JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN, CORONER
HEARD	**:**	5 - 7 JUNE 2024
DELIVERED	**:**	31 JULY 2024
FILE NO/S	**:**	CORC 2823 of 2021
DECEASED	**:**	ABELA, JOSEPH CHARLES

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Mental Health Act 2014 (WA)
Prisons Act 1981 (WA)

Counsel Appearing:

Ms S Markham appeared to assist the coroner.

Ms P Femia and Ms A Nowak (State Solicitor's Office) appeared for the Department of Justice, the East Metropolitan Heath Service, and the Western Australian Police Force.

Ms B Kerr (Belinda Burke Legal) appeared for Mr E Rayapen.

SUPPRESSION ORDER

On the basis that it would be contrary to the public interest, I make an Order under section 49(1)(b) of the *Coroners Act 1996* that there be no reporting or publication of any document or evidence that would reveal police policies and standard operating procedures, tactics, or training methods in relation to the use of force, including, but not limited to, firearms.

Order made by: MAG Jenkin, Coroner (05.06.24)

Coroners Act 1996
(Section 26(1))

AMENDED RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Joseph Charles ABELA*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 5 -7 June 2024, find that the identity of the deceased person was* ***Joseph Charles ABELA*** *and that death occurred on 25 October 2021 at 162 Fremantle Road, Gosnells, from gunshot injuries in the following circumstances:*

TABLE OF CONTENTS

INTRODUCTION

1. Joseph Charles Abela (Joseph)[1] was 34-years of age when he died on 25 October 2021, after being shot by police, who were attending his home to conduct a mental health check. Immediately prior to his death, Joseph had been stabbing at an officer with a plasterer's saw.[2,3,4,5,6,7,8,9,10]

2. Under the terms of the *Coroners Act 1996* (the Act), Joseph's death was a "*reportable death*", and pursuant to section 22(1)(b) of the Act, because his death may have been caused by a member of the Western Australia Police Force (the Police), a coronial inquest was mandatory. I note that section 22(1)(b) of the Act 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 any member of the Police.[11]

3. I held an inquest into the Joseph's death on 5 - 7 June 2024 which was attended by members of his family. The documentary evidence adduced at the inquest comprised two volumes, and the inquest focused on the care, treatment and supervision provided to Joseph in the period before his death, as well as the circumstances and cause of his death.

4. When assessing the evidence in this case, I must be mindful of two key principles. The first is the phenomenon known as hindsight bias, which is the common tendency to perceive events that have occurred as having been more predictable than they actually were.[12]

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[1] Mr Abela's family requested that he be referred to as "Joseph" at the inquest and in this finding
[2] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (25.10.21)
[3] Exhibit 1, Vol. 1, Tab 2, P98 - Mortuary Admission Form (25.10.21)
[4] Exhibit 1, Vol. 1, Tab 3, P92 - Identification of deceased (26.10.21)
[5] Exhibit 1, Vol. 1, Tab 3, Affidavit - Sen. Const. S Durka (26.10.21)
[6] Exhibit 1, Vol. 1, Tab 3, Coronial Identification Report (26.10.21)
[7] Exhibit 1, Vol. 1, Tab 4.1, Supplementary Post Mortem Report (12.02.23)
[8] Exhibit 1, Vol. 1, Tab 5.2, Supplementary Toxicology Report (29.12.21)
[9] Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. District Officer L Barron (07.11.23)
[10] Exhibit 1, Vol. 1, Tab 27.1, IAU Report - Det. Sgt. S Perejmibida (01.11.23), p22
[11] Sections 3 & 22(1)(b), *Coroners Act 1996* (WA)
[12] See for example: www.britannica.com/topic/hindsight-bias

5. The other principle with which I must engage is known as the Briginshaw test. This principle is derived from a High Court judgment of the same name, in which Justice Dixon said:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "*reasonable satisfaction*" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.[13]

6. In a nutshell, the Briginshaw test requires that the more serious the allegation, the higher the degree of probability that is required before I can be satisfied as to the truth of the allegation.

7. Later in this finding, I will review actions of the police officers who attended Joseph's home and interacted with him before he died. I will apply the Briginshaw test to my analysis of the response of these officers, and also to the care provided to Joseph by the Armadale Community Mental Health Service (the Service).

8. I note that the following witnesses gave oral evidence at the inquest:

a. Mr Daniel Fraser (Joseph's housemate);
b. A/Sgt. Steven Millar, (Attending police officer);
c. First Class Const. Harry Beecher, (Attending police officer);
d. Dr Adam Brett (Independent Consultant Psychiatrist);
e. Const. Iris Marcelo (Attending police officer);
f. Dr Georgina Dell (A/Head of Psychiatry, AMHS);[14]
g. Mr George Miocevich (Attending police officer);[15]
h. Ms Lyn Madaffari (Mental Health Nurse, AMHS);
i. Dr Kevin Smith (Consultant Forensic Psychiatrist, Hakea Prison);
j. Mr John Morrison (Police use of force expert);
k. Mr Edouard Rayapen (Mental Health Nurse, AMHS); and
l. Det. Sgt. Stephen Perejmibida (Police Internal Affairs Unit).

[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336 per Dixon J at 362
[14] Armadale Community Mental Health Service
[15] At the relevant time, Mr Miocevich was a Senior Constable, but he has since retired from the Police

JOSEPH

Background[16,17,18,19,20,21,22]

9. Joseph was born on 1 March 1987, and was 34 years of age when he died on 25 October 2021. He had three older sisters, and his parents separated when he was about two years old. As a child, Joseph reportedly experienced deprivation, and may also have been the victim of familial childhood sexual abuse. Joseph reportedly had delayed speech development, and he was suspended from school for behavioural issues. After finishing school, Joseph did some casual work before successfully applying for the Disability Support Pension.

10. In 2011, Joseph rented a room in a house in Gosnells owned by Mr Fraser, who had advertised for boarders on a real estate website. Joseph rented a room in Mr Fraser's home until about 2014, when he said he was moving into a "*religious boarding house*". A short time later, Joseph returned and he stayed with Mr Fraser until about mid-2015, when he said he was moving to a house his uncle owned.

11. Mr Fraser did not have any contact with Joseph until some years later, when he happened to see Joseph walking around Champion Lakes Following that chance meeting, Joseph appeared on Mr Fraser's doorstep early one morning in late September 2021. Joseph told Mr Fraser he had been "*kicked out*" of his previous accommodation, and needed somewhere to stay, and at about 11.00 am that day, Joseph's mother arrived at Mr Fraser's home to drop off some of Joseph's things.

12. Mr Fraser told Joseph he could stay at the house and sleep, and that they would "*talk about the situation*" when Mr Fraser came home from work. That evening, Mr Fraser told Joseph he could stay as long as no "*dramas*" came through the front door, and they agreed on Joseph's weekly rent. I will say more about Joseph's time at Mr Fraser's home later in this finding.

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[16] Exhibit 1, Vol. 1, Tab 11, Statement - Ms E Browne (10.11.21), paras 4-64
[17] Exhibit 1, Vol. 1, Tab 12, Statement - Ms R De Bont (09.11.21), paras 2-32
[18] Exhibit 1, Vol. 1, Tab 24, Report - Dr A Brett (31.10.23), pp9-10
[19] Exhibit 1, Vol. 1, Tab 29, History for Court - Criminal and Traffic
[20] Exhibit 1, Vol. 1, Tab 33.3, SFMHS Discharge Summary (23.03.20) and ts 06.06.24 (Smith), pp183-185
[21] Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. District Officer L Barron (07.11.23), pp2-3 & 9-10
[22] Exhibit 1, Vol. 1, Tab Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 6-76

Medical and mental health history[23,24,25,26,27,28,29,30]

13. Joseph had an extensive mental health history and he was referred to a school psychologist when he was 14 years of age in relation to behavioural issues. Joseph experienced his first psychotic episode when he was 16 years of age, and he reportedly attempted to take his life by means of a deliberate overdose. Joseph had multiple admissions to hospital and he received various diagnoses, including: paranoid and catatonic schizophrenia, and antisocial personality disorder.

14. Joseph also had a significant history of suicide attempts, and a longstanding history of polysubstance use (including alcohol, cannabis, and methylamphetamine) and this complicated the management of his mental health. Joseph's frequent non-compliance with his medication regime was related to his chronic lack of insight into his mental illness and his need for treatment. Joseph had also reportedly developed an obsession with weapons and he collected knives. He had also disclosed to clinicians that he often went armed in public.[31,32,33]

15. Joseph would sometimes discuss religious matters, and he displayed poor impulse control. His behaviour was often volatile and aggressive, especially when he was unmedicated. He was difficult to engage in the community, and resented any attention from mental health services. However, because of the risks Joseph posed to himself and others, at various times he was "*assertively managed*" by the Community Forensic Mental Health Team (CFMHT) as an involuntary patient under community treatment orders (CTO)[34] and prescribed long-acting depot injections of the antipsychotic medication, haloperidol.[35,36]

[23] Exhibit 1, Vol. 1, Tab 24, Report - Dr A Brett (31.10.23), pp9-10 and ts 05.06.24 (Brett), pp73-76
[24] Exhibit 1, Vol. 1, Tab 33.3, State Forensic Mental Health Service Discharge Summary (22.06.20)
[25] Exhibit 1, Vol. 1, Tab 11, Statement - Ms E Browne (10.11.21), paras 45-46 & 64
[26] Exhibit 1, Vol. 1, Tab 31, Statement - Dr G Dell (30.05.24), paras 8-16
[27] Exhibit 1, Vol. 1, Tab 27.1, IAU Report - Det. Sgt. S Perejmibida (01.11.23), pp23-25
[28] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), paras 15-20 and ts 06.06.24 (Smith), pp183-185
[29] Exhibit 1, Vol. 2, Tab 1, Medical Records - Frankland Centre (F3188597)
[30] Exhibit 1, Vol. 2, Tab 2, EcHO Medical Records - Department of Justice (20/456043)
[31] Exhibit 1, Vol. 1, Tab 8, Statement - Mr R Craze (03.11.21), paras 5-7
[32] Exhibit 1, Vol. 1, Tab 11, Statement - Ms E Browne (10.11.21), paras 27 & 63
[33] Exhibit 1, Vol. 1, Tab 12, Statement - Ms R De Bont, paras 25 & 28
[34] A CTO is an involuntary order under the MHA requiring a person to submit to medical treatment
[35] Exhibit 1, Vol. 1, Tab 11, Statement - Ms E Browne (10.11.21), paras 27 & 63
[36] See also: Exhibit 1, Vol. 1, Tab 27.1, IAU Report - Det. Sgt. S Perejmibida (01.11.23), pp17-20

16. In 2020, Joseph was being managed in the community by the CFMHT, and on 16 March 2020, he was admitted to the Frankland Centre on a hospital order and prescribed olanzapine. Joseph was subsequently in custody from 24 March 2020 until 8 April 2020, although during that period he refused to take his medication.

17. Joseph's case illustrates the difficulties with managing persons in custody who have mental illness that require medication, and who refuse to take it. Whilst it may be possible to transfer such persons to the Frankland Centre and manage them on a hospital order, this is a temporary solution at best, and relies on the availability of a bed at the Frankland Centre. As I will discuss later, a plan to restart Joseph on his depot medication when he was remanded in custody to Hakea Prison (Hakea) in July 2021 was thwarted by the lack of any available beds.

Criminal and incarceration history[37,38]

18. Joseph had an extensive criminal record, and between 2006 and his death he had accumulated 34 convictions for offences including: assault occasioning bodily harm, common assault, stealing a motor vehicle, and breaches of various community orders. Joseph was incarcerated in 2007 in relation to various offences, and he was also remanded in custody at Hakea in 2020 and 2021. Joseph also received fines and was placed on various community orders in relation to other offences.

19. In addition to his period of custody in March and April 2020, Joseph was also incarcerated on several other occasions, namely:

a. *5 - 29 June 2020*: Joseph was remanded in custody at Hakea, and was seen by consultant psychiatrist, Dr Smith, on 15 June 2020. Dr Smith placed Joseph on a Form 1A under the Mental Health Act 2014 (MHA)[39] and referred him to the Frankland Centre so he could be started on his depot antipsychotic medication. Joseph was admitted to the Frankland Centre where he received his depot injection, before he was returned to Hakea on 22 June 2020.[40,41]

[37] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), paras 15-20 and ts 06.06.24 (Smith), pp185-190
[38] Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. District Officer L Barron (07.11.23), pp3-4
[39] A Form 1A requires a person to be transported to an authorised hospital for assessment and treatment
[40] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), paras 24-28

b. *29 June 2020 - 9 March 2021*: Joseph was transferred to Casuarina Prison, where he remained until his release on 9 March 2021. During this time, EcHO health records confirm that Joseph was challenging to manage, and he was transferred to the Frankland Centre on multiple occasions to receive his depot medication, which he regularly refused. Joseph continued to deny he had any mental health issues, and claimed that his depot medication was the "*cause of all his problems*", and that being sent to the Frankland Centre "*caused him major distress*". Joseph was released on bail on 9 March 2021.[42]

c. *12 - 16 July 2021*: Joseph was remanded in custody at Hakea, was seen by Dr Smith on 13 July 2021. Dr Smith confirmed that Joseph had been unmedicated since his release from prison on 9 March 2021. Despite Joseph's distress at "*facing treatment against his will*", Dr Smith considered this was necessary because Joseph's potential risk for "*serious aggression*" only improved when he was medicated.

Prior to Joseph's release from custody on 16 July 2021, he had been placed on a Form 1A and he was waiting for a bed at the Frankland Centre so he could be transferred there to restart his depot medication. However, no beds were available, and Joseph was released without receiving his depot medication (which he had refused), although he was referred to the Service.[43,44]

[41] Exhibit 1, Vol. 1, Tab 33.4, EcHO records (KHS4) (15.06.20)
[42] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), paras 29-32
[43] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), paras 33-41
[44] Exhibit 1, Vol. 1, Tab 33.5, EcHO records (KHS5) (13.07.21)

ISSUES RELATING TO JOSEPH'S CARE

Management by the Service: March - April 2021[45,46,47]

20. Joseph's last depot injection of haloperidol prior to his death occurred on 1 March 2021. Given that Joseph was prescribed this depot medication once every month, this means that Joseph was unmedicated for a period of seven months. As noted, Joseph was unexpectedly released from Hakea on bail on 9 March 2021.

21. A clinical nurse at Hakea sent a detailed referral email to the Service on 9 March 2021 outlining Joseph's background and the risks that Joseph posed when he was unmedicated.[48] In an email to the Service on 11 March 2021, Dr Smith expressed the view that in Joseph's case, CTO was "*most certainly required*".[49] However, despite these sensible and well-grounded concerns, and the fact that Joseph's bail conditions required him to report to the Police three times per week, Joseph was not contacted by the Service until 24 March 2021.

22. On 24 March 2021, a nurse phoned Joseph to advise him that his next depot injection of haloperidol was due on 2 April 2021, but Joseph reportedly said he would not take the depot injection. Despite this refusal, Joseph was not assessed in person, nor was he placed on a CTO. Instead, Joseph was discharged from the Service on 22 April 2021 for "*lack of engagement*".[50]

23. In my view given his history of violence when not medicated, and his history of non-compliance with medication, Joseph should have been placed on a CTO in March 2021, and given his depot medication monthly as prescribed on 2 April 2021. In my view, the fact that neither of these things occurred represents a missed opportunity where Joseph's mental illness could, and should have been assertively managed by the Service.

[45] Exhibit 1, Vol. 1, Tab 24, Report - Dr A Brett (31.10.23), p2
[46] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), paras 29-32
[47] Exhibit 1, Vol. 1, Tab 30.1, Statement - Ms L Madaffari (24.05.24) and ts 06.06.24 (Madaffari), pp153-180
[48] Exhibit 1, Vol. 1, Tab 26, Email - Mr M Edmunds to Service (09.03.21)
[49] Exhibit 1, Vol. 1, Tab 24, Report - Dr A Brett (31.10.23), p2
[50] ts 06.06.24 (Smith), pp187-188

Release from prison: 16 July 2021[51,52,53]

24. On 12 July 2021, Joseph was remanded in custody to Hakea, after he was charged with a breach of his protective bail conditions. As noted, Dr Smith reviewed Joseph on 13 July 2021, and recognised that Joseph was very unwell. Dr Smith placed him on a Form 1A, and referred him to the Frankland Centre so that Joseph's depot antipsychotic medication could be restarted.

25. On 15 July 2021, at a mental health case conference at Hakea, it was noted that Joseph was currently unmedicated, and that he was refusing to attend the prison medical centre to receive his depot medication. It was also noted that Joseph was still the subject of a Form 1A, and that a brief transfer to the Frankland Centre to restart his depot medication was appropriate. However, despite this very sensible plan, Joseph was not transferred to the Frankland Centre because there were no available beds, and there was a waiting period of six weeks.

26. Despite the fact that Joseph had now been unmedicated for almost four months, he was released from Hakea on 16 July 2021, following a court appearance by video-link, during which he was fined for breaching his protective bail conditions.[54] Joseph was referred to the Service by Hakea, and the Mental Health Emergency Response Line (MHERL) documented they had been notified that Joseph had been released "*on forms*" whilst unwell. Although MHERL questioned the safety of this arrangement and the apparent anomalous situation, no action was taken, and Joseph was simply released from custody.

27. The magistrate dealing with Joseph's breach of protective bail charges was not told Joseph had recently been the subject of a Form 1A, nor that Joseph was considered to be very unwell, and had not received his prescribed depot injections of haloperidol for several months. Worryingly, following Joseph's release from custody, his whereabouts were unknown for a period of about a week.

[51] Exhibit 1, Vol. 1, Tab 24, Report - Dr A Brett (31.10.23), pp2-3
[52] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), paras 33-41
[53] Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. District Officer L Barron (07.11.23), pp3-4
[54] Exhibit 1, Vol. 1, Tab 34, Transcript of proceedings - Magistrates Court of WA (21.07.21)

Management by the Service: July 2021[55,56,57]

28. On 21 July 2021, Joseph was assessed by Ms Madaffari (a mental health nurse who worked at the Service) during a home visit. Joseph's background information was noted, and it was documented that he had been exhibiting signs of paranoid ideation, suspiciousness, and aggressive behaviour prior to his release. It was also noted that Joseph had been non-compliant with his depot medication, and that he denied any self-harm ideation.

29. In her statement, Ms Madaffari says that Joseph was initially "*very angry*" at what he perceived was a "*breach of privacy*" by mental health services. However, Ms Madaffari says that Joseph was "*able to self soothe*", until his speech was at normal rate and volume, and that she saw no signs of paranoid ideation. Ms Madaffari also says Joseph was "*future focussed*", and that he told her he wanted to get a job, and "*just wanted to be left alone*".[58]

30. Despite the clear risks which had been articulated by mental health staff at Hakea, and the fact that Joseph had by this stage been unmedicated for several months, the Service determined that Joseph "*was able to demonstrate capacity*". Further when Joseph refused to have his depot medication, no further action was taken.

31. In my view Joseph should have been placed on a CTO and given his depot medication monthly, as prescribed. The fact that neither of these things happened at this time, represents a further missed opportunity where Joseph's mental health could, and should have been assertively managed by the Service.

[55] Exhibit 1, Vol. 1, Tab 30.1, Statement - Ms L Madaffari (24.05.24), paras 6-11 and ts 06.06.24 (Madaffari), pp159-164
[56] Exhibit 1, Vol. 1, Tab 24, Report - Dr A Brett (31.10.23), pp2-3 and ts 05.06.24 (Brett), pp78-83
[57] Exhibit 1, Vol. 1, Tab 25, Medical Records - Armadale Health Service (F3188597)
[58] Exhibit 1, Vol. 1, Tab 30.1, Statement - Ms L Madaffari (24.05.24), para 11

Concerns raised by Joseph's mother: 5 October 2021[59,60,61,62]

32. After his release from Hakea in July 2021, Joseph's mother had maintained contact with him, and she had noted that her son's paranoia had not improved, and that he believed "*he was constantly being watched and that people were breaking into his home*". Joseph had also told his mother that he wanted a new mobile phone because "*someone was hacking into his and monitoring him*".

33. On 5 October 2021, Joseph's mother contacted the Service to report her concerns. In her statement, Ms Madaffari says Joseph's mother reported Joseph was "*behaving in a paranoid way, believed his two phones were being tracked, and that he had recently assaulted a housemate*" and was to appear in court in relation to the assault on 8 October 2021. Joseph's explanation for the assault had been that the housemate he assaulted had urinated in a place that could be seen by children and Joseph "*did not think this was right*".

34. Joseph's mother also told Ms Madaffari that Joseph had moved to Gosnells, and although he was not using drugs or alcohol, he was staying in his room most of the time because he believed that if he left the house someone would "*break in*". Ms Madaffari told Joseph's mother that the Service was aware of Joseph's history, and would follow him up.

35. In her statement, Ms Madaffari explained the triage process she followed, and that she reviewed Joseph's history on the Psychiatric Services Online Information System (PSOLIS), an electronic mental health services record which records vital patient information. From her review, Ms Madaffari was aware that Joseph had been diagnosed with paranoid schizophrenia, and that he consistently declined engagement with mental health services. She also noted Joseph's extensive history of polysubstance use, and that he had been reported to exhibit "*signs of paranoia which presented as suspicious and aggressive behaviour*".[63]

[59] Exhibit 1, Vol. 1, Tab 24, Report - Dr A Brett (31.10.23), pp3-4 and ts 05.06.24 (Brett), pp83-85
[60] Exhibit 1, Vol. 1, Tab 30.1, Statement - Ms L Madaffari (24.05.24), paras 12-26 and ts 06.06.24 (Madaffari), p165 & 168-169
[61] Exhibit 1, Vol. 1, Tab 30.2, Mental Health Triage Form (06.10.21)
[62] Exhibit 1, Vol. 1, Tab 11, Statement - Ms E Browne (10.11.21), paras 56-62
[63] Exhibit 1, Vol. 1, Tab 30.1, Statement - Ms L Madaffari (24.05.24), paras 16-20

36. Ms Madaffari assessed the referral from Joseph's mother as "*urgent*", but a home visit could not be immediately conducted. That is because Ms Madaffari's had determined that Joseph's history, including his aggressive and violent behaviour towards health staff (including assaulting staff), meant that a home visit would require two mental health clinicians (one of whom had to be male), and a police escort of two officers.[64]

Home Visit: 6 October 2021[65,66,67,68,69]

37. Ms Madaffari managed to arrange a male mental health nurse (Mr Rayapen) and a police escort (namely Officers Marcelo and Beecher), and at about 11.00 am on 6 October 2021, the group visited Joseph's home. Ms Madaffari says the officers were carrying "*shields and batons*", but they stayed back and did not interact with Joseph, although they were visible to him.

38. Ms Madaffari and Mr Rayapen spoke briefly with Joseph (who was in his dressing gown) at the front door of his home. In his statement Officer Beecher says: "*the mental health staff spoke with Joseph for between five and 10 minutes*", although at the inquest Officer Beecher said the interaction had lasted "*no more than five minutes perhaps*".[70,71]

39. In any case, during the home visit, Ms Madaffari says she asked Joseph questions designed to assess his mental state. Joseph was described as "*not very talkative*" and "*quite guarded*", and he made it clear he did not like mental health staff, who he claimed had "*ruined*" his life.

40. Ms Madaffari says that despite the fact that Joseph was "*very blunt in his delivery*", he was more receptive than she had expected. She also says that Joseph denied he had any issues, and that he "*consistently refused engagement with mental health services*".

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[64] Exhibit 1, Vol. 1, Tab 30.1, Statement - Ms L Madaffari (24.05.24), paras 27-47
[65] Exhibit 1, Vol. 1, Tab 32, Statement - Mr E Rayapen (30.05.24) and ts 07.06.24 (Rayapen), pp210-228
[66] Exhibit 1, Vol. 1, Tab 24, Report - Dr A Brett (31.10.23), pp3-4 and ts 05.06.24 (Brett), pp83-89
[67] Exhibit 1, Vol. 1, Tab 30.1, Statement - Ms L Madaffari (24.05.24) and ts 06.06.24 (Madaffari), pp165-172
[68] Exhibit 1, Vol. 1, Tab 30.2, Mental Health Triage Form (06.10.21)
[69] Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. District Officer L Barron (07.11.23), p4
[70] Exhibit 1, Vol. 1, Tab 16, Statement - Const. H Beecher (29.10.21), para 35 and ts 05.06.24 (Beecher), p59
[71] See also: ts 05.06.24 (Marcelo), pp95-97 where Officer Marcelo agrees the interaction lasted less than 10 minutes

41. Ms Madaffari says Joseph told her he was upset he had been forced to leave his previous premises, and he denied that the alleged assault on his former housemate was his fault. She also said that during her interaction with Joseph, she was "*constantly assessing whether he was a risk to himself or to others*", and that she closely observed his language and physical behaviours, in the context of historical information.

42. Ms Madaffari says that although she did not dismiss the concerns expressed by Joseph's mother, she did not "*perceive any evidence that* (Joseph) *was experiencing a psychotic episode*". In her statement, Ms Madaffari says that as a result of her observations of Joseph, she concluded that:

> (Joseph) had a mental illness but at that time he was able to demonstrate capacity. (Joseph) appeared to be coping with his mental illness to a degree that I could not pinpoint anything that made me think he should be subjected to the restriction of an involuntary treatment order.[72]

43. However, in the Triage form completed after the visit, Ms Madaffari made the following observations under the heading "Mental State Examination":

> Insight and judgement impaired, doesn't believe he has a mental illness, does not want to engage with services and is happy to await court outcome and take the consequences.[73]

44. Ms Madaffari was aware of Joseph's upcoming court date in relation to the alleged assault, and thought this "*could be a trigger for his mental health*". Ms Madaffari also considered it would be appropriate for Joseph's case to be discussed at the Service's team meeting that afternoon, and for Joseph's referral to remain open "*for further engagement and assessment*". Ms Madaffari says she discussed her observations with Mr Rayapen, and that they both agreed that there were no grounds to exercise their powers under the MHA.

[72] Exhibit 1, Vol. 1, Tab 30.1, Statement - Ms L Madaffari (24.05.24), para 38
[73] Exhibit 1, Vol. 1, Tab 30.2, Mental Health Triage Form (06.10.21), p2

45. In his statement, Mr Rayapen says: "*Unfortunately, I do not have any recollection of (Joseph). I cannot recall the care if any that I gave to him*". Further, despite continuing to work at the Service in the period following Joseph's death, Mr Rayapen also asserts that he was unaware Joseph had died until receiving an email (probably from the Court in 2024) informing him there was to be an inquest into Joseph's death.[74]

46. Despite the assertions in his statement, and the fact that at the inquest he said his recall of the home visit was "*not much*", Mr Rayapen was actually able to recall a number of details. Mr Rayapen said he remembered going to a police station before the home visit , where there was "*some sort of a debrief*". Mr Rayapen also accepted that he had agreed with Ms Madaffari's assessment that there were no grounds to place Joseph on forms under the MHA, and that Joseph should have received a follow up home visit.[75]

47. Following the home visit, Ms Madaffari recorded the following assessment in the Triage form:

> Joseph is a 34 year old young single man who was average height and build, short cropped balding hair line. It was reported that Joseph's mental state was deteriorating and he had been charged with assault in the last week when…a former housemate…was urinating in front garden of the home. Joseph is in Court for this charge on Friday 8th October, 2021. Now moved to Gosnells.
>
> Mother reported that Joseph was exhibiting paranoid ideation, believing that people would break into the home if he should leave, also reported to be carrying 2 mobiles and often turned them off to stop people from tracking him. Home visit was conducted. Joseph was reluctantly cooperative and denied any psychotic phenomena. Happy to wait for the outcome of court case on Friday, denied the assault was driven by his mental health. Joseph also declined mental health input but has Mead Centre contact details for future reference.[76]

[74] Exhibit 1, Vol. 1, Tab 32, Statement - Mr E Rayapen (30.05.24), p2 (paras 1-2) and ts 07.06.24 (Rayapen), p224
[75] ts 07.06.24 (Rayapen), pp213-215 & 218-219
[76] Exhibit 1, Vol. 1, Tab 30.2, Mental Health Triage Form (06.10.21), p2

48. The upshot of the home visit was that Joseph was not placed on a CTO, nor was he restarted on his depot medication. This is despite the fact that by this stage Joseph had been unmedicated for over six months, and that he was reportedly exhibiting worrying symptoms. Joseph had also recently been charged with an alleged assault. Nevertheless, despite the lack of any immediate action by Ms Madaffari and Mr Rayapen, Joseph was discussed at the Service's team meeting that afternoon.

49. In passing I note that although the "*Action Plan*" section of the Triage form was ticked "*No further action is required*", this is apparently done for internal procedural purposes.[77] At the inquest, Officer Marcelo said she recalled one of the mental health nurses say words to the effect of "*Joseph knows what to say to make us go away*". Mr Rayapen said he did not recall this statement "*at all*", but in her evidence, Ms Madaffari agreed that she may have said this, and that this is not unusual.[78]

50. At the team meeting following the home visit, it was decided a follow up home visit was warranted. The following entry was made in Joseph's notes: "*H/V (home visit) completed. See…for MH assessment, not formable under the Act - client declined service. Referral to be open till court date on 08.10.2021. Need another home visit after Court* (to) *reassess*". This outcome is consistent with Ms Madaffari's view that although Joseph did not appear to be psychotic, "*further engagement and assessment was warranted*".

51. Although attempts were made to contact Joseph and his next of kin, and a message was left asking Joseph to call the Service, no follow up home visit ever occurred.[79,80,81] Entries in Joseph's notes state:

> 9 October 2021 (4.25 pm): Unable to compete home visit today due to acuity and also staff gender. Multiple alerts for threats of assaulting community staff. Need a male nurse for home visit.
>
> 11 October 2021 (2.10 pm): Intake (staff names) Outcome - not willing to engage.[82]

[77] Exhibit 1, Vol. 1, Tab 30.1, Statement - Ms L Madaffari (24.05.24), para 17 and ts 06.06.24 (Madaffari), pp173-174
[78] ts 05.06.24 (Marcelo), pp96-97; ts 07.06.24 (Rayapen), p220 and ts 06.06.24 (Madaffari), p179
[79] Exhibit 1, Vol. 1, Tab 30.2, ATT PSOLIS Referral Outcome Form (05-09.10.21)
[80] Exhibit 1, Vol. 1, Tab 30.2, Mental Health Triage Form (06.10.21), p2
[81] Exhibit 1, Vol. 1, Tab 30.1, Statement - Ms L Madaffari (24.05.24), paras 42-48
[82] Exhibit 1, Vol. 1, Tab 30.3, Integrated Progress Notes (06-11.10.21)

ASSESSMENT OF JOSEPH'S MENTAL HEALTH CARE

SAC1 review[83]

52. Following Joseph's death, a clinical investigation (SAC1) reviewed his mental health care against relevant East Metropolitan Health Service (EMHS) policies. The SAC1 expressed the following conclusion:

> In reviewing the circumstances for this event, the panel are of the view that there were contributory factors from the perspective of the healthcare provided that may have influenced the outcome of the adverse event for the consumer. Consideration was given to the current assessment of the patient, prior engagement with other services for clinical decision making and discharge processes with the panel making findings and recommendations that they believe will improve safety systems in relation to management of risk in the future.[84]

53. The SAC1 findings may be summarised as follows:

a. *Triage assessment:* the information from Joseph's mother on 5 October 2021 was correctly assessed by Ms Madaffari and the rating score assigned (urgent) was appropriate. A home visit was conducted promptly, as soon as the police escort and male clinician were booked;

b. *Risk assessment*: the SAC1 panel considered that the assessment for violent/aggressive factors following the home visit on 6 October 2021 was "*inadequate*" and resulted in a missed opportunity to further consider the consumer's level of risk for relapse;

c. *Lack of follow-up*: although Joseph had been referred to the Service's intake team following the home visit, the SAC1 panel considered there was a missed opportunity "*to apply the (MHA) as there was no assessment for risk of relapse or further exploration of (Joseph's) capacity*";[85] and

[83] Exhibit 1, Vol. 1, Tab 31, Statement - Dr G Dell (30.05.24), paras 20-28.1
[84] Exhibit 1, Vol. 1, Tab 31.1, SAC1 Clinical Incident Investigation Report (09.02.22), p8
[85] Exhibit 1, Vol. 1, Tab 31.1, SAC1 Clinical Incident Investigation Report (09.02.22), p7

d. *Discharge from the Service*: the SAC1 panel noted that in relation to Joseph's Service healthcare records, there was an absence of documentation of "*a risk assessment, liaison with the consumer's next of kin, collateral information, welfare check, or examination by a Consultant Psychiatrist*" prior to Joseph's discharge from the Service.[86]

54. The SAC1 panel made the following three recommendations to address issues identified during the review of Joseph's care:[87]

a. *Recommendation 1:* in order to address the lack of clear comprehensive policy in the area, the Service should develop a guideline aligning the policy framework for the clinical care of people with mental health problems who may be at risk of becoming violent and/or aggressive;

b. *Recommendation 2*: to address inadequacies in the instruction for patient safety plans, the Service should implement a "*structured procedure for the completion of patient safety plans within Mental Health with defined accountability and responsibilities of the stakeholders*";[88] and

c. *Recommendation 3*: the Service's home visits policy should be reviewed and updated to identify the level of risk required to initiate police attendance, determine the number of clinicians who should attend, and the gender attendance requirements "*based on current alerts*".[89]

Dr Dell's evidence[90]

55. In her statement, and during her evidence at the inquest, Dr Dell (the Service's Acting Head of the Department of Psychiatry) outlined the SAC1 findings and recommendations. Dr Dell agreed that during the home visit on 6 October 2021 there had been a missed opportunity to consider Joseph's risk of relapse, and that a CTO should have been considered.

[86] Exhibit 1, Vol. 1, Tab 31.1, SAC1 Clinical Incident Investigation Report (09.02.22), p7
[87] Exhibit 1, Vol. 1, Tab 31.1, SAC1 Clinical Incident Investigation Report (09.02.22), pp14-16
[88] Exhibit 1, Vol. 1, Tab 31.1, SAC1 Clinical Incident Investigation Report (09.02.22), p16
[89] Exhibit 1, Vol. 1, Tab 31.1, SAC1 Clinical Incident Investigation Report (09.02.22), p7
[90] Exhibit 1, Vol. 1, Tab 31, Statement - Dr G Dell (30.05.24) and ts 06.06.24 (Dell), pp111-128

56. Dr Dell also agreed that Joseph's healthcare record was incomplete, and there was no documentation about his current risk assessment, or his ongoing management. There was also an absence of intake proformas and assessments, and when Joseph was discharged from the Service, there was no discharge letter to his GP, nor had there been any involvement by a consultant psychiatrist. Further, no collateral information had been gathered, there was no liaison with Joseph's next of kin, and no documented risk assessment.

57. Dr Dell noted that EMHS had conducted its own review of Joseph's healthcare, and in addition to factors relating to Joseph's mental health history, that review had identified "*matters of significance*" under the following headings:

a. *Communication:* information provided by service providers referring Joseph to the Service was not documented on his intake proforma, meaning his assessment on admission and discharge was incomplete. There were also issues with the accurate identification of Joseph's risk factors for aggression and violence, resulting in an increased risk that "*critical information was not collated*" thereby affecting Joseph's treatment, support and discharge.[91]

b. *Knowledge/Skills/Competence*: the triage conducted on Joseph's admission to the Service did not adequately consider information from the referrer, previous risk assessments, or current alerts, resulting in "*an incorrect triage rating scale*". This limited the Service's opportunity to identify deteriorations in Joseph's mental state, and to "*formulate appropriate ongoing care*".[92]

c. *Work Environment/Scheduling*: at the relevant time, the Service's home visits policy was inadequate and did not outline processes for managing a consumer's risk of violence and aggression.[93]

[91] Exhibit 1, Vol. 1, Tab 31, Statement - Dr G Dell (30.05.24), paras 31-32
[92] Exhibit 1, Vol. 1, Tab 31, Statement - Dr G Dell (30.05.24), para 33
[93] Exhibit 1, Vol. 1, Tab 31, Statement - Dr G Dell (30.05.24), para 34

d. *Policies/Guidelines/Procedures*: there was an inadequate response to Joseph's "*limited engagement*", and his failure to attend scheduled appointments. Relevant information had not been considered during Joseph's admission to the Service, and opportunities to identify any deterioration in his mental state and offer appropriate ongoing care were thereby limited.[94]

e. *Safety Mechanisms*: Joseph's discharge from the Service was inadequate and did not involve a review "*of outcomes for follow up prior to the admission to the health service*", or input from a consultant psychiatrist.[95]

58. In her statement, Dr Dell confirmed that EMHS had undertaken work on all three recommendations made by the SAC1, and that work in relation to policies relating to violent and aggressive consumers was also continuing.[96]

59. In her statement, Dr Dell said she agreed with Dr Brett's assessment that there had been a "*disconnect*" between prison and community mental health services in relation to the transfer of Joseph's mental health care. Dr Dell also agreed that the SAC1 had identified missed opportunities in relation to Joseph's care, and at the inquest De Dell confirmed that it was her view that a follow up home visit should have been conducted, as mandated by the team meeting held following the 6 October 2021 visit by Ms Madaffari and Mr Rayapen.[97]

Dr Brett's assessment[98,99]

60. Dr Brett (an experienced consultant psychiatrist) reviewed Joseph's case, and provided a comprehensive report to the Court. Dr Brett's observations included:

a. *Level of risk:* Joseph had a "*high base line risk to both himself and others*" and this was reflected in risk assessments using contemporary professional assessment tools.

[94] Exhibit 1, Vol. 1, Tab 31, Statement - Dr G Dell (30.05.24), paras 36-38
[95] Exhibit 1, Vol. 1, Tab 31, Statement - Dr G Dell (30.05.24), para 39
[96] Exhibit 1, Vol. 1, Tab 31, Statement - Dr G Dell (30.05.24), paras 40-53.3
[97] Exhibit 1, Vol. 1, Tab 31, Statement - Dr G Dell (30.05.24), paras 54-59
[98] Exhibit 1, Vol. 1, Tab 24, Report - Dr A Brett (31.10.23) and ts 05.06.24 (Brett), pp72-93
[99] See also: ts 06.06.24 (Smith), pp191-202

b. *Untreated mental illness:* during his admission to Hakea in July 2021, Joseph's untreated mental illness was identified and a case conference recommended he be restarted on depot haloperidol, which he refused. Although a referral was made to the Frankland Centre, this did not occur because of a six week waiting list for beds. Dr Brett concluded:

> [I]n (Joseph's) case, his risk and management needs were identified while he was in custody, however, the systems were not in place to address them. His care was not consistent with the equivalent in the community. I would therefore conclude that his care was not good enough during his final period in custody.[100]

c. *Management in hospital:* Dr Brett expressed the view that given Joseph's history, he would have been better managed in a hospital setting, but noted this was thwarted by the lack of available beds at the Frankland Centre at the relevant time.

d. *Disconnect between prison and mental health services:* Dr Brett highlighted the "*disconnect*" between prison and mental health services, which he noted began in March 2021 when Joseph was released from custody without the knowledge of the prison mental health team. Further, although the prison psychiatrist had considered that Joseph needed to be managed on a CTO, "*this never happened*".

Dr Brett pointed out that Joseph was in and out of the community, and that although there needed to be a "*joint agreement regarding (Joseph's) long term management*" this appeared to be "*siloed between custody and community*".

Dr Brett referred to a community mental health service he had worked at in the UK , which maintained responsibility for the ongoing care of "*remand prisoners and short term sentenced prisoners*". Although the service did not provide care to the prisoner, it liaised closely with the prison mental health team that did, and Dr Brett observed that such a service: "*would have helped (Joseph)*".[101]

[100] Exhibit 1, Vol. 1, Tab 24, Report - Dr A Brett (31.10.23), p12
[101] Exhibit 1, Vol. 1, Tab 24, Report - Dr A Brett (31.10.23), p12

e. *Management on a CTO:* Dr Brett said that in his view (with which I agree) Joseph should have been placed on a CTO on both occasions he was released from custody in 2021. However, as Dr Brett pointed out, the prison mental health team "*are not always aware whether prisoners are going to be granted bail or not*", and that this was the case with Joseph. I would also note that when dealing with bail applications, judicial officers may be unaware of the applicant's psychiatric history and/or their level of risk. In my view, the practical benefits of judicial officers being so advised when considering releasing the person on bail are self-evident.

f. *Care provided by the Service:* Dr Brett said he believed the quality of care the Service provided to Joseph from July to October 2021 was "*suboptimal*". Dr Brett said Joseph's risk profile "*clearly showed that when he was unmedicated he was a significant risk to himself and others*", and that Joseph should have been on antipsychotic medication in depot form. Dr Brett also considered that Joseph fulfilled the criteria for a CTO,[102] and that Joseph should have received a follow-up home visit from the Service in conjunction with the Mental Health Co-Response Unit in October 2021.

Was Joseph's death preventable?

61. In his report, Dr Brett made the following observation about whether or not Joseph's death was preventable: "*I believe that (Joseph's) death could have been prevented. There were a number of occasions where his mental trajectory could have been changed*".[103] In my view, Dr Brett's use of the phrase "*could have been prevented*" is appropriate.

62. In his statement, Dr Smith said he did not consider Joseph's chronic psychotic mental illness was "*the only contributor which led to his frequent rejection of treatment and his death*". Dr Smith also identified Joseph's history of serious trauma, his dys-social personality traits, and Jospeh's use of illicit substances which had the potential to make him highly irrational and aggressive.[104]

[102] Exhibit 1, Vol. 1, Tab 24, Report - Dr A Brett (31.10.23), p13
[103] Exhibit 1, Vol. 1, Tab 24, Report - Dr A Brett (31.10.23), p13
[104] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), para 59

63. As I have outlined, in my view there were a number of missed opportunities where Joseph's mental health care could (and should) have been assertively managed by the Service. I also agree that Joseph should have been placed on a CTO and given his monthly depot injection of antipsychotic medication after his release from custody in 2021.[105]

64. However, after carefully considering all of the available evidence, and taking full account of the Briginshaw principle and the concept of hindsight bias, I have been unable to conclude (to the relevant standard) that any particular action, at any particular time would necessarily have meant that Joseph would not have died in the manner that he did.

65. What does seem clear however is that if, at any time in 2021, Joseph had been admitted to hospital as an involuntary patient and restarted on his depot antipsychotic medication, and then managed in the community on a CTO, then there is at least a possibility that the outcome in this case may have been different.

Comments on Joseph's care

66. As I have identified, in my view there were gaps in Joseph's mental health care, including after his release from custody in March 2021, and in July 2021. On both occasions, it is clear there was inadequate liaison between the prison and community mental health teams.

67. It is also true that whilst he was in custody, Joseph's regular refusal to accept his prescribed depot antipsychotic medication was an ongoing issue. Other than placing Joseph on a hospital order and transferring him to the Frankland Centre (where beds are extremely limited), prison mental health staff had limited other options.

68. As Dr Smith pointed out in his statement, the Frankland Centre is the only secure forensic mental health facility in Western Australia, and it provides clinical care for persons in custody. When it opened in 1993, the Frankland Centre had 30 beds at a time when the average daily number of prisoners in Western Australia was about 2,000.[106,107,108]

[105] See also: ts 05.06.24 (Brett), p91
[106] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), paras 48-49
[107] See: Australia Prisoners 1993 at: www.aic.gov.au/sites/default/files/2020-07/npc1993.pdf

69. In 2024 (some 31 years later) the Frankland Centre still has only 30 beds, whereas the prison population is upwards of 6,500.[109,110,111] Clearly access to beds at the Frankland Centre is an ongoing issue, and although a new secure forensic mental health facility with increased capacity is planned, there is no firm indication of when this facility will actually open, and when the new beds will become available.[112]

70. In his statement, Dr Smith said he thought CTO's should be an option for clinicians managing persons in custody, but he added this caveat:

> However, I qualify this opinion with the view that prisoners would only be able to be injected against their will with medication at the Frankland Centre after being advised they were in breach of the CTO requirement to comply with medication.[113]

71. Dr Smith acknowledged that his views about CTOs are not supported by the Royal Australian and New Zealand College of Psychiatrists, and that the necessary psychiatric resources to "*manage the administration of CTOs which would include writing Mental Health Tribunal reports and attending hearings*" are not currently available within the custodial system.[114] Nevertheless, it is clear that Joseph "*fell through the cracks*" during his movements between the community and prison, and for that reason I have recommended that the Departments of Justice and Health confer with a view to identifying possible solutions.

72. As I have explained, on the occasions when Joseph was released from custody, he was neither placed on a CTO, nor was he given his prescribed depot antipsychotic medication. In my view, both of these things should have occurred. At the inquest, various witnesses agreed that this would have been appropriate, and Dr Brett noted that for Joseph, the "*cornerstone of management was regular depot medication*".[115,116]

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[108] See also: ts 05.06.24 (Brett), pp76-77
[109] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), paras 48-49
[110] See: https://www.wa.gov.au/system/files/2023-10/department-of-justice-annual-report-2022-2023.pdf
[111] See also: ts 05.06.24 (Brett), pp76-77
[112] ts 06.06.24 (Smith), p195
[113] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), paras 45 and ts 06.06.24 (Smith), pp193-195
[114] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), paras 46-47 & 52
[115] For example see: ts 06.06.24 (Madaffari), p164 and ts 07.06.24 (Rayapen), pp225-226
[116] ts 05.06.24 (Brett), p75

73. As I have noted, Joseph's release from custody in March 2021 and July 2021, were unexpected and mental health staff at Hakea were not adequately forewarned. Although there is no evidence about what (if anything) the magistrate dealing with Joseph's bail application in March 2021 was told about his mental health, on 21 July 2021, the magistrate dealing with Joseph's breach of protective bail conditions was told nothing about Joseph's mental health.[117]

74. I agree with the following observation Dr Smith makes in his statement:

> [I]t should be a requirement of prison mental health services to inform the Courts, and a requirement of the Courts to acknowledge, when prisoners attending the Court are on a Form 1A. The busy Court would be better informed and could seek advice regarding the possible need for a Hospital Order. I do not think that it is desirable that defence lawyers usually take carriage of this issue as the objectives of the prison mental health team and the defence lawyer may not align.[118]

75. After reviewing the available evidence and for the reasons I have expressed, I have concluded that the treatment, supervision and care that the Service provided to Joseph between March 2021 and October 2021 was substandard. In my view, Joseph should have been more assertively managed by the Service during this period, and his refusal to accept mental health treatment should have been challenged, and followed up.

76. Further, in my view, the fact that the Service took no action in relation to Joseph's mental health after the failed attempt to contact him on 9 October 2021 represents a truly appalling lapse, especially given Joseph's background and recent history, and the fact that by that time he had been unmedicated for over six months. In my view, this failure represents a further missed opportunity where Joseph's mental health should have been assertively assessed and managed. At the inquest, no explanation was offered as to how this appalling lapse had occurred.[119]

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[117] Exhibit 1, Vol. 1, Tab 34, Transcript of proceedings - Magistrates Court of WA (21.07.21)
[118] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), paras 46-47 & 53 and ts 06.06.24 (Smith), pp190-191
[119] ts 06.06.24 (Madaffari), pp169-170 and ts 07.06.24 (Rayapen), pp219-221

EVENTS LEADING TO JOSEPH'S DEATH

Mr Fraser's concerns and report to police[120,121]

77. I now turn to the events which led to Joseph's death. In his statement, Mr Fraser said that when Joseph moved in to his home in late September 2021, he immediately realised that "(Joseph) *was different from last time*". Mr Fraser said he was aware that clinicians from the Service had visited Joseph, but that Joseph had told him "*everything was fine and he was ok to stay*".[122]

78. Nevertheless, Mr Fraser says Joseph would talk about conspiracies, including that "*the government was poisoning the drinking water*" and that he (Joseph) believed neighbours were spying on him when he walked to the shops. Joseph would also express concern for Mr Fraser's safety when he (Mr Fraser) left home to walk his dog.[123]

79. Mr Fraser said that from his perspective, Joseph was "*irrational, psychotic and paranoid*", and Mr Fraser felt "*a bit uneasy*" about Joseph's apparent paranoia and the things he was saying. Mr Fraser received a text message from Joseph on 20 October 2021, in which Joseph said he was worried "*something bad*" had happened to Mr Fraser. After receiving the text message, Mr Fraser tried calling Joseph but there was no reply.[124]

80. When Mr Fraser came home from work that night, he asked Joseph about the text message. Instead of a reply, Joseph went to his room and then handed Mr Fraser a handwritten note which referred to issues such as "*prophets from Satan*" and "*evil*" being "*like a sport to a fool*". Mr Fraser said he had seen other similar notes from Joseph in the past and that he told Joseph he was "*not interested in that kind of stuff*". Joseph replied that just trying to "*educate*" Mr Fraser, who told Joseph that if wanted to continue to stay in the house he would "*need to go and get some help*".[125]

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[120] ts 05.06.24 (Fraser), pp9-29
[121] Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. District Officer L Barron (07.11.23), p8
[122] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 77-81
[123] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 84-88
[124] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 93-97
[125] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 98-105

81. When he came from work at about 6.00 pm on 21 October 2021, Mr Fraser told Joseph he would have to move out. Mr Fraser said he would help Joseph find alternative accommodation, and that Joseph could keep the mattress in his bedroom, which belonged to Mr Fraser. Mr Fraser says Joseph walked back to his bedroom and slammed the door, and Mr Fraser told Joseph (through the closed door) that he was "*only trying to help him*". Joseph told Mr Fraser to "*fuck off*", and said Mr Fraser was "*screwing him over*" as he had nowhere else to go.[126]

82. Mr Fraser called Joseph's mother for advice, before going to the Cannington police station at about 7.30 pm. Mr Fraser explained his situation and was advised to check the websites for the Department of Commerce, and Real Estate Institute of WA for eviction options. Mr Fraser says he was told by police that unless Joseph "*got physical, or threatened me, the house, or the animals then they would not have grounds to assist*". Mr Fraser said although he was disappointed police could not assist him, he understood what they had told him.[127]

83. Mr Fraser did not see Joseph again until 23 October 2021, when he bumped into Joseph in the front hallway, and they had a brief conversation. Mr Fraser also had a further brief conversation with Joseph the following day (24 October 2021) at about 4.00 pm.[128]

84. At about 12.30 am on 25 October 2021, Mr Fraser says he returned home from visiting a friend to find Joseph was standing in the front doorway with his arms folded and glaring in "*a very aggressive pose*". Mr Fraser said he felt threatened by Joseph's attitude and after walking past him, Mr Fraser asked Joseph what was wrong.[129]

85. Joseph response was "*What the fuck's going on here*" as he pointed to a mirror in his room that he had taken down. The mirror had been concealing a power point, which Joseph accused Mr Fraser of deliberately hiding.[130]

[126] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 112-117
[127] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 118-126
[128] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 127-136
[129] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 137-145
[130] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 146-150

86. Mr Fraser told Joseph he had forgotten about the power point, and says Joseph was "*flexing his muscles, rigid in his stance, clenching his fists, and getting very angry*". Joseph told Mr Fraser he had Mr Fraser's dog's bed in his room, which Mr Fraser retrieved, before Joseph slammed the door, with the dog inside his bedroom.[131]

87. Mr Fraser says that given Joseph's mood, he was not happy for his dog to be in Joseph's room, and he called on Joseph to let the dog out, but was told to "*fuck off*". Mr Fraser says he kicked at the door which opened, and he went inside. Mr Fraser says he told Joseph not to worry about the next week's rent and to "*just get out*". Mr Fraser says Joseph said it was his room, and that Joseph kept repeating "*it's our house*" and saying he wasn't leaving as he had nowhere to go.[132]

88. Mr Fraser says he told Joseph that if he were not out of the house by the following day he would make other arrangements to ensure Joseph left. Mr Fraser says that Joseph then came out of his bedroom and stood directly in front of him. Joseph appeared very angry and was clenching his fists and glaring at Mr Fraser whilst "*puffing up his chest*". Mr Fraser says he was concerned about Joseph's behaviour, but "*was trying to appear confident and wasn't letting him see I was afraid of him*".[133]

89. Mr Fraser says Joseph began shouting at him to get out of his room, and then placed his hands on Mr Fraser's upper chest and pushed him out of the room. Joseph then slammed the door and when Mr Fraser told Joseph if he didn't leave the next day, he would call the Mead Centre (a mental health service). Joseph replied that if Mr Fraser called the Mead Centre, he (Joseph) "*would burn the fucking house down*". Mr Fraser told Joseph he had "*crossed the line*" before grabbing his dog and heading towards the front door.[134]

[131] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 151-157
[132] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 158-167
[133] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 168-172
[134] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 174-182

90. Mr Fraser says that as he was leaving the house, Joseph opened his bedroom door and said: "*where the fuck are you going*", to which Mr Fraser replied he was going to call the police. Mr Fraser says Joseph then yelled "*this is what you've been waiting for, you've riled me up and now you're going to fuck me over*".[135]

Police attendance: 25 October 2021[136,137,138,139,140,141,142,143]

91. At about 1.00 am on 25 October 2021, Mr Fraser got in his car and drove up the road before calling emergency services to report "*an aggressive, argumentative housemate who's threated to burn my house down*". As a result of that call, four police officers (the Officers) attended a local shopping centre close to Mr Fraser's house to speak with him.

92. The four police who attended were Acting Sergeant Steven Millar (Officer Millar), Constable Harry Beecher (Officer Beecher), and Constable Iris Marcelo from Gosnells police station; and Senior Constable George Miocevich (Officer Miocevich)[144] who was usually based at the Cannington police station, but who was assisting Gosnells police that night.

93. At the shopping centre, the Officers met up with Mr Fraser who briefed them on the events of that evening. In his statement, Officer Millar says he told Mr Fraser police had no powers to evict tenants, but that based on what Mr Fraser had told him, he considered Joseph may have mental health and welfare issues. Officer Millar did not consider that Joseph was "*an arrestable suspect for any offences*", but considered that it would be appropriate to drive to Mr Fraser's house to check on Joseph's welfare "*and ensure he had no intention of burning down the house*".[145]

[135] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Fraser (25.10.21), paras 183-185 and ts 05.06.24 (Fraser), pp25-29
[136] Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. District Officer L Barron (07.11.23), pp1-2
[137] Exhibit 1, Vol. 1, Tab 9, Statement - Ms M Bridge (25.10.21)
[138] Exhibit 1, Vol. 1, Tab 10, Statement - Mr P Bridge (25.10.21)
[139] Exhibit 1, Vol. 1, Tab 13, Statement - Ms J Jackson (25.10.21)
[140] Exhibit 1, Vol. 1, Tab 15, Statement - A'Sgt S Millar (29.10.21), paras 26-78 ts 05.06.24 (Millar), pp30-36
[141] Exhibit 1, Vol. 1, Tab 16, Statement - Const. H Beecher (29.10.21), paras 10-62 and ts 05.06.24 (Beecher), pp61-62
[142] Exhibit 1, Vol. 1, Tab 17, Statement - Sen. Const. G Miocevich (25.10.21), paras 4-31 and ts 05.06.24 (Miocevich), pp129-130
[143] Exhibit 1, Vol. 1, Tab 18, Statement - Const. I Marcelo (25.10.21), paras 4-24 and ts 05.06.24 (Marcelo), p98
[144] At the relevant time, Mr Miocevich was a Senior Constable, but he has since retired from the Police
[145] Exhibit 1, Vol. 1, Tab 15, Statement - A'Sgt S Millar (29.10.21), paras 37-38

94. At the inquest, each of the Officers confirmed that prior to making their way to Mr Fraser's house, none of them were satisfied that Joseph had committed any arrestable offence, and that their purpose in going to Mr Fraser's house in order to speak with Joseph was to conduct a mental health/welfare check.[146,147]

95. On arrival at Mr Fraser's house, Officer Millar told Mr Fraser to wait next to the police vehicle in the driveway. Meanwhile, Officers Miocevich and Marcelo approached the house and knocked on the front door, whilst Officers Millar and Beecher moved to positions where they could see down the right and left sides of the house respectively.

96. When there was no answer to the knocks on the front door, the Officers (less Officer Marcelo who remained at the front door) entered the home by the back door using a key provided by Mr Fraser. Before entering the house, Officer Millar took out his OC spray[148] because of what Officer Beecher had told him about interactions he had with Joseph in June 2021 and October 2021.

97. Officer Beecher had told Officer Millar that on 5 June 2021, he and his partner went to arrest Joseph in relation to various alleged offences (including an aggravated assault involving an ex-partner). Although Joseph came to the front door armed with a hammer, he placed the hammer on the floor when Officer Beecher's partner asked him to do so, and did not behave aggressively when he was arrested.[149,150]

98. Officer Beecher also told Officer Millar that on 6 October 2021, he and Officer Marcelo had accompanied Ms Madaffari and Mr Rayapen when they conducted a home visit to assess Joseph. As I have noted, Ms Madaffari and Mr Rayapen spoke with Joseph briefly before deciding he did not need to be admitted to hospital under the MHA. Officer Beecher had also noted that although Joseph seemed agitated, he was not aggressive.[151]

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[146] Exhibit 1, Vol. 1, Tab 16, Statement - Const. H Beecher (29.10.21), paras 42-47 and ts 05.06.24 (Beecher), p63
[147] ts 05.06.24 (Millar), p36; ts 05.06.24 (Marcelo), pp97-98 and ts 05.06.24 (Miocevich), pp129-130
[148] OC spray is the abbreviation for oleoresin capsicum spray, which is designed to temporarily blind a person
[149] Exhibit 1, Vol. 1, Tab 16, Statement - Const. H Beecher (29.10.21), paras 24-31 and ts 05.06.24 (Beecher), pp56-58
[150] ts 05.06.24 (Millar), pp35-36
[151] Exhibit 1, Vol. 1, Tab 16, Statement - Const. H Beecher (29.10.21), paras 32-37 and ts 05.06.24 (Beecher), pp58-61

99. Meanwhile, as Officer Miocevich and Officer Beecher moved through Mr Fraser's house followed by Officer Millar, they called out "*clear*" as they passed through each room, to indicate Joseph was not present. As he walked through the kitchen, Officer Millar saw a knife on the dining room table which he placed on some high shelves out of the way, in accordance with standard procedure.

100. Officer Miocevich reached Joseph's bedroom at the front of the house, and knocked on the closed bedroom door. Joseph said: "*Who is it?*" and Officer Miocevich replied "*Police*". The Officers then heard what sounded like furniture being moved around inside the bedroom. When Officer Miocevich opened the bedroom door, Joseph was standing with his back against the opposite wall, about three metres away. He had used furniture to create a barricade around himself, and there was a small cabinet, and a coffee table in front of him.

Outline of events: 25 October 2021[152,153,154,155,156,157]

101. The events which occurred next and which led to Joseph's death may be summarised as follows:

a. As soon as Officer Miocevich opened the bedroom door, Joseph began yelling and swearing, and was telling the Officers to get out, and this was "*his house*". Joseph was clearly highly agitated and distressed and as Officer Miocevich tried to placate Joseph and explain why police were there, Officer Millar entered the bedroom and took up a position at a 45° angle to where Joseph was standing;

b. Officer Miocevich asked Joseph how he was, and tried to reassure him that police were only there to check on him. Despite Officer Miocevich's efforts, Joseph became increasingly more agitated, and was shouting and swearing at the Officers and demanding they leave his bedroom and get out of the house;

[152] Exhibit 1, Vol. 1, Tab 28, Use of Force Report - Mr J Morrison (23.10.23), paras 308-549 and ts 06.06.24 (Morrison), pp137-153
[153] Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. Dist. Officer L Barron (07.11.23), pp1-2 & 6-9
[154] Exhibit 1, Vol. 1, Tab 15, Statement - A'Sgt S Millar (29.10.21), paras 79-125 and ts 05.06.24 (Millar), pp36-54
[155] Exhibit 1, Vol. 1, Tab 16, Statement - Const. H Beecher (29.10.21), paras 63-94 and ts 05.06.24 (Beecher), pp62-71
[156] Exhibit 1, Vol. 1, Tab 17, Statement - Sen. Const. G Miocevich (25.10.21), paras 32-58 and ts 05.06.24 (Miocevich), pp130-135
[157] Exhibit 1, Vol. 1, Tab 18, Statement - Const. I Marcelo (25.10.21), paras 25-45 and ts 05.06.24 (Marcelo), pp98-106

c. As Officer Miocevich continued his attempts to engage with Joseph, Officer Beecher, and Officer Marcelo (who had been let into the house through the front door) stood in the hallway;

d. Joseph suddenly stopped yelling and swearing and appeared to be "*bracing up like he was getting ready to fight*". Joseph then made "*a strange noise like a dog growl*" before leaning forward and picking up what appeared to be a knife[158] from the coffee table in front of him (the Weapon). He then began using the Weapon to threaten the Officers;

e. Officer Miocevich said words to the effect of "*You don't want to do that*" or "*Don't pick that up*", and it appeared to Officer Millar that Joseph was about to lunge forward and stab Officer Miocevich. He (Officer Millar) then took a few steps forward and deployed his OC spray, although it had no apparent effect;

f. While still armed with the Weapon, Joseph picked up the small cabinet in front of him and used it to strike Officer Millar in the head, causing a cut lip and a damaged tooth, and knocking Officer Millar to the ground;[159]

g. While Officer Millar was in a seated position with his back against the wall, Joseph hit him the cabinet, but Officer Millar managed to use his hands to deflect the blow. Joseph then stood over Officer Millar and started stabbing at him with the Weapon;

h. Officer Millar held his hands in front of him to try to defend himself as Joseph continued stabbing wildly at him with the Weapon, causing minor lacerations to Officer Millar's head and face, and a 5 cm wound to his upper arm;[160]

i. Meanwhile, Officer Beecher, who feared Officer Millar was about to be stabbed to death, entered the bedroom and discharged his Taser[161] at Joseph. Although both Taser probes hit Joseph in the torso, this had no apparent effect;

[158] The "knife" was later identified as a plasterer's saw that had a sharp, serrated, 15 cm blade
[159] Exhibit 1, Vol. 1, Tab 28, Use of Force Report - Mr J Morrison (23.10.23)
[160] See photo: Exhibit 1, Vol. 1, Tab 27.1, IAU Report - Det. Sgt. S Perejmibida (01.11.23), p28
[161] A Taser is a device that fires two probes into the offender to cause temporary neuromuscular incapacitation by electric shock

j. After he fired the Taser, Officer Beecher lost his footing and fell to the floor. Joseph then turned his attention to Officer Beecher, and began stabbing him repeatedly with the Weapon to the back and chest, causing minor lacerations to Officer Beecher's left elbow and damaging Officer Beecher's ballistic vest;

k. Despite Joseph's repeated blows, Officer Beecher did not sustain fatal injuries because his ballistic vest offered a degree of protection, although the outer covering of the vest was penetrated by the Weapon;[162]

l. Nevertheless, Officer Beecher remained in grave danger because although his ballistic vest provided some protection to his back and chest, it offered no protection to Officer Beecher's head, neck, arms or legs as Joseph's frenzied attack continued;[163] and

m. As Officer Beecher scrambled towards the bedroom door on all fours, he was pursued by Joseph. By this stage, Officer Millar had regained his footing and he drew his police pistol;

n. Fearing that Officer Beecher was about to be killed, Officer Millar fired three shots at Joseph. Two of the shots struck Joseph in the chest, while the third struck him in the left shoulder; and

o. After Joseph was shot, he slouched onto his bed against the wall. Although he was still holding the Weapon, moments later he dropped it and it fell to the floor. Officer Millar kicked the knife away and told Officer Marcelo to call VKI (Police Operations Command) and request an ambulance, which she did. Officer Millar then holstered his pistol and moved to where Joseph lay to provide first aid.

102. The terrible events I have just described took place within the confines of Joseph's cramped bedroom, in less than three minutes. Graphic footage from the body worn cameras worn by the Officers clearly shows that despite their concerted efforts to deescalate the situation, Joseph became increasingly more agitated and distressed.

[162] Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. District Officer L Barron (07.11.23), p6
[163] ts 05.06.24 (Beecher), pp70-71

First aid and Joseph's death[164,165,166,167,168]

103. As noted, after Joseph was shot, he collapsed onto the bed in his bedroom. After the Weapon had been moved safely out of the way, Officers Millar and Beecher immediately provided first aid, assisted by Officer Marcelo, who called VKI to request an ambulance, before bringing "*chest seals*" into the bedroom which she applied to Joseph's three gunshot wounds.

104. As Officer Miocevich was on his mobile giving instructions to emergency services several ambulances arrived, along with other police. Police and ambulance officers (including a clinical support paramedic, and an area manager) continued their resuscitation attempts, but Joseph could not be revived.[169,170,171,172,173,174,175]

105. Joseph was declared deceased at 1.41 am on 25 October 2021 by the clinical support paramedic.[176,177,178,179,180,181,182,183]

[164] Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. District Officer L Barron (07.11.23)
[165] Exhibit 1, Vol. 1, Tab 15, Statement - A'Sgt S Millar (29.10.21), paras 133-147 ts 05.06.24 (Millar), pp48-
[166] Exhibit 1, Vol. 1, Tab 16, Statement - Const. H Beecher (29.10.21), paras 95-121 and ts 05.06.24 (Beecher), pp68-71
[167] Exhibit 1, Vol. 1, Tab 17, Statement - Sen. Const. G Miocevich (25.10.21), paras 59-67 and ts 05.06.24 (Miocevich), pp135
[168] Exhibit 1, Vol. 1, Tab 18, Statement - Const. I Marcelo (25.10.21), paras 46-64 and ts 05.06.24 (Marcelo), pp106-108
[169] Exhibit 1, Vol. 1, Tab 19, Statement - Clinical Support Paramedic D Aris (04.11.21)
[170] Exhibit 1, Vol. 1, Tab 19, SJA Patient Care Record CSS01N2 (25.10.21)
[171] Exhibit 1, Vol. 1, Tab 20, Statement - Paramedic M Weavers (04.11.21)
[172] Exhibit 1, Vol. 1, Tab 20, SJA Patient Care Record SER21N2 (25.10.21)
[173] Exhibit 1, Vol. 1, Tab 21, Statement - Paramedic L Bernard (27.10.21)
[174] Exhibit 1, Vol. 1, Tab 22, Statement - Paramedic N Graefling (05.11.21)
[175] Exhibit 1, Vol. 1, Tab 23, Statement - Paramedic Area Manager H Northey (27.10.21)
[176] Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. District Officer L Barron (07.11.23), pp4-5
[177] Exhibit 1, Vol. 1, Tab 19, Statement - Clinical Support Paramedic D Aris (04.11.21), para 31
[178] Exhibit 1, Vol. 1, Tab 19, SJA Patient Care Record CSS01N2 (25.10.21)
[179] Exhibit 1, Vol. 1, Tab 20, Statement - Paramedic M Weavers (04.11.21), para 36
[180] Exhibit 1, Vol. 1, Tab 20, SJA Patient Care Record SER21N2 (25.10.21)
[181] Exhibit 1, Vol. 1, Tab 1, P100 - Report of Death (25.10.21)
[182] Exhibit 1, Vol. 1, Tab 2, P98 - Mortuary Admission Form (25.10.21)
[183] Exhibit 1, Vol. 1, Tab 3, P92 - Identification of deceased (26.10.21)

CAUSE AND MANNER OF DEATH[184,185,186]

106. Two forensic pathologists (Dr Vagaja and Dr Downs) conducted a post mortem examination of Joseph's body on 27 and 28 October 2021, and noted the following injuries:

i. Two gunshot wounds to Joseph's chest and one gunshot wound to the front of Joseph's left shoulder; and

ii. Injuries to Joseph's right lung, diaphragm, liver, inferior vena cava, right kidney, stomach, abdominal fat, the soft tissue of the retroperitoneum and chest, and fractures to a rib, the left humerus, and a portion of a lumbar vertebra.

107. No exit wounds were noted, and three metal projectiles were retrieved from Joseph's body. Two abrasion marks (which were thought to be possible Taser probe marks) were seen on the skin of Joseph's torso, and he was noted to have a fatty liver, and a small left kidney. Microscopic examination of tissues found no underlying disease, and specialist examination of Joseph's brain found no significant abnormalities.[187]

108. Toxicological analysis of samples taken after Joseph's death detected low levels of haloperidol. The analysis did not detect alcohol or other common drugs.[188,189]

109. At the conclusion of the post mortem examination, Dr Vagaja and Dr Downs expressed the opinion that the cause of Joseph's death was gunshot injuries.[190] I accept and adopt the opinion expressed by Dr Vagaja and Dr Downs as my finding as to the cause of Joseph's death. Clearly, the shots fired by Officer Millar caused Joseph's death, but in view of all the circumstances, I find that the manner of Joseph's death was homicide by way of self-defence.

[184] Exhibit 1, Vol. 1, Tab 4.1, Supplementary Post Mortem Report (12.02.23)
[185] Exhibit 1, Vol. 1, Tab 4.2, Post Mortem Report (28.10.21)
[186] Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. District Officer L Barron (07.11.23), p5
[187] Exhibit 1, Vol. 1, Tab 6, Neuropathology Report (30.12.21)
[188] Exhibit 1, Vol. 1, Tab 5.1, Final Toxicology Report (03.11.21)
[189] Exhibit 1, Vol. 1, Tab 5.2, Supplementary Toxicology Report (29.12.21)
[190] Exhibit 1, Vol. 1, Tab 4.1, Supplementary Post Mortem Report (12.02.23)

USE OF FORCE[191,192,193]

Criminal Code

110. The *Criminal Code* authorises police officers to use force while effecting an arrest.[194] In this case, after Joseph had armed himself with the Weapon and used it to threaten and then assault the Officers, he was liable to arrest. Where the use of force by a police officer is lawful, the use of more force than is justified is unlawful.[195] However, a harmful act (including the killing of another) is lawful if that act is done in self-defence. An act is done by a person 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; and

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.[196]

Police Manual

111. The Police Manual explains that the force options available to general duty officers include: baton, OC spray, Taser, and pistol. The Police Manual also deals with the circumstances in which force options, including firearms, may be used by police officers.

112. For present purposes, it is sufficient to note that there is no policy requirement that an officer use a less dangerous force option before using a more dangerous one. The decision as to the appropriate force option to use in any given circumstance will depend on a multitude of factors, which must often be assessed very quickly. For obvious reasons therefore, the decision as to which force option to use is left to the discretion of the officer facing the threat.[197]

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[191] Exhibit 1, Vol. 1, Tab 27.1, IAU Report - Det. Sgt. S Perejmibida (01.11.23) and ts 07.06.24 (Perejmibida), pp228-237
[192] Exhibit 1, Vol. 1, Tab 28, Use of Force Report - Mr J Morrison (23.10.23) and ts 06.06.24 (Morrison), pp137-153
[193] Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. District Officer L Barron (07.11.23), pp5-6 & 10-11
[194] Criminal Code, section 231
[195] Criminal Code, section 260
[196] Criminal Code, section 248
[197] ts 05.06.24 (Millar), pp43 & 52-54 and ts 06.06.24 (Morrison), pp141-143

113. Prior to the start of the inquest I made a suppression order in relation to the police policies that were tendered into evidence, including policies relating to the use of force and the use of firearms. That suppression order was made in the public interest, and in light of the terms of that order, I do not intend to canvas the relevant provisions of those policies in this finding.

114. However, having carefully considered all of the available evidence, including Mr Morrison's use of force report, the report of the Internal Affairs Unit (IAU) investigation conducted by Officer Perejmibida, and their evidence at the inquest,[198,199] I am satisfied that the use of force by Officer Millar, and by Officer Beecher on 25 October 2021, was justified by the circumstances those officers found themselves in, and was in accordance with the provisions of the *Criminal Code*, the Police Manual, and relevant policies and guidelines.[200]

115. In this respect, I agree with the conclusions reached by Officer Perejmibida in his IAU report into the conduct of Officer Millar and Officer Beecher during their interactions with Joseph on 25 October 2021, where Officer Perejmibida relevantly states that:

> The managerial investigation concluded that (Officer Millar) and (Officer Beecher) should be exonerated as their use of force did not breach training protocols or policy.[201]

116. At the conclusion of his comprehensive use of force report, Mr Morrison expressed the following conclusions about the appropriateness of the force options used by Officer Millar and Officer Beecher:

a. (Officer) Millar's use of OC Spray for draw and discharge purposes, to reduce the threat and gain control of Joseph, are actions that were reasonably necessary in the circumstances and in accordance with the WA Police Use of Force policy and the training and guidelines of the OSTTU;[202,203]

[198] Exhibit 1, Vol. 1, Tab 28, Use of Force Report - Mr J Morrison (23.10.23) and ts 06.06.24 (Morrison), pp138-153
[199] Exhibit 1, Vol. 1, Tab 27.1, IAU Report - Det. Sgt. S Perejmibida (01.11.23)
[200] See also: Exhibit 1, Vol. 1, Tab 7, Memorandum - Asst. District Officer L Barron (07.11.23), pp10-11
[201] Exhibit 1, Vol. 1, Tab 27.1, IAU Report - Det. Sgt. S Perejmibida (01.11.23), p32 & also pp29-30
[202] OSTTU is the WA Police Operational Safety and Tactics Training Unit
[203] Exhibit 1, Vol. 1, Tab 28, Use of Force Report - Mr J Morrison (23.10.23), para 558 and ts 06.06.24 (Morrison), pp143-144

b. (Officer) Beecher's use of a Taser CEW for draw and discharge purposes, to reduce the threat and gain control of Joseph, are actions that were reasonably necessary in the circumstances and in accordance with the WA Police Use of Force policy and the training and guidelines of the OSTTU;[204] and

c. (Officer) Millar's use of his firearm for draw and discharge purposes and the discharge of three (3) rounds from his firearm, to reduce the threat and gain control of Joseph, are actions that were reasonably necessary in the circumstances and in accordance with the WA Police Use of Force policy and the training and guidelines of the OSTTU.[205]

117. For the avoidance of doubt, having carefully considered all of the available evidence, I find that:

a. Officer Millar's deployment of OC spray at Joseph was justified and in accordance with applicable legislation and Police policy. At the relevant time, Officer Millar had reasonable grounds for suspecting there was "*an imminent risk of bodily injury to any person*", namely that Joseph (who was then armed with the Weapon) appeared to be about to lunge towards Officer Miocevich and stab him;[206,207]

b. Officer Beecher's deployment of his Taser was justified and in accordance with applicable legislation and Police policy. In my view, Officer Beecher had reasonable grounds for believing there was "*an imminent risk of serious injury to any person*". At the relevant time, Joseph was stabbing Officer Millar with the Weapon, and had already inflicted a 5 cm laceration to Officer Millar's upper arm;[208,209] and

c. Officer Millar's deployment of his service pistol was justified and in accordance with applicable legislation and Police policy. In my view, Officer Millar had reasonable grounds for believing there was "*an imminent risk of grievous bodily harm or death to any person*".

[204] Exhibit 1, Vol. 1, Tab 28, Use of Force Report - Mr J Morrison (23.10.23), para 560 and ts 06.06.24 (Morrison), pp146-147
[205] Exhibit 1, Vol. 1, Tab 28, Use of Force Report - Mr J Morrison (23.10.23), para 562 and ts 06.06.24 (Morrison), pp147-148
[206] Exhibit 1, Vol. 1, Tab 28, Use of Force Report - Mr J Morrison (23.10.23), para 170-171
[207] Exhibit 1, Vol. 1, Tab 15, Statement - A'Sgt S Millar (29.10.21), paras 91-100 and ts 05.06.24 (Millar), pp43-44
[208] Exhibit 1, Vol. 1, Tab 28, Use of Force Report - Mr J Morrison (23.10.23), paras 189-190
[209] Exhibit 1, Vol. 1, Tab 16, Statement - Const. H Beecher (29.10.21), para79-83 and ts 05.06.24 (Beecher), p71

> At the relevant time Joseph was repeatedly stabbing Officer Beecher with the Weapon in the back and chest. Although Officer Beecher's ballistic vest provided protection to these areas, the vest provided no protection to Officer Beecher's head, neck, arms or legs, and Joseph's furious attack was ongoing.[210,211]

118. In passing, I note that on 14 May 2021, Officer Millar completed his annual critical skills training (CST). This training covered use of all force options including the Taser and the police pistol, as well as first aid. Officer Beecher completed his CST on 17 September 2021, and Officer Marcelo completed hers on 9 September 2021.[212,213,214]

119. Although Officer Miocevich last completed his CST on 24 January 2020, he (along with other police officers) had been granted an administrative extension due to "*training issue pressures arising from the COVID19 pandemic*".[215,216]

120. Finally, I note that shortly after Joseph's death, the Officers attended the Gosnells police station where the IAU conducted alcohol and illicit drug testing. Each of the Officers returned negative results to this testing.[217]

[210] Exhibit 1, Vol. 1, Tab 28, Use of Force Report - Mr J Morrison (23.10.23), paras 207-208
[211] Exhibit 1, Vol. 1, Tab 15, Statement - A'Sgt S Millar (29.10.21), paras 116-123 and ts 05.06.24 (Millar), pp47-48
[212] Exhibit 1, Vol. 1, Tab 27.1, IAU Report - Det. Sgt. S Perejmibida (01.11.23), pp9 & 30-31
[213] ts 05.06.24 (Millar), pp50-51 and ts 05.06.24 (Beecher), pp55-56
[214] ts 06.06.24 (Morrison), pp148-149
[215] Exhibit 1, Vol. 1, Tab 27.1, IAU Report - Det. Sgt. S Perejmibida (01.11.23), pp9 & 30-31
[216] Exhibit 1, Vol. 1, Tab 27.2, Asst. Commr. Broadcast re Critical Skills Requalification Training
[217] Exhibit 1, Vol. 1, Tab 27.1, IAU Report - Det. Sgt. S Perejmibida (01.11.23), p21

OTHER ISSUES RAISED BY THE EVIDENCE

Release of prisoners who are on a Form 1A

121. As I have identified, there is currently a significant gap in the management of persons with mental health issues requiring a CTO who are released from custody, whether on bail or otherwise. As I have outlined, in Joseph's case, although there was a legitimate basis for him to have been placed on a CTO on both occasions he was released from prison on bail in 2021, this did not occur.

122. As I have indicated, I have made a recommendation about this issue, and I also note a related issue raised by Dr Smith in his statement concerning the situation where a Court is considering whether a Hospital Order is necessary. I agree with Dr Smith's view that in these circumstances:

> [T]he making of a Hospital Order would only be appropriate if the prisoner is to be placed back on remand. If they are released on bail or unconditionally, the prison treating team should be given the opportunity to re direct the Form 1A to a service other than the Frankland Centre.[218]

Access to PSOLIS by prison mental health clinicians

123. In his report, Dr Smith said he agreed with Dr Brett's views that a person's previous Court mental health reports should be more readily available to "*stakeholders involved in the management of people with severe mental illness, including Courts, prison mental health services and community health services*". However, Dr Smith thought it unlikely that the single records system suggested by Dr Brett would be possible.

124. However, Dr Smith noted that since 2023, prison psychiatrists and some prison mental health nurses had been given read-only access to PSOLIS. Dr Smith says this was "*an important change*", and I agree with his view that access to PSOLIS "*should be available to all members of the teams*".[219]

[218] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), para 54 and ts 06.06.24 (Smith), pp188-191
[219] Exhibit 1, Vol. 1, Tab 33, Statement - Dr K Smith (31.05.24), para 56 and ts 06.06.24 (Smith), pp203-204

RECOMMENDATIONS

125. In view of the observations I have made in the finding, I make the following recommendations:

Recommendation No. 1

The Department of Justice should amend relevant policies to ensure that when a prisoner who is being held on remand and is the subject of a Form 1A under the *Mental Health Act 2014* (WA) (requiring the person be examined by a psychiatrist at an authorised hospital), appears before any court in relation to an application for bail or sentence, the presiding judicial officer of that court is made aware of the existence of the Form 1A, and the options which are available to the Court in terms of dealing with that prisoner.

Recommendation No. 2

In order to ensure that the mental health of prisoners can be more effectively managed, the Department of Justice (the Department) should seek approval from State Forensic Mental Health Services for all psychiatrists and mental health clinicians employed by the Department to have read-only access to the Psychiatric Services Online Information System, otherwise known as PSOLIS.

Recommendation No. 3

The Department of Justice and the Department of Health should confer and identify and implement strategies to ensure the effective management of the mental health of persons admitted to prison whilst the subject of a Community Treatment Order made under the *Mental Health Act 2014* (WA), who are subsequently released.

Comments on recommendations

126. In accordance with my usual practice, Ms Markham (Counsel Assisting) emailed a draft of my proposed recommendations to Ms Femia,[220] and Ms Kerr[221] on 7 June 2024. Any feedback on the draft recommendations was requested by close of business on 28 June 2024.[222]

127. In an email dated 18 June 2024, Ms Kerr advised that Mr Rayapen had no feedback about the draft recommendations.[223]

128. In an email dated 28 June 2024, Ms Femia advised that the Police had no feedback about the draft recommendations.[224]

129. In an email dated 28 June 2024, Ms Femia advised that East Metropolitan Health Service (EMHS) noted that Recommendation 2 had "*system-wide*" implications and would require consultation with the Department of Health. Further, although EMHS agreed with the "*intent and purpose of Recommendation 3*", it noted that the responsibility for actioning "*each recommendation needs to occur as a whole of Government exercise*".[225]

130. In an email dated 28 June 2024, Ms Femia advised that the response of the Department to the recommendations was as follows:[226]

a. *Recommendation 1*: the Department suggested alternative wording which would have required liaison with "*Courts*" to "*ascertain the practical benefits*" of judicial officers being advised when a remand prisoner seeking bail is the subject of a Form 1A under the MHA. In my view, the "*practical benefits*" of a judicial officer being so advised are obvious, and the Department's suggested amendment to Recommendation 1 is unhelpful. I have therefore decided not to amend this recommendation in the manner suggested.

[220] Counsel for East Metropolitan Health Service, the Department of Justice, and the Western Australian Police Force
[221] Counsel for for Mr Rayapen
[222] Email from Ms S Markham to Ms P Femia & Ms B Kerr (07.06.24)
[223] Email from Ms B Kerr to Ms K Christie (18.06.24)
[224] Email from Ms P Femia to Ms K Christie (28.06.24)
[225] Email from Ms P Femia to Ms K Christie (28.06.24)
[226] Email from Ms P Femia to Ms K Christie (28.06.24)

b. *Recommendation 2*: the Department and Dr Smith suggested some sensible amendments to this recommendation which I have adopted.

c. *Recommendation 3*: the Department says Recommendation 3 is not appropriate on the basis that:

> [A] Community Treatment Order (CTO) is not an effective order for individuals incarcerated as prisoners cannot be treated involuntarily in prison. A Form 1A is therefore used to refer prisoners to the Frankland Centre for treatment under the (MHA) whilst in custody. Prison Health Services have previously considered and discussed CTO's on release however previous attempts to utilise such orders have been unsuccessful due to (1) insufficient psychiatry resources in prisons to enable a referral; (2) the inability to find a treating psychiatrist willing to accept a CTO; and (3) practical difficulties with meeting the requirements for a CTO such as the inability to identify a catchment due to prisoners not having/providing a set address. The Department refers prisoners with a major mental illness to the State Forensic Mental Health Service's Prison In Reach Treatment Team (PIRTT) 6 months prior to release and the PIRTT arrange appropriate care in community mental health clinics.[227]

With respect, the Department's response misconstrues the intent of Recommendation 3. This recommendation does not suggest that persons who are admitted to prison while subject to a CTO be managed on that CTO while in prison. Rather, Recommendation 3 is aimed at addressing the problem that currently occurs when persons who are the subject of a CTO are admitted to prison, and then subsequently released.

By its plain terms, Recommendation 3 suggests the development of strategies to ensure the effective management of the mental health of persons admitted to prison whilst the subject of a CTO, who are then released. In my view, Recommendation 3 is sensibly aimed at a pressing issue, but I have made a minor amendment to the wording of the recommendation in an attempt to further clarify its intent.

[227] Email from Ms P Femia to Ms K Christie (28.06.24)

CONCLUSION

131. This is a tragic case, dealing as it does with the death of a deeply troubled, but much loved 34-year-old man, who died after he was shot by police on 25 October 2021. I found that the cause of Joseph's death was gunshot injuries, and that the manner of death was homicide by way of self-defence.

132. When police attended Joseph's home, they were confronted with an extremely dangerous and volatile situation. After carefully considering the available evidence, I concluded that the actions of the attending officers (including the use of force options against Joseph) were reasonable. In my view, attending officers acted within the scope of applicable legislation, relevant Police policies, and their training.

133. Joseph had a chronic mental health illness, and his persistent polysubstance use, and his chronic lack of insight about his mental health, made him an extremely challenging and difficult person to manage in the community. As Joseph's mother poignantly said in her statement to police:

> (Joseph) was a very sick young man but I know when in the right frame of mind, he was a good person, and I just wish he had got the help he needed.[228]

134. In relation to the management of Joseph's mental illness, having carefully examined the available evidence, I concluded there were gaps, and missed opportunities in the mental health care and treatment provided to Joseph when he was released from prison on bail. I also concluded that the care and treatment provided to Joseph by the Service between March and October 2021 was demonstrably substandard.

135. In my view, the Service should have managed Joseph far more assertively. He should have been placed on a CTO, and given the risks to himself and others when he was not medicated, Joseph should have received his monthly antipsychotic depot medication, as prescribed.

[228] Exhibit 1, Vol. 1, Tab 11, Statement - Ms E Browne (10.11.21), para 64

136. In my view the Service's failure to conduct a follow-up home visit after the assessment which occurred on 6 October 2021 was particularly appalling, and the reason for this staggering lapse was not explained.

137. After careful consideration, I determined that it was appropriate for me to make three recommendations to address issues I identified during the inquest. It is my sincere hope that these recommendations will be embraced by the Department and fully implemented.

138. Finally, as I did at the conclusion of the inquest, I wish to extend my sincere condolences to Joseph' family and loved ones for their terrible loss.

MAG Jenkin
Coroner
31 July 2024