concentration of 0.04 milligrams per litre, and its metabolite amphetamine found at a concentration of 0.01 milligrams per litre, in the ante mortem blood sample, and noting they are central nervous stimulants, the amounts are nonetheless: "*relatively low*", though he would expect: "*some .... element of intoxication*"; They are suggestive but not conclusive of intoxication; The time frame from use would depend on the dose and the number of times the drug was ingested; Typically, this concentration may be seen after one to two days, following a single ingested dose;[129]

b) In respect of the tetrahydrocannabinol (the principal active constituent of cannabis) found at a concentration of 6.0 micrograms per litre, in the ante mortem blood sample, and noting that it has a sedating, disinhibiting effect that can increase the chance of an emotional rather than rational response, the concentration was: "*quite a bit higher*" and: "*you would expect a level of intoxication*"; it may have resulted in JC being: "*overly emotional*", which may have led to an: "*over exaggerated outburst*". Typically, this concentration may be seen around four to eight hours after ingestion.[130]

189. At the time of the shooting, it is likely that JC was minimally affected by the methylamphetamine that she appears to have ingested approximately one or two days previously. However, the more recently ingested cannabis was having a significant impact upon her, especially given her tendency towards mood dysregulation and impulsivity.[131]

190. The possibility of a drug induced psychosis at the time of the shooting cannot be discounted, given her mental health history.

Manner of death

191. Under s 25(1)(b) of the Coroners Act I must find, if possible, the manner of JC's death.

[129] Exhibit 4, tab 15; ts 928.
[130] Exhibit 4, tab 15; ts 929.
[131] Exhibit 4, tab 15; ts 931.

192. The function and purpose of s 25(1)(b) of the Coroners Act was considered in ***Re the State Coroner; Ex parte Minister for Health*** [2009] WASCA 165 [42]:

> "*s 25(1)(b) confers on the coroner the jurisdiction and obligation to find, if possible, the manner in which the deceased happened to die. This does not refer only to the means or mechanism by which the death was suffered or inflicted. It extends to the circumstances attending the death. In my opinion, a construction of s 25(1)(b) which entitles and requires the coroner to find, if possible, by what means and in what circumstances the death occurred reflects the public interest which is protected and advanced by a coronial investigation.*"

193. On 20 February 2020, First Class Constable Wyndham was arrested and charged with the murder of JC in contravention of s 297 of the *Criminal Code*. He pleaded not guilty.

194. The trial of the matter occurred in October 2021.

195. On 22 October 2021, the jury returned a verdict of not guilty in relation to the murder and not guilty to the alternative offence of manslaughter. A judgment of acquittal was entered.

196. By reason of s 53(1)(a) of the Coroners Act, this inquest could not be held until those criminal proceedings were concluded. The associated coronial investigation therefore awaited the conclusion of the criminal proceedings.

197. By reason of s 53(2) of the Coroners Act, my finding as to the manner of JC's death must not be inconsistent with the result of the criminal proceedings, namely, the acquittal.

198. **I find that the manner of JC's death was lawful homicide**.

199. Findings and comments on the circumstances attending JC's death appear under the below heading: *Adverse findings and comments*.

ADVERSE FINDINGS AND COMMENTS

Principles in making findings and comments

200. As noted previously in this finding, pursuant to 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.

201. The power under s 25(2) is ancillary to my role to make relevant findings as to the death under s 25(1): ***Re State Coroner*** [2009] WASCA 165 [52].

202. While the power under s 25(2) is ancillary, it does not diminish that power. Various submissions were made about the breadth of this power.

203. The power is governed by the statutory language. That expressly enables me to comment on: "***any*** *matter* ***connected with*** *the death*" (my emphasis). The test of: "*connected with*" requires a material connection with the death, but it is not of itself limited to specific matters. Any matter with a material connection to the death may be commented upon. Section 25(2) gives examples of what may be connected with the death, but it is not exhaustive.

204. I consider that it is important to comment on the manner in which JC came to die, being the circumstances attending her death, and in particular, the actions of attending police officers and their compliance with policies and procedures, being matters of safety.

205. That JC died because she was fatally shot by First Class Constable Wyndham, while a serving police officer, cannot be ignored. The training, policies and procedures that were undertaken that led to decisions made by him and his colleagues on that day are materially connected with JC's death.

206. Further, the aftermath of JC's death and the steps taken by WA Police (or not taken) in connection with de-briefing the attending police officers and revising training are important in considering the safety of the public and this Court's role in death prevention.

207. As noted previously in this finding I am also conscious of s 53(2) of the Coroners Act which precludes me making any finding on this inquest which is inconsistent with the "*result*" of the criminal proceedings, which in this case means the acquittal: ***Re the State Coroner; Ex parte Loohuys*** [2019] WASC 147 [32].

208. I cannot make a comment or a finding that would controvert the jury's acquittal.

209. However, I am not precluded from exploring the circumstances of JC's death on 17 September 2019 so as to identify, as I must, if possible, under s 25(1)(b) of the Coroners Act, how the death occurred.

210. Nor does s 53(2) prevent me making any comment on First Class Constable Wyndham's actions. The: "*result*" of the criminal trial does not extend to the particular findings of fact, or to the reasoning by which the result was achieved: ***Re the State Coroner*** [2019] WASC 147 [33].

211. Applied here, by reason of ss 25(5) and 53(2), I cannot frame my comments and my findings in such a way as to suggest that First Class Constable Wyndham (or any other person) was guilty of an offence. The findings as to how JC's death occurred, and the cause of death cannot be inconsistent with the result that First Class Constable Wyndham is not criminally liable for causing JC's death by murdering her or committing manslaughter: see ***Re the State Coroner*** [2019] WASC 147 [34].

212. While I am conscious that the jury must have accepted First Class Constable Wyndham's defence of self-defence, that does not mean that any comment on First Class Constable Wyndham's conduct is necessarily inconsistent with that finding of self-defence, or otherwise impermissible under s 53(2).

213. Section 248(4) of the *Criminal Code* provides that a person's harmful act is done in self-defence if:

a) the person believes the act is necessary to defend the person or another person from a harmful act, including a harmful act that is not imminent;

b) the person's harmful act is a reasonable response by the person in the circumstances as the person believes them to be; and

c) there are reasonable grounds for those beliefs.

214. The relevant act here is First Class Constable Wyndham's firing of the gun at JC. Implicit within the verdict of the jury was that they determined that:

a) First Class Constable Wyndham believed his firing of the gun was necessary to defend himself or another person from a harmful act;

b) First Class Constable Wyndham's firing of the gun was a reasonable response by him in the circumstances as he believed them to be; and

c) there were reasonable grounds for those beliefs.

215. While the implicit findings as to self-defence are not part of the: *"result"* and therefore, s 53(2) does not expressly prevent me making findings that

contradict those elements of self-defence, their connection with the result is such that findings of a direct nature that contradict those elements, thereby contradicting the acquittal, are outside the scope of my role.

216. A finding of self-defence, which must have been implicit in the jury's acquittal, did not require the jury to be satisfied that First Class Constable Wyndham had no other option, as maintained by First Class Constable Wyndham at the inquest, and subsequently submitted through his legal counsel.[132]

217. It simply required the jury to be satisfied that First Class Constable Wyndham had the requisite belief, his response was a reasonable response in the circumstances as he believed them to be, and there were reasonable grounds for those beliefs.

218. With those principles in mind, I deal now with the adverse findings or comments suggested by Counsel Assisting and the legal counsel for the interested persons.

219. While I have a duty under s 44(2) to consider submissions made by an interested person about findings adverse to them, I am under no obligation to consider the submissions made by an interested person as to further adverse findings that should be made. However, while I am under no obligation to do so, I have carefully considered the additional adverse findings suggested by the interested persons, through their legal counsel.

220. In making the findings and comments below I have, as outlined previously, been conscious of not engaging in hindsight bias. After having dissected the last minute of JC's life over a two week inquest, I appreciate that there is a risk of perceiving events very differently to how the police officers perceived them on the day, when in reality those events occurred quickly and in a heightened state of emotion for many involved.

Health Entities and witnesses

221. Counsel Assisting and the interested persons did not submit that any adverse findings or comments ought to be made in respect of any of the health-related entities or witnesses.

222. As referred to previously in this finding, the quality of JC's discharge from Sir Charles Gairdner Hospital on 13 September 2019 was subsequently

[132] ts 517 to 519; First Class Constable Wyndham's Submissions dated 23 August 2024 [64] and [111].

reviewed by A/Professor Hussain, and the quality of JC's treatment at Geraldton Regional Hospital on 17 September 2019 was subsequently reviewed by Dr Rao. Both clinical experts provided reports to the coroner and gave evidence at the inquest on the matter of the quality of JC's medical care and treatment.

223. I accept their opinions and therefore make no adverse findings or comments in respect of any of the health-related entities or witnesses.

Internal Affairs and Independent Panel Investigations

224. I note, for completion, the outcomes of the various Internal Affairs Unit investigations in relation to First Class Constable Wyndham, that occurred after his criminal trial as follows:

a) On 7 December 2021, a report was completed by the Internal Affairs Unit, and the actions of First Class Constable Wyndham were referred to the Independent Review Panel for consideration as to whether those actions departed from the principles outlined in WA Police Use of Force policies and tactical training requirements as detailed in Mr Markham's initial report dated 11 September 2020 (referred to previously in this finding) and evidence provided in the Supreme Court trial;[133]

b) On 21 April 2022, a supplementary report was completed by the Internal Affairs Unit to further assist the Independent Review Panel, with the intention of capturing additional comments and observations made by Mr Markham in his supplementary report to the Internal Affairs Unit, subsequently provided to the coroner, dated 13 April 2022. In the Internal Affairs Unit supplementary report, the following was noted:

i. Mr Markham's references to First Class Constable Wyndham exacerbating and creating the potential lethal situation by closing to with three metres of JC;

ii. Mr Markham's advice that there was no consideration by First Class Constable Wyndham to tactical disengagement or the traditional strategies and tactics of cordon, contain, negotiate and resolve, referred to in the WA Police Use of Force policy

[133] Exhibit 4, tab 2.

and the Situational Tactical Options Model training (referred to later in this finding);

iii. Mr Markham's conclusion that these actions were not in accordance with the Operational Skills Training Faculty training and guidelines.[134]

c) The Internal Affairs Unit Supplementary Report noted the determinations of an Internal Affairs Evidence Assessment Meeting that First Class Constable Wyndham failed to apply the options in his Situational Tactical Options Model training and thereby breached policy by not complying with the WA Police Use of Force policy for failing to assess his proximity, failing to tactically disengage, failing to cordon and contain (in that he created the threat to himself) and failing to negotiate (having regard to the approximately 16 seconds from getting out of his police vehicle and firing his gun).[135]

d) The Internal Affairs Unit Supplementary Report also noted that First Class Constable Wyndham accepted those findings, and outlined the further, planned, bespoke training for him. At the inquest First Class Constable Wyndham confirmed he told WA Police that he accepted those findings, but later in evidence clarified that he accepted the fact those findings were made (as opposed to accepting the substance of them). The tenor of his evidence overall was that he did not accept the substance of those findings;[136]

e) Ultimately the Internal Affairs Unit Supplementary Report concluded that the matter was to be referred to the Independent Review Panel for consideration of Outcome and Sanction.[137]

225. On 26 April 2022 the Independent Review Panel decided that an Assistant Commissioner's Warning Notice should be issued to First Class Constable Wyndham (the other referred options, not preferred, were a disciplinary charge or a Commissioner's Loss of Confidence proceeding, both under the *Police Act* 1892). At the inquest First Class Constable Wyndham confirmed he had received the Warning Notice.[138]

[134] Ibid.
[135] Ibid.
[136] Exhibit 4, tab 2; ts 529 to 531; ts 558; ts 562.
[137] Exhibit 4, tab 2.
[138] Exhibit 4, tab 2; ts 558.

226. I am relevantly informed, though not bound, by the outcomes of the Internal Affairs Unit and Independent Review Panel investigations and outcomes. The relevance is in the following areas:

a) Whether First Class Constable Wyndham's reviewed actions fell short of the expectations outlined in relevant WA Police policies, guidelines and/or training (together referred to as WA Police expectations) – I am satisfied that his actions did fall short of WA Police expectations; and

b) Whether WA Police took steps to review and reflect upon the incident to better understand it, and to address deficiencies identified in First Class Constable Wyndham's reviewed actions – I am satisfied that they did this, in connection with First Class Constable Wyndham, including by way of a sanction and arrangements for bespoke training.

227. My comments that follow in this finding take account of WA Police's expectations of police officers attending an incident such as the one involving JC, within the context of the relevant policies, guidelines and/or training. They are made in order for me to address the circumstances attending JC's death, comment on matters connected with the death, consider whether JC's death was preventable, and make recommendations directed towards avoiding a death in similar circumstances.

First Class Constable Wyndham ran towards the threat

228. Police Officers are trained to maintain a safe distance of seven metres from a person who is armed with a knife, so as to allow for sufficient time to respond with an appropriate tactical option. At the inquest Mr Taylor explained that this is an ideal range and not the absolute rule.[139]

229. JC was holding a 30 centimetre knife in her right hand, that appears to be a kitchen knife, most likely a bread knife having regard to its serrated edge.[140]

230. Counsel Assisting submits it is open to me to make an adverse finding that First Class Constable Wyndham ran towards the threat posed by JC and that he did not keep a safe distance from JC.

231. Counsel Assisting relies on, amongst other things, the short time between First Class Constable Wyndham's arrival and shooting, his split-second

[139] Exhibit 3, tab 11; ts 670.
[140] Exhibit 1, tab 16; Exhibit 3, tab 1; ts 478 to 480.

decisions and his decision to close the distance between him and JC to about two to three metres despite the effective cordoning and containment of JC.[141]

232. These submissions are supported by JC's family.[142]

233. First Class Constable Wyndham opposes such a finding saying it is not open as a finding under s 25(1) or as a comment. In particular, he relies on the evidence of Mr Taylor and Mr Markham, to the effect that WA Police officers are expected to have to be able to close a threat down and gain control of the situation. First Class Constable Wyndham says the situation required him to act urgently, in response to the serious threat posed by JC. He described his approach towards JC, when he got out of the police vehicle, as a: "*jog*".[143]

234. Further, First Class Constable Wyndham emphasises that the so-called safe distance of seven metres is a matter for the relevant officer to subjectively assess and is dependent on the circumstances. He draws attention to Mr Markham's evidence at the inquest, that JC was armed with an edged weapon and needed to be arrested and controlled. He also contends that a finding that he fired instead of moving back would encroach upon the jury verdict, as to his mind there were no other options.[144]

235. I have considered these submissions.

236. In his report to the coroner Mr Markham distinguishes between this incident, and the case of an Active Armed Offender armed with a knife or an edged weapon. He explains the role of a police officer in an Active Armed Offender situation as follows:

> "*AAO [Active Armed Offender] incidents are high risk and often occur in an uncontrolled and unpredictable environment which requires police officers to intervene decisively and rapidly whilst demonstrating a high degree of situational awareness.*"[145]

237. In the case of an Active Armed Offender, the police response departs from the traditional strategy and tactics of cordon, contain, negotiate and resolve. Failure to intervene decisively and rapidly in an Active Armed Offender

[141] Counsel Assisting's Submissions dated 2 August 2024 [2]-[9].
[142] AJ's and CJ's Submissions dated 23 August 2024 [21]; B Clarke's Submissions dated 23 August 2024 [6].
[143] First Class Constable Wyndham's Submissions dated 23 August 2024 [20]-[33]; ts 495; ts 504.
[144] First Class Constable Wyndham's Submissions dated 23 August 2024 [56]-[70]; ts 721.
[145] Exhibit 3, tab 11.

situation increases the likelihood of placing innocent persons at risk of serious injury or death.[146]

238. However, in the case of JC, Mr Markham's view was that it was not an Active Armed Offender incident, and that First Class Constable Wyndham should have been cognisant of that in terms of tactics to be employed to seek to reduce the threat and gain control:

> "*[JC] is not actively causing the immediate death or serious injury of any victims, there are sufficient police resources in attendance such that the situation can be contained and in doing so the risk to members of the public can be substantially reduced*."[147]

239. At the inquest Mr Taylor also testified that in the case of JC, it was not an Active Armed Offender incident.[148]

240. Mr Markham considered that although JC was armed with a large knife in a public street, First Class Constable Wyndham should have been aware that this was not an Active Armed Offender incident in terms of the tactics to employ to reduce the threat and gain control of JC. I am satisfied that JC was not an Active Armed Offender and this was not an Active Armed Offender incident.[149]

241. On balance I have accepted Mr Markham's evidence that JC was in possession of an edged weapon and that she needed to be arrested and controlled, and that it was expected that police officers would draw force options. However, she did not need to be treated as an Active Armed Offender, and it was not necessary to intervene rapidly (meaning within a number of seconds). There were eight police officers present, and four police vehicles containing her. It was neither necessary nor desirable for a police officer to immediately run towards JC in those circumstances.

242. It follows that I reject First Class Constable Wyndham's submission that there were no other options, and therefore reject his submission that it encroaches upon the jury's verdict.

243. I am satisfied that First Class Constable Wyndham ran towards the threat posed by JC and that he did not keep a safe distance from JC.

---

[146] Ibid.
[147] Exhibit 3, tab 11; ts 754.
[148] ts 688.
[149] Exhibit 3, tab 11.

First Class Constable Wyndham should have considered communication with Senior Constable Barker

244. At the inquest First Class Constable Wyndham's evidence was that he initially concluded that JC was a threat because of Senior Constable Barker's proximity to her without him holding a weapon. First Class Constable Wyndham did not believe he had time to call out to Senior Constable Baker to caution him to stay back or retreat. He did not think of, or consider, that option at the time. He believed he could not have known what plan Senior Constable Barker had, nor what he was doing at that time.[150]

245. Counsel Assisting submits it is open to me to make an adverse finding that First Class Constable Wyndham did not consider, when he could have, communicating with Senior Constable Barker to reduce any threat he perceived to Senior Constable Barker.[151]

246. Counsel Assisting draws attention to the desirability for First Class Constable Wyndham to, ideally, have fully assessed the situation and to have, at least, attempted communications with Senior Constable Barker to better assess the situation.[152]

247. These submissions are supported by JC's family.[153]

248. First Class Constable Wyndham opposes such a finding, submitting that he did not and could not have known what Senior Constable Barker was planning. He draws attention to his evidence that he did not speak to Senior Constable Barker because he was so focused on JC, although with the benefit of hindsight, he could have done that differently. Through his counsel, First Class Constable Wyndham cautions against hindsight bias.[154]

249. With the benefit of hindsight, it would have been ideal for First Class Constable Wyndham to fully assess the situation. However, I separate the ideal position from the events as they transpired on the day of the incident and put the ideal position to one side.

[150] ts 431; ts 508; ts 539.
[151] Counsel Assisting's Submissions dated 2 August 2024 [10]-[15].
[152] Counsel Assisting's Submissions dated 2 August 2024 [14]-[15].
[153] AJ's and CJ's Submissions dated 23 August 2024 [21]; B Clarke's Submissions dated 23 August 2024 [7].
[154] First Class Constable Wyndham's Submissions dated 23 August 2024 [85], [96], [97], [102]; ts 492 to 493; ts 539.

250. I am nonetheless satisfied that, even if he had no time to fully assess the situation, First Class Constable Wyndham did not consider, when he could have, at least communicating with Senior Constable Barker to reduce any threat he perceived to Senior Constable Barker.

First Class Constable Wyndham put himself in a situation where he perceived the need to fire

251. Counsel Assisting submits it is open to me to find that by reason of First Class Constable Wyndham having put himself within an unsafe distance of the threat or his failure to consider covering himself if he were to be close to JC, he put himself in the situation where he perceived he needed to fire.[155]

252. This is said to follow from the other two adverse findings which Counsel Assisting submits ought to be made, and that I have now made.

253. These submissions are supported by JC's family.[156]

254. First Class Constable Wyndham opposes such a finding, on grounds similar to his opposition to the other two adverse findings sought by Counsel Assisting. He also relies upon the potential for a Body Alarm Reaction on his part (identified by him not hearing anyone else saying anything during the incident). He also contends that such a finding would encroach on the jury's verdict.[157]

255. At the inquest Mr Markham testified that he did not think there was any necessity for First Class Constable Wyndham to close to within three or four metres of JC immediately having exited the police vehicle, and further that:

> "*I cannot see why he would not have remained at a distance of around seven metres, and potentially, if the vehicle was there, stay beside the vehicle, use the vehicle as a barrier to – some extra cover. Again, time, reaction.*"[158]

256. In his supplementary report dated 13 April 2022 directed to the Internal Affairs Unit, subsequently provided to the coroner Mr Markham opined that First Class Constable Wyndham's decision to select and use a firearm as a tactical option for: "*Draw and Cover*" purposes in an attempt to

[155] Counsel Assisting's Submissions dated 2 August 2024 [16]-[17].
[156] AJ's and CJ's Submissions dated 23 August 2024 [21]; B Clarke's Submissions dated 23 August 2024 [8].
[157] First Class Constable Wyndham's Submissions dated 23 August 2024 [108]-[112]; ts 493.
[158] ts 728.

reduce the threat and gain control of JC was in accordance with the Operational Safety and Tactics Training Unit's training and guidelines.[159]

257. Mr Markham posited that First Class Constable Wyndham's urgency to close in on JC appears to have been predicated on the autonomous actions of Senior Constable Barker and the unpredictable behaviour of JC, causing him to have grave concerns for Senior Constable Barker's safety. However, Mr Markham opined that, having drawn his firearm and closing: "*so quickly*" to within approximately three metres of JC whilst she presented as a lethal threat were actions not in accordance with the Operational Safety and Tactics Training Unit's training and guidelines. I accept this categorisation.[160]

258. I turn now to Body Alarm Reaction. In his first report to the coroner Mr Markham outlines the Body Alarm Reaction training provided by the Operational Safety and Tactics Training Unit, for new recruits. Mr Markham explains that Body Alarm Reaction is a complex and nearly instantaneous physiological response to high stress, such as the perception of life-threatening danger, for example the threat of attack from a subject who is armed with an edged weapon.[161]

259. Mr Markham outlined a number of physio-psychological effects of body alarm reaction such as tunnel vision, auditory exclusion or occlusion, shortening or distortion of perceived distance, exaggeration of the size of the perceived threat and a distorted perception of time such that events are perceived as if in: "*slow motion*". He also outlined a number of measures, forming part of police training, to minimise the effects of Body Alarm Reaction.[162]

260. At the inquest Mr Markham had regard to the evidence of First Class Constable Wyndham not having heard (or been aware of) Constable McLean's command to JC, to drop the knife or she would be tasered, and posited that it was probably as a result of Body Alarm Reaction. He was also questioned about the other physio-psychological effects of Body Alarm Reaction, as described above, insofar as they applied to the evidence of First Class Constable Wyndham's reactions and Mr Markham's evidence was that they are consistent with a Body Alarm Reaction.[163]

[159] Exhibit 3, tab 11.
[160] Ibid.
[161] Ibid.
[162] Ibid.
[163] ts 736. to 738.

261. I have taken account of Mr Wyndham's submission. The matter of Body Alarm Reaction is explored further, below, under the heading: *Whether First Class Constable Wyndham's honest perception that JC lunged at him was objectively mistaken*.

262. I have considered whether this adverse finding would encroach on the jury's verdict but am satisfied that it would not. Section 53(2) prevents me from making findings that contradict the acquittal itself. However, this provision does not prevent me from making findings that contradict any findings of fact made by a jury that may have led to the acquittal: ***Re the State Coroner*** [2019] WASC 147 [33].

263. It follows from my previous findings that JC was not an Active Armed Offender, that it was not necessary to intervene within a number of seconds, that First Class Constable Wyndham ran towards the threat posed by JC without at least considering communication with Senior Constable Barker to reduce any threat, that First Class Constable Wyndham put himself within an unsafe distance of JC, and therefore put himself in the situation where he perceived he needed to fire.

Whether First Class Constable Wyndham's honest perception that JC lunged at him was objectively mistaken

264. In his evidence during the criminal proceedings, First Class Constable Wyndham testified as follows in respect of JC's movement immediately before he shot her:

> "*She raised the knife up and out like that and then her body's come forward towards me **like she's** going to lunge at me ….*"[164] **(emphasis added)**

265. Ms B Clarke submits that it is open to the Court to make an additional adverse finding that First Class Constable Wyndham's honest perception that JC lunged at him was objectively mistaken and that the Court can positively find that JC did not lunge towards any of the officers.[165]

266. As seen previously in this finding, under the heading: *The gunshot*, there was varying evidence as to whether JC stepped towards First Class Constable Wyndham. By the time of the inquest, the only evidence in support of that contention was a civilian's statement of JC taking a step forward

[164] Exhibit 3, tab 1.
[165] B Clarke's Submissions dated 23 August 2024 [9]-[12].

immediately before the gunshot. Also as noted previously in this finding under the same heading, there was varying evidence about movements of JC's right hand while she held the knife.[166]

267. At the inquest, First Class Constable Wyndham did not give evidence that JC took a step towards him, nor that she: "*lunged*" at him, but as outlined previously, gave evidence that JC moved her right hand up and there was a: "*forward momentum*" of her body (having regard to her shoulder and her upper body) when the distance between him and JC was two to three metres.[167]

268. First Class Constable Wyndham was then questioned at the inquest about whether there was a: "*lunge*" by a number of the counsel for the interested persons. He accepted, based upon him having viewed CCTV footage, that it does not show a lunge.[168]

269. It is to be borne in mind that First Class Constable Wyndham did not testify that JC lunged at him at the inquest. Essentially his evidence was that the moving of JC's right hand up, and the forward momentum of JC's upper body, while she was stationary (previously described) was: "*like*" she was going to lunge at him. Meaning he perceived it in that way. He did not accept that his: "*perception*" of JC lunging could be wrong.[169]

270. This brings into focus the likely impacts of Body Alarm Reaction, a state that was recognised, at the inquest, by Chief Psychiatrist Dr Nathan Gibson (Dr Gibson) as being similar to: "*fight-flight-freeze responses*". Dr Gibson gave the examples that included persons losing focus on the broader environment, becoming fixed on the particular issue at hand, and feeling like things are going in slow motion.[170]

271. Mr Markham outlined the WA Police Use of Force policy, that provides direction and guidance in regard to the justification for police officers to use reasonable force in the management of conflict situations where there is a need to reduce a threat and gain control of a subject. He explained its context as follows:

> "*The WA Police Force Use of Force policy and the [Situational Tactical Options Model] have been developed and aligned to Western Australia's*

[166] Exhibit 1, tab 21.
[167] ts 509 to 511.
[168] ts 608 to 616.
[169] ts 616.
[170] ts 639.

> *legislative standards in order to support members in their decision making and the legitimacy for them to use reasonable force in appropriate circumstances, that is, only when they are lawfully justified to do so.*"[171]

272. In his supplementary report to the coroner, Mr Markham refers to First Class Constable Wyndham's claim of having an honestly held belief of there being an imminent risk of grievous bodily harm or death to himself, premised on a perceived movement of the knife and opines as follows:

> "*Albeit [JC] is static and there appears to have been no movement towards SC WYNDHAM, PC MCLEAN or SC BARKER, I am of the opinion that SC WYNDHAM's discharge of his firearm occurred as a result of a reactive and instinctive response to a perceived movement of the knife held in the right hand of [JC]. This reactive and instinctive response by SC WYNDHAM would appear to have been exacerbated by the effects of [Body Alarm Reaction].*" [172]

273. At the inquest Mr Markham's evidence was that he considered First Class Constable Wyndham's response in discharging his firearm came about as a result of his subjective interpretation of the threat whilst under the influence of Body Alarm Reaction. [173]

274. In connection with a movement of JC's arm holding the knife (previously described) Mr Markham's evidence was as follows:

> "*…. whatever that movement was, I suspect that that was exaggerated in Officer Wyndham's mind because of the effects of – of body alarm reaction. However, …. I do believe that he had an honestly held belief that that – that there was a movement, and he believed the threat had escalated, that there was a risk of an imminent threat to him from JC with that knife, and, instinctively, he discharged his firearm.*" [174]

275. It is not possible to tease out the extent to which First Class Constable Wyndham was affected by a Body Alarm Reaction, though I accept there was likely to be an effect.

276. I do not find that JC lunged at First Class Constable Wyndham. I am satisfied that JC remained stationary, and did not step towards him. However, it is likely that there were some movements of her arm, hand and/or shoulder that

[171] Exhibit 3, tab 11.
[172] Exhibit 3, tab 11.
[173] ts 710.
[174] ts 730 to 731.

were interpreted by First Class Constable Wyndham as a forward momentum of her upper body and therefore in his mind, there was an honestly held perception of a threat.

277. Having regard to the criminal proceedings, and the matters outlined above under the heading: *Principles in making findings and comments*, it is outside the scope of my role to make any finding on the question of whether First Class Constable Wyndham's honestly held perception of an overall threat was based upon reasonable grounds, or whether it was objectively mistaken.

Whether First Class Constable Wyndham's discharge of the firearm was reasonably necessary in the circumstances

278. Ms B Clarke submits that it is open to the Court to make an additional adverse finding that First Class Constable Wyndham's discharge of his firearm was not reasonably necessary because his conduct created the situation where he perceived he needed to discharge the firearm.[175]

279. Reference is made to Mr Markham's: "*ultimate view*" that if First Class Constable Wyndham reasonably believed that there was an imminent risk of grievous bodily harm or death to any person, with grounds to support that belief being aligned to relevant WA Police policy, then it would follow that his discharge of the firearm was justified under the Operational Safety and Tactics Training Unit's training and guidelines.[176]

280. It is submitted that this: "*ultimate view*" looks too narrowly at the: "*final frame*", and not to First Class Constable Wyndham's actions which Ms B Clarke says precipitated that action. Ms B Clarke draws attention to Mr Markham's comments about First Class Constable Wyndham's proximity to JC potentially escalating the threat, and that it may have been the stimulus to provoke a reaction which he subsequently perceived as an attack response.[177]

281. I have already found that First Class Constable Wyndham put himself in the situation where he perceived he needed to fire. In respect of this submission however, having regard to the criminal proceedings, and the matters outlined above under the heading: *Principles in making findings and comments*, it is outside the scope of my role to make any finding on the question of the reasonableness of First Class Constable Wyndham's discharge of his

[175] B Clarke's Submissions dated 23 August 2024 [13]-[20].
[176] Exhibit 3, tab 11; ts 730.
[177] Exhibit 3, tab 11.

firearm, as that has already been decided in the result of the criminal proceedings.

Whether Senior Constable Barker should have attempted to communicate and/or whether his positioning was potentially unsafe

282. Counsel Assisting submits it is open to the Court to make an adverse comment that Senior Constable Barker could have attempted communications with First Class Constable Wyndham about his intentions with JC.[178]

283. Counsel Assisting further submits that it is open to the Court to find that while Senior Constable Barker considered that JC was not a threat to him, his positioning was potentially unsafe in the eyes of other police officers (as not all of them knew of his prior interactions with JC, and none of them knew of his intention to draw on that prior relationship to try and talk to JC).[179]

284. To some extent, these submissions are supported by First Class Constable Wyndham who submits that Senior Constable Barker's actions were not orthodox or to be expected, they were not consistent with training, and they had not been communicated to the other police officers. Referencing Mr Markham's evidence, First Class Constable Wyndham also submits that if Senior Constable Barker had communicated his intentions, it would have assisted other police officers by way of information or awareness.[180]

285. Senior Constable Barker opposes such a comment on the grounds that communications prior to attendance at the scene were hard over the police radio, he did not believe it was JC until he saw her, communications on the ground were unnecessary given he was not in an unsafe position, and he was not aware (and should not have been aware) that First Class Constable Wyndham was escalating the situation by jogging towards JC and drawing his firearm.[181]

286. JC's family also opposes such a comment.

287. AJ and CJ submit that Senior Constable Barker had a plan to engage with JC in a meaningful manner (and that he was the only police officer to do so). They draw attention to Senior Constable Barker's empathy and his caring

[178] Counsel Assisting's Submissions dated 2 August 2024 [18]-[24].
[179] Ibid.
[180] First Class Constable Wyndham's Submissions dated 23 August 2024 [73], [80], [85], [96], [98].
[181] Senior Constable Barker's Submissions dated 22 August 2024 [2].

and compassionate approach to JC. Had Senior Constable Barker been given more time to do so, the incident could have ended very differently they submit. Ms B Clarke submits Senior Constable Barker was not in an unsafe position and Senior Constable Barker was not aware First Class Constable Wyndham was on the street prior to the shots being fired. She too appreciates Senior Constable Barker's efforts to try and communicate with JC rather than drawing a use of force option.[182]

288. At the inquest Senior Constable Barker explained that he was not going to draw his firearm because it would be a barrier to communicating with JC. He testified that he did not draw his taser because a taser looks like a gun, a baton would communicate that a person is about to be struck, and OC spray was not an option for reasons he provided. Senior Constable Barker tried to speak with JC, without issuing commands, to see if she recalled him from the time he took her to the hospital on 7 September 2019, but it appears she did not hear him. Then when Senior Constable Barker was about four or five metres from JC, he heard Constable McLean call out to JC to drop the knife or she will be tasered.[183]

289. I accept Senior Constable Barker's evidence, given at the inquest, that he did not see First Class Constable Wyndham until after the shot was fired. Under the circumstances, I will not make an adverse finding to the effect that Senior Constable Barker could have attempted communications with First Class Constable Wyndham, specifically, about his intentions with JC.[184]

290. In his reviews of the incident, Mr Markham opined that Senior Constable Barker would have been entirely justified in drawing his firearm or taser as he approached JC, and that it would have been recommended and supported by his training. The decision to select and draw these as a tactical option to reduce a threat and gain control is at the discretion of an individual police officer.[185]

291. I turn to the question of whether Senior Constable Barker's positioning was potentially unsafe in the eyes of other police officers.

292. At the inquest Senior Constable Barker referred to a number of factors which reflect upon his belief that he was not in an unsafe position. He referred to

[182] AJ's and CJ's Submissions dated 23 August 2024 [21], [30]-[36]; B Clarke's Submissions dated 23 August 2024 [21]-[23].
[183] ts 399 to 401.
[184] ts 397.
[185] Exhibit 3, tab 11.

the knife being on the far side of JC, that she was at right angles to him, that his feet were facing a different direction, and that he would have been able to: "*scuttle away*" if she had turned to face him.[186]

293. Senior Constable Barker's evidence was that he thought his partner First Class Constable Caracatsanis would have known that his plan was to speak with JC due to his experience, though he accepted that with the benefit of hindsight he could have conveyed his plan to First Class Constable Caracatsanis.[187]

294. At the inquest Senior Constable Barker accepted that he came within a: "*personal distance*" of JC and he showed an understanding of how this proximity may have made the other police officers worry about him. He acknowledged that there was no way First Class Constable Wyndham could have known what his plan was. He also testified as to his feeling, at the material time, that he did not need to be protected by another police officer.[188]

295. While Senior Constable Barker's intentions were laudable, I am satisfied that he nonetheless placed himself in a position that other police officers may have perceived to be unsafe, without a use of force option. Senior Constable Barker had prior knowledge of JC's mental health issues. The rapport that he had previously established with JC when he took her to hospital on 7 September 2019 could have assisted him, but others did not know about that rapport.

296. I accept First Class Constable Wyndham's evidence given at the inquest, that from his own viewpoint, he considered Senior Constable Barker's position, as he was closing in on JC, to be: "*dangerous*". He did not know about the prior rapport between Senior Constable Barker and JC.[189]

Whether Constable McLean could have improved communication

297. Counsel Assisting submits it is open to the Court to make an adverse comment that with the benefit of hindsight, one area which might have been improved is if Constable McLean attempted communication with First Class Constable Wyndham about his position or his intentions with JC.[190]

[186] ts 401 to 402.
[187] ts 409.
[188] ts 416; ts 452.
[189] ts 508.
[190] Counsel Assisting's Submissions dated 2 August 2024 [25]-[26].

298. JC's family supports this submission.[191]

299. WA Police opposes such a finding, including because Constable McLean did, through the warning he shouted to JC (*"Drop the knife, or you will be tased*"), communicate with First Class Constable Wyndham; that First Class Constable Wyndham's failure to appreciate Constable McLean's position was due to First Class Constable Wyndham's situational awareness (or lack thereof) because he was suffering the effects of Body Alarm Reaction; that Constable McLean did not have sufficient time to communicate further with First Class Constable Wyndham because First Class Constable Wyndham fired his gun and it is speculative to suggest that any communication may have assisted.[192]

300. Constable McLean was the third police officer to get out of his police vehicle and had the least amount of time to act, as between him and the other two police officers who were already out. Constable McLean was aware that First Class Constable Wyndham had drawn his firearm, and at the inquest he testified that, with such awareness, he drew his taser because it was a lesser lethal force option.[193]

301. First Class Constable Wyndham was not aware of Constable McLean's location, or his command to JC or that he had drawn his taser, before he discharged his firearm. Senior Constable Barker, standing further away, did hear Constable McLean's command, and was therefore aware of Constable McLean having drawn his taser.[194]

302. In his supplementary report to the coroner Mr Markham opined that there would have been sufficient justification for Constable McLean to have discharged his taser against JC, having regard to the WA Police Use of Force policy. At the inquest Mr Markham gave evidence about the steps that could hypothetically have been taken to deploy the taser, noting however that Constable McLean still had forward momentum at the time the gun was fired, and that he wanted to stop short of going forward of First Class Constable Wyndham (self-evidently to avoid being in the line of fire).[195]

303. At the inquest Mr Markham, having regard to the training provided to police officers, posited that Constable McLean's command to JC to drop the knife

[191] AJ's and C J's Submissions dated 23 August 2024 [21]; B Clarke's Submissions dated 23 August 2024 [24].
[192] WA Police's Submissions dated 23 August 2024 [11]-[27].
[193] ts 289.
[194] ts 401 to 402; ts 505.
[195] Exhibit 3, tab 11; ts 747.

or that she would be "*tased*" would have been sufficient to alert the police officers present that he had his taser drawn, thereby serving a dual purpose of communicating with JC and with the other police officers, including First Class Constable Wyndham.[196]

304. Ideally there would have been time for Constable McLean to have attempted a more direct communication with First Class Constable Wyndham. However, the reality is that, given the few seconds available to him, with him having shouted the command to JC, that was heard by Senior Constable Barker standing on the other side of the street, I cannot criticise Constable McLean for not making a more direct approach to First Class Constable Wyndham. I accept that Constable McLean's shouted command was not heard by First Class Constable Wyndham due to the likely effects of Body Alarm Reaction.

WA Police missed opportunities to effectively train its officers

305. Counsel Assisting submits it is open to the Court to make an adverse finding that the eight police officers that attended Petchell Street were not sufficiently trained as to how to deal with the situation as a team. Reliance is placed on the lack of coordination amongst the eight officers and the lack of communication between the three police officers who were out of their police vehicles.[197]

306. Counsel Assisting also submits it is open to the Court to make an adverse finding that there were no adequate policies, principles, practices or training as to how to deal with a situation such as this; in particular, as a group, including the specifics of how to cordon and contain to manage the situation with the benefit of more time.[198]

307. Counsel Assisting draws attention to the evidence of most of the attending police officers who testified that they could not think of ways they could have altered their conduct on the day, relying on the fact that the incident happened so quickly.[199]

308. These submissions are supported by JC's family.[200]

309. I have also considered Ms B Clarke's submissions that I should find that:

[196] ts 744.
[197] Counsel Assisting's Submissions dated 2 August 2024 [27]-[29].
[198] Counsel Assisting's Submissions dated 2 August 2024 [30]-[32].
[199] Ibid.
[200] AJ's and CJ's Submissions dated 23 August 2024 [21]; B Clarke's Submissions dated 23 August 2024 [25]-[26].

a) the eight officers that attended were not sufficiently trained in effective communication and how to de-escalate situations, particularly when responding to individuals experiencing mental distress;

b) there were no adequate policies, principles, practices or training in effective communication skills or de-escalation techniques;

c) the lack of information sharing between the eight police officers was caused by a lack of training and the lack of resources to facilitate adequate communication;

d) the training delivered to regional officers prior to 17 September 2019 was not to the same standard of metropolitan training and there was a lack of oversight with respect to training regional officers.[201]

310. The evidence at the inquest demonstrated that no police officer took the lead, and it was not necessarily a shared expectation amongst them that this should have occurred. Whilst Mr Markham and Mr Taylor, upon their review of the incident, considered an effective cordon and containment had been achieved by the attending police officers, this view was not shared by a number of the attending police officers. First Class Constable Cleghorn, First Class Constable Caracatsanis, Constable McLean and First Class Constable Wyndham testified to the effect that they did not consider JC to have been contained before JC was shot, or that they did not consider an effective cordon had been established.[202]

311. The evidence also established that prior to the gunshot there was little to no communication between the three police officers who did get out of their police vehicles, being Senior Constable Barker, First Class Constable Wyndham and Constable McLean.

312. WA Police opposes the adverse findings submitting that there was no deficiency in training (whilst accepting that the particular eight: "*general duties*" police officers who attended were not specifically trained to deal with the situation as a team). Another primary reason given for opposing the adverse findings is that the police officers did not have sufficient time to communicate more fulsomely to deal with the situation because First Class Constable Wyndham shot JC within seven seconds after the four vehicles and eight officers had all arrived at the scene. For this

[201] B Clarke's Submissions dated 23 August 2024 [28]-[35].
[202] ts 104; ts 178; ts 183 to 184; ts 339 to 340; ts 532.

reason, it is submitted that their ability to act as a team with one person taking the lead was cut short, and that they were still in the process of establishing a cordon. It is also noted that the lead is not necessarily the most senior police officer at the incident.[203]

313. WA Police also draw attention to their training model (for police officers as recruits, repeated annually) known as the Situational Tactical Options Model (STOM) that guides them when responding to high risk operational tasks with continuous assessment and reassessment. A component of STOM is training in: "*tactical communications*" which is important where multiple police officers attend a scene. At the inquest Mr Markham described STOM as a cornerstone of police training, providing guidance in the areas of risk assessment, situational awareness and selection of an appropriate tactical option to reduce a threat and gain control. Mr Taylor explained that, consistent with training, all attending police officers would have a role in cordoning and containing, working together as a team. The STOM training is complemented by a range of ongoing Critical Skills In-Service training.[204]

314. WA Police also refer to the earlier communications between police officers on the way to the incident by means of the police radio, and the initial requests to JC to drop the knife, as being further steps taken to communicate and reduce the threat. They refer to Constable McLean having issued a command that would have communicated his intentions with the taser to the other police officers. They submit that, in addition to the short time frame available by the time all police officers had arrived at the scene (being seven seconds), Senior Constable Barker and First Class Constable Wyndham, in acting without communicating their intentions or plans, further deprived the other police officers of the opportunity to communicate more fulsomely.[205]

315. At the inquest Mr Markham was asked about the missed opportunities for direct communication between First Class Constable Wyndham, Senior Constable Barker and Constable McLean, by reference to his reports to the coroner. On his review of the incident, Mr Markham had noted that there appeared to be no tactical communication between First Class Constable Wyndham, Senior Constable Barker and Constable McLean; specifically, there was no plan communicated between them as to how they might manage the threat presented by JC.[206]

[203] WA Police's Submissions dated 23 August 2024 [29]-[41].
[204] Exhibit 3, tab 11; ts 706; ts 711.
[205] WA Police's Submissions dated 23 August 2024 [40].
[206] Exhibit 3, tab 11; ts 744 to 745.

316. At the inquest Mr Markham explained this within the context of the training offered by the STOM model: "…. *tactical communication is not just communication between the officer and the subject, it's communication between the officers themselves*."[207]

317. The tenor of the evidence of the attending police officers, and of the submissions of WA Police, is that the incident ended so quickly that there was no time for police to communicate with each other. For the same reason, there were no reflections offered by them on how things could have been done differently.

318. This reasoning is circular. The incident ended quickly because First Class Constable Wyndham shot JC. The question to explore is whether better coordination and communication could have avoided the incident ending quickly, in this tragic manner.

319. I am satisfied that insufficient communication and lack of coordination between the police officers contributed to split second decisions being made, without a full awareness of the scene and of each other. It was these missed opportunities that contributed to an escalation of the threat, due to First Class Constable Wyndham's proximity to JC, that in turn was contributed to by his concern for Senior Constable Barker.

320. The evidence of the police officers regarding the effectiveness of their existing and/or subsequent training was as follows. First Class Constable Cleghorn did not consider she had the training to deal with this situation, and even with subsequent training, she believed the only choice that was available in these circumstances was the use of force. Senior Constable Walker, First Class Constable Caracatsanis, Senior Constable Cooney, Senior Constable Bird, and Constable McLean, having regard to their subsequent training and/or the benefit of hindsight, did not consider it would have changed their own actions on the day.[208]

321. Senior Constable Barker considered that prior to getting out of his police vehicle, he could have radioed the other police officers to explain that he was going to speak to JC, but he felt that the police radio did not have that capability, due to other traffic on it. He also considered that he probably could have conveyed to his partner, First Class Constable Caracatsanis, that he was going to speak with JC and not draw a weapon (although as

[207] ts 745.
[208] ts 50; ts 70; ts 75; ts 119; ts 173 to 174; ts 177; ts 218 to 219; ts 301;

previously noted in this finding, he felt that, due to his experience, First Class Constable Caracatsanis would have known this).[209]

322. With the benefit of hindsight, and with the training he had at the material time, First Class Constable Wyndham did not consider that, instead of firing his gun, he could have taken some steps backwards, because JC was too close to him. Nor, with the benefit of hindsight, did he consider that there was anything he could have done to protect Senior Constable Barker, other than running towards JC with his gun out. However, when it was suggested as to whether, with the benefit of hindsight, he could have tried to get Senior Constable Barker to move away from JC, First Class Constable Wyndham posited that he could have yelled at him.[210]

323. Having regard to his subsequent training, especially in communication in such incidents, First Class Constable Wyndham felt that, in hindsight, instead of yelling commands to JC, he could have stayed further back and employed the: "*Empathy, Rapport, Influence, Change*" model, essentially trying to establish some rapport with JC through open ended questions. First Class Constable Wyndham also felt that, with the benefit of hindsight, he would have been assisted if there had been a police officer who was taking the lead and giving instructions.[211]

324. In his supplementary report to the coroner, Mr Markham noted that due to a lack of resources (that is, a lack of trainers to assist with role playing and safety/assessor responsibilities), the Acting District Training Officer and Satellite Trainer for the Mid West Gascoyne training area (the Police Trainer) had not been able to deliver scenario-based training in the In-Service Critical Skills Training, that had been delivered to all of the attending police officers prior to the incident. The scenario-based training, if it had been delivered, would have been based upon an Active Armed Offender scenario, being the training scenario closest to the one confronting the eight attending police officers on 17 September 2019.[212]

325. Also, in his supplementary report to the coroner, Mr Markham noted that the Police Trainer for the Mid West Gascoyne training area did not have confidence in the effectiveness of the taser as a tactical option and was unable to articulate the WA Police Use of Force policy governing the justification for the use of a taser. It appeared the Police Trainer's awareness of the taser's

[209] ts 408 to 409.
[210] ts 517; ts 538 to 539.
[211] ts 545; ts 549.
[212] Exhibit 3, tab 11.

capacities was outdated. Further, that he had shared his views on its lack of effectiveness, that were incorrect, during the In-Service Critical Skills Training.[213]

326. During his review Mr Markham also noted that the Police Trainer is required to maintain instructor qualifications by delivering the relevant Critical Skills Weapons Training and Requalification program at least twice within a 12 month period and is required to demonstrate competency in their training delivery when audited by the Operational Safety and Tactics Training Unit. At the inquest Mr Markham explained that each regional West Australian Police District is audited annually for the delivery of their In-Service Critical Skills Training (levels 1 to 3).[214]

327. This audit would ordinarily have alerted WA Police to the lack of scenario based training in the Mid-West Gascoyne and the outdated information being provided regarding the effectiveness of the taser. It should ordinarily have resulted in these omissions or deficiencies in training being rectified.[215]

328. First Class Constable Wyndham had been trained in accordance with WA Police policies and guidelines but had not received his scenario-based training whilst at Geraldton Police Station.[216]

329. Generally, the attending police officers had undergone different levels of training on the day of the incident, but they had all been trained in In-Service Critical Skills Training (levels 1 to 3), though without the scenario-based component, while at Geraldton Police Station. Some of them felt insufficiently trained or would have wanted someone to be in charge (a lead). Even with subsequent training, most of them felt they would not have done anything differently.[217]

330. Counsel Assisting submits that there was a collective failure, with no particular police officer responsible for the lack of coordination and lack of communication. I accept this submission and consider that it reflects adversely on the sufficiency of their training at the material time.

331. I do not consider that adequate attempts were made to de-escalate the situation.

[213] Ibid.
[214] Exhibit 3, tab 11; ts 785 to 786.
[215] ts 785 to 786.
[216] Exhibit 3, tab 11; ts 784 to 786.
[217] Exhibit 3, tab 11.

332. I do not consider that there was sufficient recognition or understanding of JC's mental distress, complicated by her being a member of the Aboriginal community, that has historically experienced negative interactions with police, that can generate ongoing suspicion and fear. A clearer understanding of the impacts of intergenerational trauma, how it can contribute to substance abuse, to foetal alcohol spectrum disorder, and to volatility and impulsivity may have placed some of JC's behaviour into context and may have prompted a consideration of de-escalation options.

333. On balance I am satisfied that WA Police missed opportunities to effectively train the attending police officers. The eight officers who attended were not sufficiently trained in tactical and/or effective communication at the material time, nor were they sufficiently trained as to how to deal with the situation as a team. This is reflected in an overall lack of coordination, several deficiencies in situational awareness, a lack of communication between the three police officers who were out of their police vehicles, and a lack of confidence generally in their cordoning and containment of JC. There were missed opportunities to communicate, which may have avoided JC being approached so quickly. This may have allowed for the benefit of more time, while they waited in their vehicles and/or maintained distance from her, during which a plan to de-escalate could have been developed.

334. More formal training in respect of Aboriginal Cultural Awareness may have generated a better appreciation of JC's likely vulnerabilities.

Whether WA Police should have de-briefed the police officers involved

335. Counsel Assisting submits it is open to the Court to make an adverse finding that, after the conclusion of criminal proceedings in October 2021, WA Police did not, when it could have, debrief First Class Constable Cleghorn, Senior Constable Walker, First Class Constable Caracatsanis, Senior Constable Cooney, Senior Constable Bird and Constable McLean about the incident on 17 September 2019; and particularly, to discuss the learnings to be taken from the incident. Counsel Assisting also suggested that there may have been an opportunity for individual de-briefs prior to the trial without compromising the criminal proceedings.[218]

336. These submissions are supported by JC's family.[219]

[218] Counsel Assisting's Submissions dated 2 August 2024 [33]-[36].
[219] AJ's and CJ's Submissions dated 23 August 2024 [21]; B Clarke's Submissions dated 23 August 2024 [27].

337. WA Police opposes that finding or comment. They submit that it could not be done because it was immediately treated as a homicide investigation. Further that any such de-brief of police officers before the criminal trial would have compromised their integrity as witnesses, and that these police officers acted consistently with policy and procedures. It is also submitted that such a comment would be so remote in terms of time of the incident that it should not or could not be made, or that it is not a matter "*connected with*" the death.[220]

338. For the purpose of this finding, I will only address the potential for individual and/or group de-briefing (as appropriate) after the conclusion of the criminal proceedings as I remain concerned about complexities attending any de-briefing processes prior to criminal proceedings. Therefore, the WA Police submission regarding the potential compromising of the criminal trial by means of a de-brief prior to the trial is noted, and save for agreeing with it, it does not arise for my consideration.

339. At the inquest Mr Markham explained that he had not invited these police officers to be de-briefed due to the various other legal processes involved, including the criminal trial. Having heard the evidence Mr Markham raised two matters he intends to pursue, for which he is to be commended:

a) he plans to deliver specific de-briefing of the nominated involved police officers after the inquest; and

b) he plans to include, within the ongoing WA Police In-Service Critical Skills training, a new scenario based training module drawn from the learnings from this incident.[221]

340. I now turn to the WA Police submission concerning the length of time between the death and the proposed recommendation concerning a de-brief, and will address this aspect in this part of my finding, though it applies equally to the related recommendation.

341. Section 25(5) of the Coroners Act does not impose a cap on the length of time between the death and the proposed recommendation. To judge the ability or desirability of making a comment based on the amount of time that has passed since the death is not supported by the express words of s 25(5) of the Coroners Act.

[220] WA Police's Submissions dated 23 August 2024 [42]-[48].
[221] ts 749 to 750; ts 782 to 783.

342. Further, to reason that because a long time has passed such that a comment ought not be made, is incompatible with the important role that s 25(5) of the Coroners Act has in all Coronial inquests, including ones where historical deaths are investigated.

343. Finally, the desirability (or otherwise) of a debrief about the actions taken which resulted in JC's death is a matter connected with her death. The important death prevention function of the Coroner's Court is recognised by s 25(2) of the Coroners Act. One purpose of making comments is to ensure systemic issues leading to deaths can be identified, and where possible, addressed.

344. Whilst Mr Markham may invite police officers for de-briefing sessions, it is the WA Police as an entity, that is responsible for the framework and process for de-briefings. As outlined previously in this finding, a number of the involved police officers testified that, even having regard to their subsequent training and/or the benefit of hindsight, they did not consider it would have changed their own actions on the day. This indicates that a de-brief is warranted.

345. With respect to the WA Police submission about the nominated involved police officers having acted consistently with policy and procedures, it is to be borne in mind that a de-brief should not be regarded as being desirable only when policies and/or procedures have been breached. In the spirit of continual improvement, and having regard to the incident as it evolved, there are evident merits to a de-brief.

346. In this case, due to the number of investigatory steps and/or legal proceedings stemming from the incident the matter of a de-brief may not have been prioritised. There was potential for individual and/or group de-briefing (depending on the circumstances) after the conclusion of the criminal proceedings and it would have been preferable for WA Police to have done this, to facilitate education and reflection, and to focus on options for de-escalation, with the aim of preventing or minimising similar events occurring in the future.

347. I note that WA Police are going to consider and arrange an appropriate form of de-briefing, and have made a recommendation in support of this, later in this finding under the heading: *Recommendation 3 – De-briefing on events of 17 September 2019.*

PREVENTABLE DEATH

Whether JC's death was preventable

348. At the inquest a number of propositions were put to First Class Constable Wyndham about things he could have done differently on 17 September 2019. His response to those propositions was that he did not accept that he could have done the following:

a) taken a moment before pulling his firearm;

b) taken some time before getting out of his police vehicle;

c) not have approached as closely to JC as he did;

d) communicated with Senior Constable Barker and told him to get back;

e) communicated with the other attending police officers to try and organise a response to the threat posed by JC;

f) taken a moment to effectively look around where he may have seen Constable McLean and been able to reassess his risk assessment; and

g) sought more information about JC before getting out of his police vehicle.[222]

349. Some of those steps may have prevented JC's death.

350. If there had been more consideration given to de-escalation options and tactical disengagement, given that JC was effectively cordoned and that she was not an Active Armed Offender, it is possible that the shooting could have been avoided.

351. If First Class Constable Wyndham had not run towards the threat posed by JC, placing himself within an unsafe distance of JC, it is possible that he may not have perceived the need to fire his gun. Within about 17 seconds of getting out of his police vehicle, he closed to within approximately three metres of her, exacerbating a potentially lethal situation. Had the situation slowed down, there could have been more time to organise a coordinated response.

[222] ts 537; ts 546 to 547; ts 551

352. If there had been better communication as between First Class Constable Wyndham and Senior Constable Barker, and closer adherence to WA Police policies, guidelines and/or training, such as WA Police Use of Force policy and the Situational Tactical Options Model training, it is possible that the incident could have been resolved without a shooting.

353. There were a number of missed opportunities to de-escalate the situation. It can no longer be known whether, with more de-escalation tactics being employed, or at least, less exacerbation having occurred, the shooting could have been avoided. However, the risk of a shooting could have been mitigated by such factors.

354. I am satisfied that JC's death was a preventable death.

RECOMMENDATIONS

Recommendations 1 and 2 – Improving relations with Aboriginal communities

355. Counsel Assisting submitted two recommendations directed towards the improvement of relations between WA Police and Aboriginal persons. The interested persons were notified and provided with an opportunity to comment.

356. At the inquest, when questioned the police officers gave varying responses on the question of whether and when they had had any Aboriginal Cultural Awareness Training, and if so, what they had learnt from it.

357. First Class Constable Cleghorn recalled she had had Aboriginal Cultural Awareness Training at the WA Police academy, presented by an Aboriginal educator. When asked, she did not recall any training in respect of foetal alcohol spectrum disorder. She did not recall any Aboriginal Cultural Awareness training at Geraldton Police Station, that involved an Aboriginal person. When questioned about the training she had in respect of a police call out for a person with a mental health condition, she recalled, from the training that: "*the goal is to de-escalate*." Since this incident, she has done on-line Aboriginal Cultural Awareness Training.[223]

358. Senior Constable Walker did not recall having had any Aboriginal Cultural Awareness Training prior to the time of this incident and had not had any

[223] ts 21 to 22; ts 49 to 50; ts 52.

such training after he was deployed to Geraldton, other than on the job training. Since this incident, he has done on-line Aboriginal Cultural Awareness Training. He recalled this subsequent training addressed matters connected with colonisation and racism.[224]

359. First Class Constable Caracatsanis (a Detective Senior Constable at the time of the inquest) had not had any additional Aboriginal Cultural Awareness Training during his Detective training. He believed that prior to the incident he had had some training in connection with Aboriginal Cultural Awareness, which he felt will have assisted him, though he was unable to refer to examples. Since this incident, he has done on-line Aboriginal Cultural Awareness Training but like Senior Constable Walker, he emphasised the importance of on the job learning.[225]

360. Senior Constable Cooney, (a Detective Senior Constable at the time of the inquest) had not had any additional Aboriginal Cultural Awareness Training during his Detective training either. Since this incident, he has done on-line Aboriginal Cultural Awareness Training, which gave him a more historical perspective. He did not consider it altered the way he approached policing with respect to Aboriginal persons. Like Senior Constable Walker, and First Class Constable Caracatsanis he emphasised the importance of on the job learning.[226]

361. Senior Constable Bird did not recall any Aboriginal Cultural Competency training prior to this incident. Since this incident, he has done on-line Aboriginal Cultural Awareness Training, and learned about cultural matters, and intergenerational trauma as it affects Aboriginal persons. He agreed it taught him about the historically fraught relationship with Aboriginal persons. However, while this subsequent training gave him some helpful insight, he did not feel it would have caused him to do anything differently on the day of the incident, in connection with JC.[227]

362. Constable McLean, who had been trained at the WA Police academy more recently than the others, confirmed that an Aboriginal educator spoke to the participants about matters related to cultural awareness, though he did not recall major topics from that presentation due to the length of time that had passed. When he was deployed to the Geraldton area his induction package included information relevant to the local Aboriginal community and he

[224] ts 120; ts 129.
[225] ts 175.
[226] ts 201; ts 218.
[227] ts 257 to 256.

found it helpful. As part of his on the job training in Aboriginal Cultural Awareness he also spoke with the local Aboriginal Police Liaison Officer and felt that those interactions assisted positively in his subsequent policing communications with Aboriginal persons.[228]

363. First Class Constable Wyndham recalled he had training in Aboriginal Cultural Awareness at the WA Police academy in 2012. He did not recall any further training by way of an: "*official package*" prior to the incident. However, in terms of unofficial training or education, he referenced going out for drives on various occasions with the Aboriginal Police Liaison Officers at local police stations, including Geraldton, prior to the incident, with the aim of learning about the regional town. He testified that he did not recall it assisting him, when later performing policing duties in respect of Aboriginal persons. Since this incident, he has done on-line Aboriginal Cultural Awareness Training and said he learnt about historical atrocities that Aboriginal persons have suffered in Western Australia. He testified that this new learning did not change the way he communicates with Aboriginal persons in a policing role.[229]

364. First Class Constable Wyndham also gave evidence about his week-long bespoke training package. Other than noting it occurred as planned, it does not reflect upon the nature of the general training provided by WA Police to police officers.[230]

365. As is evident from the above, none of the police officers could identify practical learnings from their training, insofar as these may have affected their policing roles in connection with Aboriginal persons. This indicates that more needs to be done to bring about actual change and improve relations as between the WA Police and Aboriginal communities.

366. At the inquest I heard from Dr Charmaine Green, a Yamatji woman, research fellow with the Western Australian Centre for Rural Health, University of Western Australia. She has lived in Geraldton for over 20 years. On the matter of learnings from Aboriginal Cultural Awareness training, Dr Green referred to the importance of the following inclusions in the training:

> "*…. shared stories from Aboriginal community members that would give them some understanding of their community, because understanding legislation and understanding the impact – the intergenerational trauma*

[228] ts 299; 343 to 345.
[229] ts 523 to 526.
[230] ts 526 to 529.

> *from those impacts is good. But what is even stronger is for serving members of the Police Force to have some lived experiences and exposure to the lived experiences from community members – Yamatji community members.*" [231]

367. Dr Green was not supportive of on-line training in the area of Aboriginal Cultural Competency Training, noting that it does not allow for the building of a relationship with Aboriginal persons. I share her concerns in this area, insofar as the on-line training should be viewed as a starting point and supplementary to the primary in-person training designed to promote shared understandings and relationship building.[232]

368. In connection with the in-person training, Dr Green emphasised the importance of local Aboriginal persons, being the local cultural knowledge holders, delivering the training, and that it be co-designed as between WA Police and those Aboriginal persons. She explained that such training should recognise the diversity of Aboriginal cultures and the different issues they face, and that bringing persons: "*who don't belong to the region*" to do training is not helpful.[233]

369. Dr Green also cautioned against the over-reliance upon the Aboriginal Police Liaison Officers in community policing (or its equivalents), noting they are not the ones that need to build the relationship, as they already have one. She urged that non-Aboriginal Police Officers come to their community events and speak to their members as part of relationship building.[234]

370. JC's family supported these recommendations, with Ms B Clarke also noting that any proposal for establishing a section or branch (as outlined below) be developed in consultation with Aboriginal people, and that any recommendation as to training should offer specifics such as key topics and the frequency of delivery. Ms B Clarke raised a number of specific topics that should from part of the Aboriginal Cultural Awareness training, including the impacts of colonisation and Stolen Generations, and how intergenerational trauma impacts the relationship that Aboriginal persons have with police.[235]

371. WA Police opposed these recommendations. It submitted that it is not open to the Court to make the recommendation directed to training as there was

[231] ts 955.
[232] Ibid.
[233] ts 956.
[234] ts 955 to 956.
[235] B Clarke's Submissions dated 23 August 2024 [41]-[43]; AJ's and CJ's Submissions dated 23 August 2024 [22].

no evidence of a connection between JC's death and the training police received in cultural awareness. It also pointed to the developments it has made in cultural training, including through its Aboriginal Affairs Division. It also suggested a proposed rewording to Recommendation 2 below, having regard to the vastness of this State, to the effect that WA Police consider face to face training: "*where possible*".[236]

372. I am aware that WA Police have made significant efforts towards providing and maintaining their Aboriginal Cultural Awareness training. At the inquest I heard evidence from Superintendent Michael Dalla Costa (Superintendent Dalla Costa), a principal within the academy, who is responsible for coordinating resourcing to deliver training, primarily to recruits. The Superintendent spoke about the on-line Aboriginal Cultural Awareness training developed with the assistance of the Aboriginal Affairs Division. The Superintendent also explained that since 2022 WA Police have employed face to face training, by an Aboriginal person, for the new recruits (and a version of face to face training was in place for new recruits since 2018).[237]

373. When questioned on the point, Superintendent Dalla Costa testified that he was open to Dr Green's suggestion of face to face Aboriginal Cultural Awareness training for In-Service police officers. Whilst noting some logistical factors due to the size of the State and different Aboriginal groups within the State, he was prepared to explore it.[238]

374. Dr Green also testified as to the importance of the local Aboriginal community being made aware, at the material time, of an incident such as this, of the steps that police are taking, and whether breaches of WA Police Policy occurred. Dr Green considers that there is a need for transparency so that the community can feel safe and confident in the actions of the WA Police, and that when the community is not told about it, it results in further mistrust. This is supported by Ms B Clarke in her submissions.[239]

375. There are limits as to what WA Police may publicly state after an incident such as this, particularly where a prosecution may be under consideration, or under way. It is outside my remit to recommend that WA Police make an announcement about the facts surrounding the incident, or their views about

[236] WA Police's Submissions dated 23 August 2024 [50]-[62].
[237] ts 974.
[238] ts 976.
[239] B Clarke's Submissions dated 23 August 2024 [67]-[6]; ts 965.

the incident, as has been submitted to me. Nonetheless Dr Green's evidence has assisted in informing the first of my Recommendations.

376. At the inquest Deputy Commissioner Allan Adams (Deputy Commissioner Adams) shared his sincere condolences with JC's family, acknowledging the immeasurable impact on her family, referring to efforts made to improve the relationship between WA Police and Aboriginal persons, and acknowledging that there is still work to do in this regard:

> "*I give you my sincere commitment that I'll continue to do whatever it is I can to improve that relationship. I think it's through better knowledge and understanding of Aboriginal people and the challenges that they have, that we can try and reduce these types of incidents occurring.*" [240]

377. It is with the comments made by Dr Green and Deputy Commissioner Adams in mind that I make *Recommendation 1*, below, aimed at supporting the improvement in the relationship between WA Police and the Aboriginal communities, which may include more interaction and/or discussion when an Aboriginal community member dies following an interaction with WA Police.

378. In respect of *Recommendation 2* below, I have addressed, by recommendations in a previous inquest finding, the importance of face to face Aboriginal Cultural Awareness Training, the importance of Aboriginal persons being involved in the delivery of the training, the importance of tailoring it to the issues relevant to the specific region.[241]

379. Also, in respect of Recommendation 2 below, I have addressed, by recommendation in a previous inquest finding, the importance of co-designing Aboriginal cultural competency training with Aboriginal persons, and the inclusion, in such training of issues surrounding intergenerational trauma, foetal alcohol spectrum disorder and the importance of cultural wellbeing. Whilst this previous recommendation was addressed to service providers who interact with Aboriginal persons, it applies equally to police officers who interact with Aboriginal persons.[242]

[240] ts 890.
[241] Record of Investigation into the death of Ms DHU, State Coroner, delivered 15 December 2016, recommendations 3 and 4.
[242] Record of Investigation into the death of thirteen children and young persons in the Kimberley Region, State Coroner, delivered 7 February 2019, recommendation 19.

380. Recommendations 1 and 2 below are connected in that they are both directed towards improving the relationship between WA Police and Aboriginal persons and build upon recommendations I have previously made.

Recommendation 1

I recommend that consideration be given to establishing a section or branch of the WA Police dedicated to improving the relationship between WA Police and Aboriginal persons, and that there be consultation with Aboriginal persons in connection with the role of this section or branch.

Recommendation 2

I recommend that WA Police oversee Aboriginal Cultural Awareness training, to be co-designed with, and delivered by, Aboriginal persons, including face to face training on a regular basis, that consideration be given to tailoring it to the region in which the police officers are serving, and that consideration be given to emphasising the importance of the effect of intergenerational trauma, and foetal alcohol spectrum disorder, and the importance of cultural wellbeing.

Recommendation 3 – De-briefing on events of 17 September 2019

381. Counsel Assisting submitted a recommendation directed towards the de-briefing of First Class Constable Cleghorn, Senior Constable Walker, First Class Constable Caracatsanis, Senior Constable Cooney, Senior Constable Bird and Constable McLean about the incident on 17 September 2019. The interested persons were notified and provided with an opportunity to comment.

382. JC's family supported this recommendation.[243]

383. AJ and CJ, considered this recommendation should be strengthened by adding that the nominated involved police officers be directed by the Commissioner of Police (or appropriate delegate) to attend and participate in such a debriefing. Further, that the circumstances of this incident be incorporated into the training materials used by Mr Markham and his team of trainers.[244]

[243] B Clarke's Submissions dated 23 August 2024 [44]; AJ's and CJ's Submissions dated 23 August 2024 [22].
[244] AJ's and CJ's Submissions dated 23 August 2024 [43].

384. WA Police opposed the recommendation concerning the de-briefing on the basis that the recommendation is not connected to JC's death within the meaning of s 25 of the Coroners Act. It draws attention to the fact that the nominated involved police officers were found, through internal investigations, to have acted consistently with WA Police policy and/or procedures. Essentially, it takes the same position as done in opposing a finding or comment as to the debriefing of the officers.[245]

385. I repeat here what I have previously outlined under the heading: *WA Police should have de-briefed the police officers involved*, namely that:

a) a de-brief is consistent with the death prevention function of the Coroner's Court; and

b) a de-brief should not be regarded as being desirable only when policies and/or procedures have been breached.

386. As outlined previously in this finding, the evidence of the nominated involved police officers, given having regard to their subsequent training and/or the benefit of hindsight, was that they did not consider it would have changed their own actions on the day. There were also differing views on whether JC had been effectively cordoned and contained, as between the nominated involved police officers, and the trainers. There is room for improvement in their training and education, to emphasise the importance of de-escalation, and the consideration of less lethal use of force options within the context of cordoning and containing a person such as JC.

387. I have carefully considered but determined, on balance, not to recommend that the Commissioner of Police (or appropriate delegate) make a direction about the attendance of the nominated involved police officers.

388. I am satisfied that there are sufficiently robust de-brief processes within WA Police, and that in this case, the usual process may have been impacted partially by the number of legal and/or investigatory processes that needed to occur after the incident. As I have noted, Mr Markham plans to deliver this specific de-briefing, and also plans to include, within the ongoing WA Police In-Service Critical Skills training, a new scenario based training module drawn from the learnings from this incident.

389. I therefore make this recommendation in support of those plans.

[245] WA Police's Submissions dated 23 August 2024 [64].

Recommendation 3

I recommend that First Class Constable Cleghorn, Senior Constable Walker, First Class Constable Caracatsanis, Senior Constable Cooney, Senior Constable Bird and Constable McLean be de-briefed by Mr Markham or similar trainer as to the events of 17 September 2019 (including as to de-briefing on the cordon and containment).

Further, that Mr Markham or similar trainer incorporates within the ongoing WA Police training, scenario based training drawn from the learnings from this incident.

Recommendation 4 – Future tasers

390. Counsel Assisting submitted a recommendation directed towards the trialling and consideration of new tasers. The interested parties were notified and provided with an opportunity to comment.

391. Ms B Clarke supported this recommendation.[246]

392. WA Police did not seek to be heard on the recommendation, other than to maintain its position on the Suppression Order previously made in this matter, that appears at the beginning of this finding. WA Police suggested the substitution of the reference to a specific weapon with the phrase: "*new conducted energy weapon platforms*" and I accept that.[247]

393. The evidence identified that new conducted energy weapon platforms (such as tasers) have greater capabilities than existing weapons. They can overcome some of the limitations previously considered to exist with existing weapons and may encourage the use of new conducted energy weapon platforms rather than firearms.[248]

394. I make this recommendation in support of the trialling and consideration of new conducted energy weapon platforms, in the hope that if successful, it may support the use of less lethal use of force options in future.

[246] B Clarke's Submissions dated 23 August 2024 [45].
[247] WA Police's Submissions dated 23 August 2024 [65]-[66].
[248] ts 714 to 715.

Recommendation 4

I recommend that WA Police continue trialling and considering the future use of new conducted energy weapon platforms (such as tasers).

Recommendation 5 – Culturally safe and responsive health care

395. Counsel Assisting submitted a recommendation directed towards the provision of culturally safe and responsive health care. The interested persons were notified and provided with an opportunity to comment.

396. JC's family supported the recommendation.[249]

397. The Chief Psychiatrist considered the proposed recommendation and submitted that it be reworded to ensure strategic specificity. The Chief Psychiatrist drew attention to the existing obligations of mental health staff towards Aboriginal patients, regarding cultural needs and access to appropriate cultural assessment, support and treatment under the Mental Health Act.[250]

398. The Chief Psychiatrist referred to Principle 7 of the Charter of Mental Health Care Principles under the Mental Health Act, that must be complied with by the mental health services, and that provides as follows:

> "*A mental health service must provide treatment and care to people of Aboriginal or Torres Strait Islander descent that is appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal or Torres Strait Islander mental health workers.*"

399. The Chief Psychiatrist also referenced the Chief Psychiatrist's *Standards for Clinical Care* made under s 574 of the Mental Health Act: *Standard: Aboriginal Practice* that requires all West Australian mental health services and service providers (public and private) to ensure cultural competence for the non-Aboriginal mental health workforce, though cultural awareness training and supportive organisational culture.[251]

[249] B Clarke's Submissions dated 23 August 2024 [74]; AJ's and CJ's Submissions dated 23 August 2024 [22].
[250] Exhibit 9.
[251] Chief Psychiatrist's Submissions dated 27 August 2024 [5]-[6].

400. On the background of this statutory framework, the Chief Psychiatrist drew attention to the work of Gayaa Dhuwi (Proud Spirit), the peak body for Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health care and suicide prevention, that the statutory standards refer to above. One of the aims of Gayaa Dhuwi is to guide action across all governments to enable culturally safe and responsive systems of care.[252]

401. The Chief Psychiatrist's evidence at the inquest reflected upon the importance of a social and wellbeing model that looks at a more holistic approach towards healthcare for Aboriginal and Torres Strait Islander communities, that does not necessarily focus on a diagnostic approach but that looks at the role of family and community in connection with wellbeing, that considers traditional healing approaches, and that works in concert with Western medicine.[253]

402. The North Metropolitan Health Service and the WA Country Health Service submitted the recommendation ought not to be made in the terms as circulated but agreed with the Chief Psychiatrist's suggested rewording.[254]

403. The WA Country Health Service also drew attention to its: *Cultural Governance Framework* that aims to activate and support practice that is embedded in the lived culture of Aboriginal persons, families and communities across all the services of the WA Country Health Service.[255]

404. I have determined to adopt the suggested rewording of the Chief Psychiatrist, in support of his submission that health service providers be refocussed upon the existing national process and areas of accountability under Gayaa Dhuwi. There is merit in focussing the health service providers on a consistent approach with respect to the five themes of Gayaa Dhuwi: cultural strength, best practice, best evidence, Aboriginal and Torres Strait Islander presence and Aboriginal and Torres Strait Islander leadership and influence.[256]

Recommendation 5

Noting the existing statutory framework concerning the treatment and care for Aboriginal and Torres Strait Islander people provided for under the Mental Health Act 2014 (WA), to further support culturally safe and

[252] Exhibit 9.
[253] ts 641.
[254] NMHS Submissions dated 27 August 2024 [5]-[7]; WACHS Submissions dated 27 August 2024 [5]-[7].
[255] Exhibit 17.
[256] https://www.gayaadhuwi.org.au/resource/the-gayaa-dhuwi-proud-spirit-declaration/

responsive health care, I recommend that health service providers prioritise their engagement in the nationally agreed development of the Implementation Plan for the Gayaa Dhuwi (Proud Spirit) Declaration.

Recommendation 6 – Improved communications between health service providers

405. Counsel Assisting submitted a recommendation directed towards improved communications between health service providers beyond what is done when there is an active referral of a patient. The interested persons were notified and provided with an opportunity to comment.

406. It will be recalled that JC had been taken from Country in the Geraldton area, being detained under the Mental Health Act, and flown to Perth by Royal Flying Doctor Service, with her assessment and care as an involuntary mental health patient occurring under the supervision of Dr Hoyle at Sir Charles Gairdner Hospital. She was discharged on 13 September 2019 with arrangements made for her return to Geraldton and scheduled follow up with the local community services for assistance with accommodation. It was also recommended to JC that she see a GP.

407. Given the mental health assessment made upon JC's discharge from Sir Charles Gairdner Hospital, there was no required follow up, meaning that at the time of her discharge, she had no active referral for example, for follow up mental health care in Geraldton.

408. When an Aboriginal person such as JC is returning to Country, or an area where they habitually reside, following involuntary mental health treatment, there is merit in the local health service being made aware of their return, even if at that time there is no identified need for an active referral to such service. This allows for continuity of support.

409. JC's family supported the recommendation.[257]

410. North Metropolitan Health Service supported the recommendation in principle, where there is no immediate need for health care and where the patient is considered to pose a current potential risk to themselves or others. It also drew attention to sections 572, 574 and 575 of the Mental Health Act that under certain circumstances enable sharing of: "*relevant information*"

[257] B Clarke's Submissions dated 23 August 2024 [75]; AJ's and CJ's Submissions dated 23 August 2024 [22].

for example by a CEO of a mental health service without patient consent if the information is relevant to, amongst other things, the health, safety or wellbeing of a person who has or may have a mental illness.[258]

411. WA Country Health Service did not support the wording of the recommendation as circulated. It was concerned that it implied there is only communication between health service providers when there is an active referral for ongoing care, where, in fact, discharge information from all public health facilities in the State is visible to all other West Australian health service providers through the Psychiatric Services Online Information System, in the circumstances where such providers share that platform.[259]

412. WA Country Health Service also referenced the importance of privacy, consent and regulatory standards, where there is no referral to a specialist service that provides ingoing care (which was the situation for JC, who did not have an active referral). I have taken matters of patient privacy into account and have determined to adopt the suggested rewording of the WA Country Health Service, to add provision for patient confidentiality and patient consent.

413. JC had been in the prison system since 2016, and shortly after her release to freedom, she was made an involuntary mental health patient, detained at Sir Charles Gairdner Hospital. She was shot and died four days after her discharge from Sir Charles Gairdner Hospital. Prior to her 2016 imprisonment, she had been admitted to Graylands Hospital on several occasions for treatment, since 2010.

414. In hindsight, it was inevitable that, without support, JC was going to struggle with her reintegration into the community, and it is unfortunate that she initially declined any assistance or community linkages after her most recent discharge. Her prospects of reintegration and potentially of securing stable accommodation, may have been improved if, with JC's consent, the local mental health services in Geraldton had been made aware of her impending return, and were able to offer continuity of contact.

Recommendation 6

I recommend that, with the consent of the patient, a discharging health service provider consider notifying a local health service to advise that service that the patient is returning to Country, or to an area where they

[258] NMHS Submissions dated 27 August 2024 [8]-[11].
[259] WACHS Submissions dated 27 August 2024 [10]-[17].

habitually reside, even if at that time, there is no need for an active referral to that local health service.

Recommendation 7 – Information sharing

415. Counsel Assisting submitted a recommendation directed towards the sharing of mental health information as between health service providers and WA Police, subject to privacy considerations. The interested persons were notified and provided with an opportunity to comment.

416. JC's family supported the recommendation.[260]

417. The aim of the recommendation is to place WA Police in a position where they may be properly alerted to relevant mental health information about a person, so that the person's vulnerability can be taken into account if police are notified of safety risks in relation to that person, towards self or others.

418. The Department of Health did not support the initial wording of the recommendation as circulated and submitted that it be reworded to strengthen privacy protections, and to provide for such sharing within the context of: "*imminent*" safety risks.

419. I have determined to adopt the suggested rewording of the Department of Health, to balance privacy with imminent safety risks.

Recommendation 7

I recommend that the Director General of the Department of Health consults with the WA Police to continue to work on how relevant information, pertaining to a person's mental health, can be shared between the agencies in such a way that balances privacy with imminent safety risks.

Recommendation 8 – Mental Health Co-Response

420. Counsel Assisting submitted a recommendation directed towards the continued funding of the Mental Health Co-Response. The interested persons were notified and provided with an opportunity to comment.

[260] B Clarke's Submissions dated 23 August 2024 [76]; AJ's and CJ's Submissions dated 23 August 2024 [22].

421. JC's family supported the recommendation.[261]

422. The Mental Health Co-Response model is a collaboration between WA Police, the Mental Health Commission and the Department of Health. It commenced in the metropolitan area and has been expanded to some regional locations. It aims to improve responses for call outs where members of the public are experiencing a mental health crisis. A responding mobile team may include two police officers and an authorised mental health practitioner, in a police vehicle, providing a response to a mental health and/or welfare related incident.

423. For safety reasons, the authorised mental health practitioner cannot be utilised to negotiate or de-escalate a high risk policing situation, nor be involved in extended negotiations.

424. I have previously made recommendations regarding funding support for the Mental Health Co-Response, including a recommendation for external funding to expand it into regional areas.[262]

425. Hypothetically, in the case of JC, an authorised mental health practitioner, if available, would not have been able to approach JC, but may have been able, from a safe distance, to liaise with attending police, over the police radio, about potential de-escalation techniques, informed by some insight into JC's mental health condition. It will be recalled that JC's mental health records should have been available on the Psychiatric Services Online Information System.

426. Hypothetically again, the involvement of the Mental Health Co-Response, if available, might have slowed down the incident after JC was cordoned and contained and given everyone a bit of time to consider ways of approaching JC. However, the Mental Health Co-Response was not available in Geraldton at that time.

427. In his report to the coroner, Deputy Commissioner Adams informed the Court that WA Police is committed to continuously considering and evaluating potential changes and improvements to the Mental Health Co-Response model. Deputy Commissioner Adams explained that the

[261] B Clarke's Submissions dated 23 August 2024 [77]; AJ's and CJ's Submissions dated 23 August 2024 [22].

[262] Record of Investigation into death of Andrew John KEY, State Coroner [2020] WACOR 36, delivered 4 November 2020 and Record of Investigation into death of Paul James BRADY, State Coroner [2023] WACOR 12, delivered 28 February 2023

Mental Health Co-Response was expanded to operate in Geraldton in September 2021, being after the death of JC.[263]

428. When the Mental Health Co-Response was expanded to Geraldton, it consisted of two police officers, an authorised mental health practitioner and an Aboriginal mental health worker. Deputy Commissioner Adams explained that a subsequent review identified that authorised mental health practitioners and Aboriginal mental health workers had attended 13% of incidents, and that 87% of Statewide callouts were non-violent community members seeking mental health assistance, where police were the primary responder. This resulted in a change in mid-2022 to the Mental Health Co-Response model, whereby it consisted of one police officer and one authorised mental health practitioner.[264]

429. Deputy Commissioner Adams referenced the: "*Right Care, Right Person*" model, to identify the right agency to attend mental health call outs. There is merit in this approach, that promotes a health led response to call outs that do not involve violence or threats of violence. Save for this comment, I will not add anything further, as JC's case involved a risk of violence, so it would not have been a health led response.[265]

430. In his report, Deputy Commissioner Adams informed the coroner about the more recent developments in the Mental Health Co-Response model. In 2024 the authorised mental health practitioners became predominantly "*housed*" in health settings, and independently travel to tasks requiring their attendance. It is coordinated by the WA Police response coordination system. In May 2024 funding was announced for an alternative Mental Health Co-Response pilot that involves coordination between St John Ambulance paramedics and authorised mental health practitioners, as follows:

> "*WA Police Force would remain a primary responder in circumstances where mental health related call outs are reported to involve real threats of violence and/or aggression being present at the incident, to make the environment safe for the authorised mental health practitioner to provide the required care. The exact start date and resource model has not been finalised as at the date of this report*." [266]

[263] Exhibit 13.
[264] Ibid.
[265] Ibid.
[266] Ibid.

431. Allied to the Mental Health Co-Response pilot outlined by Deputy Commissioner Adams is a consideration of an alternative three digit telephone number for mental health related incidents (such as 111). Hypothetically it would be used in respect of members of the community experiencing a mental health crisis, or pre-crisis, and would direct the caller to a trained mental health practitioner.[267]

432. This might have assisted JC, before she had armed herself with the knife, if for example persons with whom she was interacting at the Joel Court residences had suspected an impending mental health crisis.

433. Deputy Commissioner Adams also informed the coroner about the potential for a Multi-Agency Contact Centre where related emergency and crisis service call centres would be co-housed so that incoming calls can be more effectively and efficiently allocated to the appropriate emergency or service agency.[268]

434. Another initiative raised by Deputy Commissioner Adams concerns the potential for police to utilise their body worn camera to live stream the incident to an authorised mental health practitioner, though this would likely require changes to the Mental Health Act. Factors militating against it include that it could compromise the safety of police officers, who would need earpieces to hear responses, in circumstances where their attention needs to be focussed on the incident itself, which may be dynamic and potentially violent. Communications may be made by police radio, but regard needs to be had to the risk of the subject of the incident overhearing it, which could compromise de-escalation attempts.[269]

435. It is clear that WA Police, along with the Mental Health Commission, Department of Health and St John Ambulance have worked together assiduously to explore the: "*Right Care, Right Person*" model, and a number of important initiatives are being assessed.

436. Turning to the incident involving JC, once she was armed with the knife, in Petchell Street, it was inevitably going to be a police-led response, and not a health-led response. The question is whether, and if so how, that police-led response could have benefitted from the advice and support of an authorised mental health practitioner, operating remotely, meaning away from the scene and out of the way of potential danger.

[267] Ibid.
[268] Ibid.
[269] Ibid.

437. By submissions, Counsel Assisting drew attention to the evidence that showed the diminishment of the Mental Health Co-Response model, effectively to the point where fewer events are attended by both an authorised mental health practitioner and a police officer as outlined by Deputy Commissioner Adams.[270]

438. By submissions in response, WA Police disagreed with this proposed recommendation saying that following various reviews, it is clear that resources are best utilised by police officers being the primary responder to incidents where there are mental health related call outs and real threats of violence or aggression, and mental health practitioners the primary responder where police attendance is not required, or as a secondary responder once police have rendered a scene secure and safe.[271]

439. Counsel Assisting also submitted the incident involving JC is one that would have greatly benefited from the involvement of a mental health practitioner, not necessarily in person, given safety risks, but to assist and guide the attending police officers, particularly if the situation had been slowed down.[272]

440. By submissions in response, WA Police disagreed with the submission that the incident would have greatly benefited from the involvement of a mental health practitioner. They submitted that even if the Mental Health Co-response had existed at the time of the incident, it did not, and does not, contemplate that a mental health practitioner would attend an incident where there is a risk of harm (even if attendance was remote). They submitted this recommendation, if made, is not something WA Police is likely to operationalise.[273]

441. WA Country Health Service supported the recommendation proposed by Counsel Assisting, noting there was value in continuing to review and refine the model of the Mental Health Co-Response. They informed the court that the Mental Health Co-Response is operational in Geraldton seven days a week.[274]

442. There is merit in the: "*Right Care, Right Person*" model, but a co-response remains an important component of the overall responses, for those

[270] Counsel Assisting's Submissions dated 2 August 2024 [51]-[52].
[271] WA Police's Submissions dated 23 August 2024 [71].
[272] Counsel Assisting's Submissions dated 2 August 2024 [51]-[52].
[273] WA Police's Submissions dated 23 August 2024 [69].
[274] WACHS Submissions dated 27 August 2024 [18]-[19].

situations that need to be police-led, due to risk of violence, in circumstances where an authorised mental health practitioner may give support and advice to attending police remotely, if an incident is able to be slowed down.

Recommendation 8

I recommend that the Mental Health Co-Response continues to be funded and that WA Police consult with stakeholders including the Department of Health, WA Country Health Service and/or the Mental Health Commission, to continue to revisit the model for the Mental Health Co-Response, in particular to explore ways in which an authorised mental health practitioner may give support and advice to police attending an incident involving a person experiencing a mental health crisis.

Recommendation 9 – Review of WA Police Training

443. Ms B Clarke submitted that a recommendation be considered to the effect that WA Police should conduct a full review of Critical Skills 1, 2, 3 and 5 training. This submission builds on her submissions made as to the inadequacy of WA Police training. I have addressed the insufficiency of the training for the eight attending police officers under the heading: "*WA Police missed opportunities to effectively train its officers*" earlier in this finding.[275]

444. In respect of the WA Police training for the Mid West Gascoyne, I have specifically noted, under that heading, the lack of scenario based training, the outdated information conveyed about the effectiveness of tasers, and the fact that the anticipated audit did not appear to have identified these training deficiencies.

445. At the inquest Mr Taylor was questioned about aspects of WA Police training. He explained that Critical Skills 1 and 2 scenario based training is done in pairs, and that regard needs to be had as to whether the training is being done at recruit level, junior officer level, or later in the police officer's career. The training provided to larger groups of police officers ordinarily involves a mass casualty scenario. He was supportive of training that would essentially reflect the scenario that the eight police officers were confronted with when they attended at Petchell Street, particularly later in their careers (or at least not as recruits or junior officers).[276]

[275] B Clarke's Submissions dated 23 August 2024 [58]-[61].
[276] ts 687 to 689.

446. At the inquest Superintendent Dalla Costa explained that the training for a police officer to determine whether or not to use force, and to select an appropriate force option, is separate and distinct from the training in effective communication. They are delivered in two separate domains of training and there is no intersection between them.[277]

447. Previously in this finding I have addressed Mr Markham's plans to include, within the ongoing WA Police In-Service Critical Skills training, a new scenario based training module drawn from the learnings from this incident. This would provide scope for integrating use of force training with effective communication training so that de-escalation techniques could be explored, in that context, in the hope that a similar outcome may be avoided in the future. I have addressed this in: *Recommendation 3*, above, in support of Mr Markham's planned efforts.

448. At the inquest Mr Markham reflected upon the outcome and like Deputy Commissioner Adams, addressed JC's family:

> "*…. we would have wanted there to have been a different outcome on the – on the day. I'm sorry that …. didn't happen. We do our best to train the officers, provide them with the – the correct equipment and skills to manage those situations. The circumstances and the outcome are extremely unfortunate. And I don't think any of those officers that were involved on that day would have wanted that to be an outcome*." [278]

449. In terms of a recommendation what remains, having regard to the evidence before me, is for there to be a review of the WA Police training, including its audit processes.

Recommendation 9

I recommend that WA Police consider a review of the training of police officers, in particular the In-Service Critical Skills training 1, 2, 3 and 5 (or equivalents) to assess whether aspects of the Use of Force training could be usefully integrated with the effective communication training, and to consider the effectiveness of audit processes in respect of the training.

[277] ts 983 to 984.
[278] ts 777.

CONCLUSION

450. JC had endured a difficult life, marred by adverse long term impacts that can be traced back to the lasting and deleterious impacts of colonisation. It is important to acknowledge the overwhelming harmful social factors that characterised her life and predisposed her to the social determinants of ill health, that in her case can be seen in episodic deteriorations in her mental health. Her likely foetal alcohol spectrum disorder contributed to her volatility. This impacted upon her employment prospects, leading to a lack of income, poverty, and abuse of drugs and alcohol. This contributed to instances of poor decision making on JC's part, resulting in several periods of incarceration. JC could have made different decisions, her outcomes were not inevitable, but the social factors predisposed her to them, and for JC, those social factors became overwhelming.

451. At the end of JC's life, her experience of homelessness exacerbated her already fragile mental state, leading her to express suicidal ideation. That she died three weeks after her release from prison, after spending most of those three weeks as an involuntary mental health patient, is very telling. I cannot exclude her having had a psychotic episode at the time that she was shot. JC fell through the cracks in the system. It is my hope that the recommendations I have made will assist in providing some continuity of care and follow up when Aboriginal persons are removed from Country, for treatment.

452. The police officers who attended the scene on 17 September 2019 should have considered de-escalation options. They say there was no time to do so, because JC was shot. I have addressed the circularity of this argument in the finding. The police officer who shot JC, within 17 seconds of getting out of his vehicle, did not know, when he exited the car, if the person holding the knife was a male or a female. He acted too hastily in running towards the threat posed by JC, not considering communication with the other police officer who was trying to engage with JC and putting himself in a situation where he perceived the need to fire.

R V C Fogliani
State Coroner
11 June 2025