JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Rosalinda Vincenza Clorinda Fogliani, State Coroner
DELIVERED	**:**	28 FEBRUARY 2023
FILE NO/S	**:**	CORC 920 of 2020
DECEASED	**:**	BRADY, PAUL JAMES

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W Stops assisted the State Coroner
Ms J Buller (State Solicitor's Office) appeared on behalf of the Western Australian Police Force

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the death of ***Paul James BRADY*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 21 June 2022 - 22 June 2022, find that the identity of the deceased person was* ***Paul James BRADY*** *and that death occurred on 15 May 2020 at 190 Aberdeen Street, Northbridge, from multiple injuries in the following circumstances:*

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INTRODUCTION

1. Paul James BRADY (Mr Brady) died on the morning of 15 May 2020 after jumping from the third floor of the apartment building where he resided. He landed on the ground below and his injuries were extensive and non-survivable. He was 35 years old.

2. Before he jumped, a bystander had seen him standing on a ledge high up on the apartment building and concerned for his welfare, contacted police. Two police officers arrived within minutes, and they endeavoured to persuade Mr Brady to sit down. The police officers tried to speak with Mr Brady, but he did not respond to them.

3. Very shortly after the two police officers arrived Mr Brady jumped. The attending police officers reported that they were in "*shock*" or "*froze*" and did not approach to check Mr Brady for vital signs. They believed him to be dead and they commenced to direct traffic away from the scene. Meanwhile other police officers in the area arrived, promptly checked on Mr Brady and they commenced CPR. An ambulance crew attended, and they took over the resuscitation efforts. Sadly, Mr Brady was unable to be revived.

4. Mr Brady's death was a reportable death within the meaning of s 3 of the *Coroners Act 1996* (WA) (the Act) and it was reported to the coroner as required by the Act. By reason of s 19(1) of the Act I have jurisdiction to investigate the death.

5. This matter involved a death following police attendance, and in police presence. Police have a duty to act to preserve and/or maintain life when confronted with a critical incident. The first responding police officers should have checked on Mr Brady and commenced to render first aid. It could not have been known by them, at the material time, that Mr Brady's injuries were non-survivable.

6. Under s 22(1)(b) of the Coroners Act, an inquest was mandated into Mr Brady's death, because it appeared that the death was caused, or contributed to, by an action of a member of the Police Force. It includes an examination of whether an omission to act caused or contributed to the death.

7. A death may have that appearance where there is a temporal nexus between an act, or omission, on the part of a member of the Police Force in connection with the deceased person, and the events leading to death.

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

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

10. Under s 25(2) of the Coroners Act, in this finding I may comment on any matter connected with the death including public health, safety or the administration of justice. This is the ancillary function.

11. 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.

12. 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.

13. I held an inquest into Mr Brady's death on 21 and 22 June 2022. I heard from four witnesses and received one Exhibit into evidence containing 26 tabs.

14. My findings appear below.

PAUL JAMES BRADY

15. Mr Brady was born in Ireland on 16 October 1984. When he was four years old, with his mother, father, and older sister, he migrated to Australia, residing in Perth. On completing his secondary schooling, he attended Joondalup TAFE and completed a computer networking course.[1]

16. After graduating Mr Brady worked for a number of insurance companies. He got on well with his colleagues, and they were supportive of him.[2]

17. As Mr Brady was growing up, he experienced anxiety, and in due course he was diagnosed with depression. He became highly concerned with aspects of his physical appearance, to the point where his family believed he suffered from body dysmorphia, though he was not formally diagnosed with Body Dysmorphic Disorder.[3]

18. Mr Brady's family tried to help him over the years. He did not to their knowledge form intimate relationships due to his concerns about his physical appearance. His family endeavoured to engage him in discussions about his self-image concerns, but he remained resistant to their efforts. He did not want to talk about it with them. They felt it best not to push him. They remained supportive and open to any discussion about it that he might wish to have in the future.[4]

19. In the period leading to his death, Mr Brady had become very concerned about catching COVID-19 and infecting his family with it. For a period, he remained isolated away from his family due to the pandemic restrictions, and he also worked from home. However, when the restrictions were lifted, he still did not want to enter his parents' home for fear of unknowingly infecting them. When he visited, he would typically speak to them from the footpath while they stood in the doorway.[5]

20. On Mother's Day 10 May 2020, shortly before his death, Mr Brady made an exception and agreed to enter his parents' home, wanting to

[1] Exhibit 1, tabs 7 and 8.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] Ibid.

make it a special celebration for his mother. His parents were delighted to see him in their home, but noted he was agitated and not his usual self.[6]

21. The next day 11 May 2020, Mr Brady commenced working back in his offices, as an insurance broker. He was worried that he might lose a large client and expressed that concern to colleagues over the next few days. While some colleagues were aware that he was worried about his work performance, his employer did not have any criticism of his work performance, save that there had been some conversations with Mr Brady regarding the time management of his client's files. On 14 May 2020 a close colleague sought to comfort Mr Brady about his work struggles, as she saw that he was especially unhappy. She stayed in touch with him into the evening, offering her support.[7]

22. At the time of his death, Mr Brady was living with one of his close friends that he had known from high school (his flatmate), in an apartment on the third (and top) floor of a building in Northbridge. The building was secure, and visitors needed to be "*buzzed in*" by residents in order to gain access.[8]

23. On the evening of 14 May 2020, Mr Brady's flatmate saw that he was upset and tearful. His flatmate comforted him and sought to spend time with him, suggesting that they eat and watch a television show together. Mr Brady declined the offer, preferring to take his meal to his room, to watch his television show there. Mr Brady told his flatmate he would not be going to work the next day.[9]

24. Tragically Mr Brady took his life the next morning, and the details of the events leading to his death are outlined below.

25. Mr Brady's family loved him dearly and they continue to mourn his loss. His flatmate, with whom he was very close, endured the trauma of seeing Mr Brady deceased on the ground below their apartment, and was deeply affected by the death.[10]

[6] Ibid.
[7] Ibid.
[8] Exhibit 1, tabs 7, 8 and 9.
[9] Ibid.
[10] Exhibit 1, tab 9.

26. For Mr Brady's family, it may be a comfort to know that, in addition to their unconditional love and support, colleagues and friends sought to offer their company and support to Mr Brady shortly before he died. His death is a loss to the community as a whole.

EVENTS LEADING TO DEATH

The flatmate's observations

27. On the night before he died, Mr Brady had taken his meal and some alcohol to his room, preferring to be by himself. Mr Brady said he would not be going to work the next day. His flatmate inferred that Mr Brady's comment related to the amount of alcohol he was drinking that night. Between 10.00 pm and 11.00 pm Mr Brady came out of his room on a couple of occasions to speak briefly with his flatmate and they exchanged some jovial comments.[11]

28. Overnight, the flatmate remined awake for a time, and at approximately 2.00 am on 15 May 2020, he heard Mr Brady moving about in their apartment. He went to the bathroom and heard Mr Brady using the keyboard on the computer and noted the light coming through the bottom of the door of their computer room.[12]

29. In the flatmate's experience, it was not unusual for Mr Brady to be up late if he was stressed or trying to unwind. The flatmate went back to bed and heard nothing further. He woke up the next morning shortly after 8.30 am and got ready to exercise. Before the flatmate left the apartment, he noticed that their balcony door was open, but did not consider it unusual, surmising that either he or Mr Brady had forgotten to close it. He did not see Mr Brady and noted that his bedroom door was ajar. He assumed Mr Brady had already gotten up.[13]

30. The flatmate's exercise routine consisted of running up and down the stairwell of their apartment block, which comprised three flights of stairs. He started at approximately 8.45 am and he had his headphones in his ears. There was a window at each level and while at some point,

[11] Ibid.
[12] Ibid.
[13] Ibid.

he saw police vehicles with emergency lights activated, he did not connect them with Mr Brady and would not be expected to have done so. He returned to the apartment at approximately 9.00 am, having completed his exercise routine. By this stage Mr Brady had died of his injuries, having climbed onto a ledge on the side of the balcony of their third-floor apartment, and jumped onto the ground below.[14]

Police actions before Mr Brady's death

31. The events leading to Mr Brady's death happened very quickly on the morning of 15 May 2020. The building where Mr Brady resided was located at the corner of Aberdeen Street and Fitzgerald Street in Northbridge. Mr Brady had gone onto his apartment balcony and then climbed onto a ledge, which was about 10 metres above the street below.[15]

32. Shortly after 8.00 am an office worker standing across the road saw a male standing on a "*grey pillar*" at the top of a building, facing away from him. This was Mr Brady, standing on the ledge. The office worker promptly called the emergency services to report his concerns for Mr Brady's welfare.[16]

33. The call was received by the Police Operations Centre at 8.10 am, and they took the following steps:

    (a) A CAD job was generated for local police attendance in relation to a male standing on a ledge;

    (b) Officers were dispatched from the Midland District Mental Health Co-Response Team;

    (c) A St John Ambulance was called to attend;

    (d) The Department of Fire and Emergency Services was called to attend.[17]

[14] Ibid.
[15] Exhibit 1, tab 7.
[16] Exhibit 1, tabs 7 and 10.
[17] Exhibit 1, tabs 7 and 11.

34. At 8.13 am Senior Constable Paul Corcoran and Probationary Constable Stephanie De Costa from the local Perth Police Station arrived at the scene and they each activated their body worn cameras. Between them they were concerned that Mr Brady might fall or jump. Senior Constable Corcoran also contacted the Police Operations Centre and requested the Department of Fire and Emergency Services to help with getting Mr Brady down from the ledge.[18]

35. The police officers stood outside the building and they both attempted to talk to Mr Brady. Senior Constable Corcoran began by calling out to Mr Brady on a couple of occasions and asking him to sit down. His aim was to avoid the risk of Mr Brady falling, and to be in a better position to speak with him. Mr Brady did not acknowledge Senior Constable Corcoran, though it is likely that he heard him call out to him. Mr Brady was turned away from the police officers and was looking downwards, moving slightly. Senior Constable Corcoran then asked Mr Brady whether he could hear him, but again Mr Brady did not acknowledge him. He was concerned that Mr Brady was going to fall, or jump.[19]

36. Two other police officers arrived, Sergeant David Cooper and Constable Thibault Devigne. They were in a marked police vehicle with emergency lights activated. They could see Mr Brady standing on the ledge and that Senior Constable Corcoran and Probationary Constable Costa were trying to talk to him.[20]

37. Senior Constable Corcoran walked over to them and asked them to block Fitzgerald Street heading southbound from Newcastle Street. They headed in that direction and contacted the Police Operations Centre requesting police vehicles to assist with roadblocks.[21]

38. While this was happening Probationary Constable De Costa tried to talk to Mr Brady. She had remained on the ground outside the building. She could see that Mr Brady was standing and fidgeting on the ledge and she also asked him to sit down. Mr Brady did not

[18] Exhibit 1, tabs 7, 11 and 12; ts 6 to 8; ts 22 to 23; ts 26 to 28.
[19] Exhibit 1, tabs 7 and 12; ts 25 to 27; ts 37.
[20] Exhibit 1, tabs 7, 11, 12, 13 and 14.
[21] Ibid.

respond or acknowledge her. She was concerned he was going to slip or fall.[22]

39. At 8.17 am, as Senior Constable Corcoran was walking back to where Probationary Constable De Costa was, Mr Brady jumped backwards off the ledge of the building and landed heavily on the ground below.[23]

40. Senior Constable Corcoran turned away and deactivated his body worn camera. Probationary Constable De Costa also turned away and she started to direct traffic to avoid members of the public seeing Mr Brady on the ground. They later explained they were in shock, or froze, and this aspect is explored later in this finding.[24]

41. In the meantime, as they were preparing to block the southbound traffic, Sergeant Cooper and Probationary Constable Devigne were informed by a passer-by that a person had jumped off a building. They quickly drove back to the scene. Sergeant Cooper went to Mr Brady where he was lying on the ground, and it was clear he was critically injured. He initially saw Mr Brady appear to take one breath, but could not find a pulse, nor see any further signs of breathing.[25]

42. Sergeant Cooper promptly commenced CPR, with assistance from Probationary Constable Devigne, who applied compresses to attempt to stop the bleeding from Mr Brady's head. The St John Ambulance paramedics arrived at 8.29 am and took over the resuscitation efforts, with the continued assistance of Sergeant Cooper and Probationary Constable Devigne for compressions and ventilation. The Department of Fire and Emergency Services had arrived, and they also assisted with the resuscitation efforts.[26]

43. Unfortunately, Mr Brady was unable to be revived. He remained in asystole with significant injuries. On the paramedics' assessment, Mr Brady's injuries were incompatible with life. At 8.46 am on 15 May 2020, Mr Brady was pronounced dead by the St John Ambulance paramedic.[27]

[22] Exhibit 1, tab 11.
[23] Exhibit 1, tabs 7, 11, 12, 13 and 14; ts 13; ts 30.
[24] Exhibit 1, tabs 7, 13 and 14; ts 13 to 14.
[25] Ibid.
[26] Exhibit 1, tabs 7, 13, 14 and 21.
[27] Exhibit 1, tabs 4, 7 and 21.

CAUSE OF DEATH

44. On 19 May 2020 the forensic pathologist Dr D. Moss made an external post mortem examination at the State Mortuary on Mr Brady's body, in conjunction with post mortem CT scanning. These showed severe injuries to the head, chest, pelvis and limbs. On that date Dr Moss formed the opinion that the cause of death was multiple injuries, and he requested toxicology analysis.[28]

45. On 22 June 2020 Dr Moss reviewed the toxicology analysis and noted that it showed a blood alcohol level of 0.191%, with a urine alcohol level of 0.265%. Methylamphetamine was detected in the urine but not in the blood. Quinine/quinidine was detected in both blood and urine and a low therapeutic level of temazepam was also detected in the blood. Dr Moss' opinion on cause of death remained unchanged.[29]

46. I accept and adopt Dr Moss' opinion on cause of death. I **find that the cause of Mr Brady's death was multiple injuries.**

MANNER OF DEATH

47. Mr Brady had struggled with the effects of his long-standing anxiety. He had been diagnosed with depression in 2009 and again in 2015 and 2017. During the period of the pandemic restrictions, he felt isolated from his family. Once the restrictions were lifted, he remained reluctant to enter his parents' home, for fear of unknowingly infecting them. This may have been a manifestation of his ongoing anxiety. In the months before his death, he had been treated for insomnia and was prescribed Temazepam (10 mg) on two occasions. His flatmate reported that it was not unusual for Mr Brady to be unsettled and up late at nights.[30]

48. In the days before his death, Mr Brady's family and friends saw that he had become increasingly anxious and upset. The night before his death he was particularly restless. Subsequent investigations found

[28] Exhibit 1, tab 5.
[29] Ibid.
[30] Exhibit 1, tab 7, 9 and 19.

that Mr Brady had handwritten a number of notes about items that he owned and who he wanted to leave them to.[31]

49. I am satisfied that Mr Brady formed the intention to take his life and that he jumped from the building to carry out his intention. The manner in which he jumped persuades me that it was a willed act and not a fall from the building.[32]

50. **I find that the manner of Mr Brady's death was by way of suicide.**

COMMENTS ON POLICE ACTIONS

51. The actions of Senior Constable Corcoran and Probationary Constable De Costa were the subject of a number of reviews. On 3 August 2020 the Internal Affairs Unit of the Western Australia Police Force, having made inquiry into the question of whether the officers breached the Duty of Care Policy (DC-01.03) in connection with Mr Brady, found that breaches were not sustained. Subsequently however, this changed.[33]

52. A review by the Ethical Standards Division reporting on 6 November 2020 found that breaches of the Duty of Care Policy were sustained. The Internal Affairs Unit published an Addendum on 2 February 2022 also finding that breaches of the Duty of Care Policy were sustained. These subsequent reviews essentially found breaches by Senior Constable Corcoran and Probationary Constable De Costa, concerning their failure to comply with the Duty of Care Policy (DC-01.03) to "*preserve/maintain life when confronted with a preserve/maintain life critical incident*."[34]

53. The reviews broadly centred around the failure of the police officers to approach Mr Brady when he came to rest on the ground, to check for signs of life, and provide first aid. At the inquest Senior Sergeant Anthony Dorosz of the Internal Affairs Unit explained that the expectation was for Senior Constable Corcoran and Probationary

[31] Exhibit 1, tabs 7, 9 and 17.
[32] Exhibit 1, tab 23.
[33] Exhibit 1, tabs 15 and 24.
[34] Exhibit 1, tab 15; ts 39 to 42.

Constable De Costa to do what Sergeant Cooper had done and commence CPR.[35]

54. In the course of the reviews, the involved police officers provided their reasons for not checking on Mr Brady and commencing CPR. Senior Constable Corcoran stated that he went into "*shock*", and Probationary Constable De Costa stated that she "*froze*" in response to Mr Brady jumping off the building.[36]

55. The Western Australia Police Force took some steps in response to the outcome of the reviews. Senior Constable Corcoran and Probationary Constable De Costa were given verbal guidance and health and welfare support (including a fitness for duty assessment). A new training course had been implemented by police in February 2020: "*Effective Communication for Vulnerable People*" (*Effective Communication*) and both officers undertook and completed that training.[37]

56. I am relevantly informed, though not bound by, the outcomes of former reviews into the conduct of Senior Constable Corcoran and Probationary Constable De Costa. My comments on their actions appear immediately below.

57. Before Mr Brady jumped, Senior Constable Corcoran and Probationary Constable De Costa had at different stages each asked Mr Brady to sit down. He was standing precariously on the ledge of the wall of the third-floor balcony. Subsequent investigations showed that there was in fact no room for him to sit down (unless he were to climb back down onto the balcony). Probationary Constable De Costa did not think Mr Brady was going to jump off the building, though Senior Constable Corcoran had factored in the risk of a fall or a jump. At one stage Mr Brady appeared to bend his knees, as if he were going to sit. However, it is now known that this action was in preparation for the jump.[38]

58. Mr Brady jumped from the building approximately four minutes after Senior Constable Corcoran and Probationary Constable De Costa had first arrived on the scene. The Midland District Mental Health Co-

[35] ts 41 to 42.
[36] Exhibit 1, tab 15; ts13 to 14.
[37] Exhibit 1, tab 15; ts 11 to 12; ts 45 to 46.
[38] Exhibit 1, tabs 7 and 15; ts 6 to 8; ts 10 to 11; ts 19; ts 25 to 26.

Response Team had accepted the call from the Police Operations Centre as the primary vehicle, but there had not been enough time for them to arrive, and this aspect is addressed later in this finding under the heading: *Mental Health Co-Response Team*.[39]

59. Unfortunately, the events unfolded very quickly. Probationary Constable De Costa felt, not unreasonably, that she did not have time to contact the Midland District Mental Health Co-Response Team over the telephone, for guidance on how to interact with Mr Brady.[40]

60. Before the new *Effective Communication* training course became available, both police officers had completed some training in the area of mental health at the academy, but they did not feel prepared for how to approach the interaction with Mr Brady. Having subsequently undertaken the *Effective Communication* training, both police officers felt they had more skills for engaging with a vulnerable person in similar circumstances.[41]

61. As part of my comments on the police actions, I have considered the question of whether Mr Brady could have survived if earlier CPR had been given by Senior Constable Corcoran and Probationary Constable De Costa.

62. Mr Brady struck the ground at 8.17 am. Senior Constable Corcoran and Probationary Constable De Costa did not go over to him, and Probationary Constable De Costa began to direct traffic away from the scene. Senior Constable Corcoran placed a request for an ambulance (priority 1) at 8.19 am. At 8.21 am Sergeant Cooper and Probationary Constable Devigne arrived and, having immediately seen the need for assistance to be rendered, commenced CPR on Mr Brady. From the time that Mr Brady struck the ground, there was a lapse of just under four minutes before CPR was commenced.[42]

63. Dr Moss was asked to provide his opinion to the court on the question of Mr Brady's survivability, given his injuries, if CPR had commenced immediately. Dr Moss reported that in his view the head injury alone was non-survivable, and that earlier CPR would not have changed that

[39] Exhibit 1, tabs 7 and 15; ts 17 to 18; ts 22; ts 35.
[40] Ibid.
[41] ts 12 to 13; ts 19 to 20; ts 23 to 24; ts 32 to 33.
[42] Exhibit 1, tab 7, 15 and 23; ts 33 to 34.

outcome. He also took account of other significant injuries to the chest, pelvis and limbs, and further opined that the injuries in total (which includes the head injury) would "*certainly*" not have been survivable. I accept that opinion.[43]

64. I am therefore satisfied that Senior Constable Corcoran and Probationary Constable De Costa did not contribute to Mr Brady's death by failing to promptly commence CPR, because his injuries were non-survivable.

65. While it is now known that Mr Brady's injuries were non-survivable, this could not be known at the time, and the proper course would have been for Senior Constable Corcoran and Probationary Constable De Costa to immediately check for signs of life and commence CPR.[44]

66. At the material time Senior Constable Corcoran and Probationary Constable De Costa believed that Mr Brady was deceased. They have subsequently each acknowledged that they should have immediately attended to him. Through their lawyer the SSO, they submit they have accepted this responsibility, and point to the guidance and additional training they have received.[45]

67. Policing work must on occasions be carried out in an intense and volatile environment. The community expects police officers to be assessed and trained for working in such environments.

68. It would have been confronting for Senior Constable Corcoran and Probationary Constable De Costa to see Mr Brady jump from the building after they had done their best to settle him and avoid that outcome. The improvements in police training, including recognising and addressing the fight, flight or freeze response are addressed below.

69. This is part of a process of continual improvement, responding to changes in the policing environment, and the increase in the number of incidents involving vulnerable persons and/or persons with mental health conditions. I make no criticism of the training that had been

[43] Exhibit 1, tab 26; ts 43 to 47.
[44] Exhibit 1, tab 26; ts 15 to 16; ts 31 to 32; ts 34.
[45] ts 58.

available to Senior Constable Corcoran and Probationary Constable De Costa at the material time.

IMPROVEMENTS IN POLICE TRAINING

70. Senior Sergeant Saskia Yates, the officer in charge of the in-service training unit at the Western Australian Police Academy reported to the coroner on the improvements in police training for communicating with vulnerable people, and she gave evidence at the inquest.[46]

71. Since 2014, the training that had been available to recruits covered the following areas:

(a) Mental Health – including appropriately assisting and dealing with people presenting with mental health issues;

(b) Duty of Care – including identifying and reducing risk to persons in police custody;

(c) Police Negotiations – including sessions presented by trained negotiators, addressing skills for engaging with, and de-escalating, presenting behaviours.[47]

72. Following a 2019 review, from March 2020 the *Effective Communication* training course referred to previously was implemented for recruits, which included sessions designed to enable recruits to identify potential vulnerability. This course was expanded, to better equip recruits with verbal tools and knowledge to assist in engaging with growing rates of people presenting with mental health issues and/or other conditions that may result in increased vulnerability.[48]

73. In addition to training for recruits, there has been in-service training. The *Effective Communication* training course was further developed and expanded for serving police officers. It was rolled out as a

[46] Exhibit 1, tab 25; ts 49 to 59.
[47] Exhibit 1, tab 25; ts 50 to 51.
[48] Exhibit 1, tab 25.

mandated critical skill for serving police officers from 1 January 2021, in recognition of the high intensity of their work environment.[49]

74. This expanded training course has been designed to provide officers with an enhanced set of communication and negotiation skills to assist them in de-escalating crisis situations involving vulnerable people. It includes practical sessions with scenarios and exercises to put theory into practice and test de-escalation techniques. This training must now be undertaken every two years.[50]

75. Consistent with this requirement, the *Effective Communication* refresher package was implemented, with a roll out commencing in May 2022. With further and extensive consultation, the refresher package provides even more tools to assist police officers in how to communicate with people in crisis, including non-escalation techniques.[51]

76. It also focusses upon personal factors affecting police officers, such as stress management, emotional awareness and control, personal and professional pressures, and tolerance levels. These are important aspects of self-awareness that may impact upon how a police officer communicates in a crisis situation.[52]

77. At the inquest Senior Sergeant Yates provided some examples of a more direct style of communication with a vulnerable person, focussed on establishing a rapport and openly addressing any concerns about suicidality. Active listening and empathy are part of the approach.[53]

78. One of the features of the conduct of Senior Constable Corcoran and Probationary Constable De Costa concerned their reports of being in shock, or freezing, when Mr Brady jumped off the building. The Western Australia Police Force through its lawyer the SSO has confirmed that the mandated *Effective Communication* training contains information for police officers on the "*fight, flight or freeze response*".[54]

[49] Ibid.
[50] Ibid.
[51] Ibid.
[52] Exhibit 1, tab 25; ts 56 to 57.
[53] ts 52 to 54.
[54] Exhibit 2.

79. The information includes an outline of the body's physiological response to a stressful incident, the more extreme reactions it can cause, including freezing, and an inability to make rational decisions due to cognitive impairment. Short and long term coping mechanisms are addressed in the training, and well as strategies that can be used immediately in a critical or stressful situation.[55]

80. Senior Sergeant Yates also outlined the training provided by the Mental Health Co-Response Unit, to the police officers attached to that unit, in order to increase their understanding of mental health issues and their role in co-responding with health practitioners to incidents involving persons experiencing a mental health crisis. This training is being expanded as more officers across metropolitan police stations are tasked with assisting with co-response duties.[56]

81. By reason of the breadth of the training, the recognition of the high intensity work environment, the fact that the training is mandated (with refreshers) and that it remains under ongoing review, there is no need for me to make any recommendation concerning training improvements for police to assist in communications with vulnerable persons in crises.

MENTAL HEALTH CO-RESPONSE TEAM

82. The Mental Health Co-Response model is a collaboration between the Western Australia Police Force, the Mental Health Commission and the Department of Health. It has been designed with the aim of improving responses for attendance to tasks within the metropolitan region, where members of the public are experiencing a mental health crisis.[57]

83. The model includes Mental Health Co-Response Mobile Teams based at the police stations at Warwick (north), Cockburn (south), Cannington (South East) and Midland (East). At the material time, the Midland team serviced the Police Districts of Midland and Perth,

[55] Ibid.
[56] Exhibit 1, tab 25.
[57] Exhibit 3.

hence their response to the call from the Police Operations Centre to attend at the scene for Mr Brady.[58]

84. Each Mobile Team generally comprises two police officers and an Authorised Mental Health Practitioner, providing a response to mental health and welfare related incidents six days per week, from 1.00 pm to 11.00 pm.[59]

85. In 2022 the Mobile Teams were considered for expansion, with plans to double their number in the metropolitan area, provide seven afternoons of coverage and establish teams in Geraldton and Bunbury. These are under way. Further expansion has been proposed, for day shifts commencing at 7.00 am.[60]

86. However, under the operating model at the material time, at 8.10 am in the morning when the call was received on 15 May 2020, there was no Mental Health Practitioner on duty at the Police Operations Centre, and there was no Authorised Mental Health Practitioner in the police vehicle (MH630) that responded to the call.[61]

87. The responding police in vehicle MH630 arrived at the scene at 8.29 am, after Mr Brady had jumped from the building. It is to be borne in mind that even if a Mental Health Co-Response Mobile Team, with an Authorised Mental Health Practitioner on board, had been available and on site shortly after 8.10 am, there would have been limitations to their role.[62]

88. Specifically, 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. If an Authorised Mental Health Practitioner had been present on the morning of 15 May 2020, it is likely that they would have been instructed to wait near the vehicle or at a safe distance and would not have engaged with Mr Brady until the attending officers had de-

[58] Ibid.
[59] Ibid.
[60] Ibid.
[61] Ibid.
[62] Ibid.

escalated the situation and deemed that there was a safe place to speak with him.[63]

89. Nonetheless the benefits to the community of the Mental Health Co-Response Model, including the Mobile Teams, are not to be underestimated. The availability of a health practitioner for one of the attending police officers to consult could have been helpful at the time that they were endeavouring to engage with Mr Brady.

90. It cannot now be known whether it would have changed the course. Events unfolded very quickly and given what became subsequently known, by the time he was seen standing on the ledge Mr Brady appears to have become committed to his course of action.

91. Despite this, all reasonable and proper opportunities to de-escalate and establish a rapport should be taken by attending police officers in similar circumstances, in the hope that a person may be dissuaded from carrying out their intention, so that options for appropriate care and support may be considered.

RECOMMENDATIONS

92. It is recognised that significant support by way of funding and resourcing has been provided, and continues to be provided, for the Mental Health Co-Response, and that it continues to be analysed and developed.

93. In support of the continuation of the Mental Health Co-Response, and with the continued in principle support of the Western Australia Police Force I make the following recommendations, in similar terms to the ones I made in the inquest into the death of Andrew John KEY (CORC 977 of 2015):

[63] Ibid.

Recommendation 1

That the Mental Health Co-Response continues to be funded, and that consideration be given to providing the Western Australia Police Force and the Western Australia Mental Health Commission with additional, external funding in order to support expansion of the programme in a way that meets demand.

Recommendation 2

That consideration be given to providing the Western Australia Police Force and the Western Australia Mental Health Commission with additional, external funding in order to support the expansion of the Mental Health Co-Response in metropolitan areas of Perth.

Recommendation 3

That work continues on the planning of the Mental Health Co-Response in regional areas of the State, and consideration be given to providing the Western Australia Police Force and the Western Australia Mental Health Commission with additional, external funding in order to support the expansion of the Mental Health Co-Response into regional areas.

CONCLUSION

94. Mr Brady was a deeply loved and well supported member of his family. Colleagues and friends cared for him and tried to comfort him shortly before his death. The life stressors and the factors personal to Mr Brady that contributed to him forming his intention to take his life are complex. His suicide could not have been predicted.

95. The attending police officers used their best endeavours to divert him from his intended course of action, but they did not have much time. Lessons have been learnt by the attending police officers about the need to act swiftly to preserve and/or maintain life. They should have checked on Mr Brady and commenced CPR. It is now known that his injuries were non-survivable, but that could not have been known at the time.

96. The duty to preserve and/or maintain life needs to be well understood and adhered to.

97. The prompt rendering of first aid, with CPR, may be a person's only realistic prospect for survival. It can undoubtedly be confronting to perform CPR in circumstances where a person has suffered extensive and traumatic injuries. One of the aims of the assessment and training for police officers is to ensure, as far as is possible, that they have the requisite first aid skills and the aptitude to apply them in a crisis situation.

R V C FOGLIANI
STATE CORONER
28 FEBRUARY 2022