[2024] WACOR 25

JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	PHILIP JOHN URQUHART, CORONER
HEARD	**:**	12 FEBRUARY 2024
DELIVERED	**:**	12 JUNE 2024
FILE NO/S	**:**	CORC 1488 OF 2022
DECEASED	**:**	MARQUIS, PETRA MICHELLE

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Counsel assisting the Coroner Ms S. Markham

Ms S Teoh (State Solicitors Office) appearing on behalf of Western Australia Police Force

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

Nil

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Philip John Urquhart, Coroner, having investigated the death of ***Petra Michelle MARQUIS*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 12 February 2024, find that the identity of the deceased person was* ***Petra Michelle MARQUIS*** *and that death occurred on 9 June 2022 outside the Rockingham Police Station, 21 - 23 Whitfield Street, Rockingham, from ligature compression of the neck (hanging) in the following circumstances:*

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LIST OF ABBREVIATIONS

Abbreviation	Meaning
the ***Briginshaw*** principle	the accepted standard of proof the Court is to apply when deciding if a matter adverse in nature has been proven on the balance of probabilities
CCTV	closed-circuit television
the Code of Conduct	the WAPF's Code of Conduct
the Court	the Coroner's Court
CPR	cardiopulmonary resuscitation
ED	emergency department
GP	general practitioner
IAU	WAPF's Internal Affairs Unit
IMS	WAPF's Incident Management System
the police station	the Rockingham Police Station
the Policy	WAPF's Policy HR-13.09
RPH	Royal Perth Hospital
SJA	St John Ambulance
WAPF	Western Australian Police Force

INTRODUCTION

"People's faces don't tell their cases." Andrew Bradley – author

1. The deceased (Ms Marquis) died after midnight on 9 June 2022 outside the front of the Rockingham Police Station (the police station). She had placed the rope of a flag pole around her neck to use as a ligature. Earlier, Ms Marquis had been detained by police after being charged with an excess 0.08% traffic offence. She was 40 years old.

2. Immediately before her death Ms Marquis had been a "*person held in care"* within the meaning of section 22(1)(a) of the *Coroners Act 1996* (WA). Therefore, a coronial inquest into her death is mandatory, and is to include an investigation into the quality of the supervision, treatment and care of Ms Marquis while in that care.[1]

3. I held an inquest into the death of Ms Marquis on 12 February 2024. The following witnesses gave oral evidence at the inquest:
   i. Constable James Natoli;
   ii. Constable Bayley Mitchell;
   iii. Acting Inspector Glenn Swannell; and
   iv. Superintendent Robert Anderson

4. The documentary evidence at the inquest comprised of one volume of the brief which was tendered as exhibit 1 at the inquest's commencement.

5. The inquest focused on the quality of the supervision, treatment and care of Ms Marquis by police officers when she was in their care on the night of 8 and 9 June 2022, with an emphasis on the actions taken by police as she left the police station.

6. In making my findings, I have applied the standard of proof as set out in ***Briginshaw v Briginshaw*** (1938) 60 CLR 336 which requires a consideration of the nature and gravity of the conduct when deciding whether a matter adverse in nature has been proven on the balance of probabilities (the ***Briginshaw*** principle).[2]

7. I am also mindful not to insert hindsight bias into my assessment of the actions taken by police officers responsible for Ms Marquis' supervision, treatment and care when she was detained by them. Hindsight bias is the

[1] *Coroners Act 1996* (WA) s 22(1)(a), s 25(3)
[2] ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, 361-362 (Dixon J)

tendency, after an event, to assume the event was more predictable or foreseeable at the time.[3]

MS MARQUIS [4]

8. Ms Marquis was born on 5 October 1981 in Elizabeth, South Australia. Her mother and her siblings all reside in Adelaide. Although she had not had face to face contact with her family for many years, Ms Marquis was in regular telephone contact with her mother.

9. At the time of her death, Ms Marquis was working part-time at an electronics company in O'Connor. She was living in Golden Bay with her ex-partner, with whom she had had a long-term relationship. Ms Marquis did not have any children.

Ms Marquis' mental health

10. Ms Marquis had a well-documented and lengthy history of mental health issues. She had been diagnosed with emotional unstable personality disorder,[5] major depression, anxiety and post-traumatic stress disorder (PTSD) arising from incidents in her childhood. The records from the GP who Ms Marquis was seeing towards the end of her life noted her complaints of low mood, poor sleep and being overwhelmed by her social stressors. She was prescribed various anti-depressant medications to treat her conditions. The GP's notes also record a history of suicidal ideation and self-harm incidents.

Previous attempts of self-harm

11. Ms Marquis' first suicide attempt occurred as a 12 year-old when she tried to hang herself from a ceiling fan. Another two self-harm attempts by overdosing are recorded as having occurred when she was aged 13 years and 17 years.

12. On 24 June 2020, Ms Marquis was referred to a community mental health service for depression and suicidal ideation.

13. In July 2021, Ms Marquis was admitted to the mental health emergency care ward at Royal Perth Hospital (RPH) for 10 days.

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[3] Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10
[4] Exhibit 1, Tab 6.1, Coronial Investigation Squad Report dated 17 May 2023, Exhibit 1, Tabs 18.1-18.6, Tabs 19.1-19.3, Tab 21, various medical records for Ms Marquis
[5] Also known as borderline personality disorder

14. On 7 October 2021, the daughter of Ms Marquis' ex-partner contacted police advising that Ms Marquis had posted an apparent suicide message on Facebook.

15. Ms Marquis was subsequently found intoxicated and having overdosed with a number of pills. She was admitted to Sir Charles Gairdner Hospital.

16. On 10 March 2022, Ms Marquis self-presented to the ED at RPH following an appointment with her psychologist. Ms Marquis' anxiety and stress levels had increased following a miscarriage in February 2022. She advised that she had never fallen pregnant before and had been looking forward to having a baby. Ms Marquis stated she had had a general decline in her mental health after the miscarriage and had plans to suicide as she felt she could not carry on anymore. She had been overwhelmed by social stressors which included the ending of her relationship with her partner, not been unable to work since the miscarriage, and financial stress. Ms Marquis also reported she was still bleeding several weeks after her miscarriage.

17. Ms Marquis was admitted to the mental health emergency care ward at RPH. On 18 March 2022, she was discharged back to the care of her GP for ongoing management of her overall health and a referral for a mental health care plan with a clinical psychologist.

THE EVENTS OF 8 AND 9 JUNE 2022 [6]

18. On the night of 8 June 2022, Constable James Natoli (Constable Natoli) and Probationary Constable Bayley Mitchell (Constable Mitchell) were conducting uniformed patrols in a marked police car in Rockingham. At about 11.40 pm, they observed Ms Marquis driving her car in excess of the posted speed limit.

19. The two police officers stopped Ms Marquis' car and spoke to her.

20. Constable Natoli asked Ms Marquis for her motor driver's licence and both officers used their mobile phones to access information regarding Ms Marquis on the WAPF's IMS.[7] They saw there was an alert for Ms Marquis' previous suicide attempt that occurred on 7 October 2021.

21. As they spoke to Ms Marquis, the two police officers had a suspicion she had been consuming alcohol due to her slurred speech. She had also

[6] Exhibit 1, Tab 6.1, Coronial Investigation Squad Report dated 17 May 2023, Exhibit 1, Tabs 7.1-7.2, Statements of Constable James Natoli dated 9 June 2022 and 12 January 2024, Exhibit 1, Tab 8, Statement of Constable Bayley Mitchell dated 9 June 2022, Exhibit 1, Tab 15.2, IAU Report dated 23 September 2022
[7] Incident Management System

admitted consuming alcohol that evening. Constable Mitchell conducted a roadside breath test with Ms Marquis which registered 0.132%. The police officers advised Ms Marquis that she was required to accompany them back to the police station for a formal breath test.

22. When Ms Marquis got out of her car it became evident to the police officers that she was scantily dressed in a short lacey garment with a long, open black cardigan over the top. When Ms Marquis mentioned she was not exactly dressed for “normal people”, Constable Natoli, who did not want her to feel embarrassed, advised her it was not an issue for them. Ms Marquis was then secured in the pod of the police car for the short drive to the police station. She remained cheerful and compliant at all times.

23. At 12.15 am on 9 June 2022, Ms Marquis’ formal breath test result at the police station returned a reading of 0.142 grams per 210 litres of blood. Constable Natoli informed Ms Marquis that as she had blown in excess of 0.08% alcohol content, she would be charged and required to attend court at a later date. She was also told she would not be able to drive that night.

24. Constable Natoli asked Ms Marquis if she had someone who could pick her up from the police station or if she would like police to take her somewhere. Ms Marquis declined these offers of assistance and said she would call her ex-partner.

25. Various documentation was completed which included a disqualification notice from driving that Ms Marquis signed. After Ms Marquis had been provided with the necessary paperwork there was no requirement to further detain her at the police station.

26. Constable Natoli then escorted Ms Marquis through to the front entrance of the police station. As the police station was closed at the time,[8] the front foyer was not well-lit and Constable Natoli had to unlock the front door. As he walked Ms Marquis to the front door, Constable Natoli heard her speaking to her ex-partner requesting that he come and get her “now”. When Constable Natoli asked Ms Marquis if she wanted him to wait with her until her ex-partner collected her, she replied: “*No he’ll be here soon, he's about 15 minutes away.*”

27. At 12.37 am, Ms Marquis left the police station through the front door. Constable Natoli did not see where she went due to the lack of lighting at

[8] Those police officers who were on duty when the police station was closed used the rear section and entered and exited through that part

the front of the police station. He walked back to the rear of the police station where he completed his shift. Constable Natoli was the last person to see Ms Marquis alive.

Circumstances leading to Ms Marquis' death

28. A CCTV camera depicting the front left entry of the police station captured the following images.

29. At 12.38.10 am, a figure (who was Ms Marquis) appeared near some flag poles situated at the front of the police station. There is an occasional glow of light that was either Ms Marquis smoking a cigarette or using her mobile phone. At 12.41.03 am, Ms Marquis moved out of camera view and returned into camera range. Fifteen seconds later she stood near the flag poles. At 12.45.13 am, there is a light glow for about six seconds which appeared to be from Ms Marquis' mobile phone that is in her hand. At 12.49.17 am, Ms Marquis collapsed and disappeared from view as one of the flag poles bends to the left.

30. Another CCTV camera at the police station depicting Whitfield Street showed a utility parking on the road at 1.06 am. I am satisfied this utility was Ms Marquis' ex-partner coming to pick her up. The utility remained at this location until 2.03 am when it drove away.

31. At about 6.00 am, two other police officers from the police station were driving on Whitfield Street when they observed one of the flag poles was bent. It was still dark at this time and after parking their car at the rear of the police station, the two police officers went to the flag pole.

32. At 6.02 am, their torchlights illuminated Ms Marquis. She was in a seated position at the base of the flag pole that was bent. Ms Marquis had the cords of the flag pole wrapped around her neck. One of the police officers cut the cords above her head and loosened the cords that were around her neck. As he did this, the other police officer used his radio to request priority one ambulance assistance from SJA. Other officers who were inside the police station attended and CPR was commenced.

33. At 6.10 am, ambulance officers attended and continued with CPR.

34. Despite maximal resuscitation efforts by the ambulance officers for about 20 minutes, Ms Marquis could not be revived. At 6.30 am on 9 June 2022, Ms Marquis was declared life extinct by one of the ambulance officers.[9]

[9] Exhibit 1, Tab 1.3, Life Extinct Certification form dated 9 June 2022

CAUSE AND MANNER OF DEATH

Cause of Death [10]

35. Two forensic pathologists, Dr Victoria Kueppers and Dr Kirralee Patton, performed a post mortem examination on Ms Marquis' body on 22 June 2022.

36. The forensic pathologists noted features of hanging, including a ligature mark to Ms Marquis' neck consistent with the ligature provided, and a fracture to the left superior thyroid horn (one of the small bony structures in the anterior neck). There were minor scratches and abrasions to Ms Marquis' limbs. There was also evidence of medical resuscitative efforts.

37. A neuropathology examination of Ms Marquis' brain showed no significant abnormalities.

38. A toxicological analysis detected a blood alcohol level of 0.14% and a urine alcohol level of 0.186%. The anti-depressant medications, diazepam, duloxetine and a metabolite of bupropion, were also detected. No common illicit drugs were detected.

39. At the conclusion of their investigations, the forensic pathologists expressed the opinion that the cause of death was ligature compression of the neck (hanging).

40. I accept and adopt the conclusion expressed by the two forensic pathologists as to the cause of Ms Marquis' death.

Manner of Death

41. I am satisfied that in the months after her miscarriage in February 2022, Ms Marquis experienced an exacerbation of her anxiety and depression. Despite exhibiting no outward signs (apart from becoming upset when she was handed the notice disqualifying her from driving[11]), I am satisfied that Ms Marquis became further depressed upon her realisation she would not be able to drive for a lengthy period of time. With her thought processes impaired due to her alcohol intoxication, Ms Marquis made the impulsive decision to hang herself from the cords of the flag pole.

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[10] Exhibit 1, Tabs 2.1-2.2, Supplementary Post Mortem Report dated 22 June 2022, Exhibit 1, Tab 3, Neuropathology Report dated 27 June 2022, Exhibit 1, Tab 4.1, Final Toxicology Report dated 8 July 2022

[11] Constable Mitchell noted this was a "normal response" when people became aware they were immediately disqualified from driving: Ts 12.2.24 (Constable Mitchell), p.36

42. Based on the information available, I find that Ms Marquis' death occurred by way of suicide.

INVESTIGATION OF THE CONSTABLES' ACTIONS BY THE INTERNAL AFFAIRS UNIT [12]

43. Following the death of Ms Marquis, an IAU investigation examined the actions of Constables Natoli and Mitchell to determine whether there was non-compliance with WAPF policy and/or the WAPF's Code of Conduct. (the Code of Conduct). That investigation was carried out by Acting Inspector Glenn Swannell (Acting Inspector Swannell). The outcome of that investigation was that both constables had breached the Code of Conduct by not ensuring the safety and welfare of Ms Marquis after she left the police station on 9 June 2022.

44. At the inquest, Acting Inspector Swannell clarified that the breach concerned the following part of the provision in the Code of Conduct which stated: "*Regardless of rank or level, we maintain a duty of care by responding if we have reason to be concerned about the ... safety or welfare of ... others.*"[13]

45. The IAU investigation was satisfied that the two constables, "*were compassionate and caring in their interaction with* [Ms] *Marquis right up until she was released from the front of the Rockingham Police Station.*"[14]

46. I am in complete agreement with this conclusion.

47. However, the IAU investigation also found:[15]

> [Ms] Marquis, however, was a scantily clad women who was affected by alcohol given she provided a breath test of 0.142%. She was released at the front of the police station when it was dark and the temperature would have been around 12°C. Regardless of the fact her ex-partner was on his way to collect her; the officers could have waited with her until he arrived. During their audio-interviews both officers advised, that in hindsight, they should have waited with [Ms] Marquis.
>
> Both officers did all they possibly could up until the moment [Ms] Marquis was released. At that point, they did not ensure her safety and welfare when they left her to her own devices at the front of the police station.

48. Each constable was dealt with by way of a managerial notice for their breach of the Code of Conduct. As Acting Inspector Swannell explained at

[12] Exhibit 1, Tab 15, IAU Report dated 23 September 2022
[13] Ts 12.2.24 (Acting Inspector Swannell) p.47, Exhibit 1, Tab 16, WAPF's Code of Conduct, p.7
[14] Exhibit 1, Tab 15.2 IAU Report dated 23 September 2022, p.15
[15] Exhibit 1, Tab 15.2 IAU Report dated 23 September 2022, p.15

the inquest, this was a written reprimand that was one above the lowest sanction of a verbal guidance.[16] Acting Inspector Swannell also explained that: "*In terms of career advancement, as long as that behaviour is not repeated, it wouldn't have any impact on their careers.*"[17]

ISSUES RAISED BY THE EVIDENCE

Was it appropriate for police not to apprehend Ms Marquis under the Mental Health Act 2014 (WA)?

49. Police officers may apprehend a person with a mental illness, provided the conditions set out in section 156 of the *Mental Health Act 2014* (WA) are met. Section 156(1) provides:

> A police officer may apprehend a person if the officer reasonably suspects that the person —
>
> (a) has a mental illness;[18] and
>
> (b) because of the mental illness, needs to be apprehended to —
>
> (i) protect the health or safety of the person or the safety of another person; or
>
> (ii) prevent the person causing, or continuing to cause, serious damage to property.

50. If a person is apprehended in accordance with the above, then a police officer is authorised to detain the person for the purpose of arranging an assessment by a medical practitioner or an authorised mental health practitioner as soon as practicable.[19]

51. As I have already noted above, the WAPF's IMS had an alert for Ms Marquis regarding her previous suicide attempt on 7 October 2021. Included in that alert was the following: "*Mental Health Alert – Posted – "Goodbye" messages Facebook. Consumed an unknown quantity of pills and liquor. SJA to SCGH.*"[20]

52. An audit of computer accesses to IMS data with respect to Ms Marquis showed that Constable Mitchell had accessed this alert at 11.43 pm on 8 June 2022, and that Constable Natoli accessed the same

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[16] Ts 12.2.24 (Acting Inspector Swannell), p.44
[17] Ts 12.2.24 (Acting Inspector Swannell), p.44
[18] A person is defined as having mental illness if they have a condition that: "*is characterised by a disturbance of thought, mood, volition, perception, orientation or memory; and significantly impairs (temporarily or permanently) the person's judgment or behaviour*": *Mental Health Act 2014* (WA) s 6(1)
[19] *Mental Health Act 2004* (WA) s 156(3)
[20] Exhibit 1, Tab 15.1, IAU Report dated 23 September 2022

alert one minute later.[21] These times indicated that this information was accessed very shortly after the constables had stopped Ms Marquis' car.

53. I am satisfied this information would have enabled the two constables to "*reasonably suspect*" Ms Marquis had "*a mental illness*". However, that is not sufficient to have apprehended Ms Marquis under the *Mental Health Act 2014* (WA) as they had to also reasonably suspect that because of that mental illness, Ms Marquis posed a current risk to her health or safety.

54. Throughout her interaction with the two constables on this night, Ms Marquis did not say anything or behave in any way to demonstrate that because of her mental illness, she had to be apprehended to protect her own health or safety (or protect the safety of another person; or prevent her from causing serious damage to property).[22] I therefore agree with the conclusions made by Acting Inspector Swannell:[23]

> The IMS alert shows that [Ms] Marquis suffered from mental health issues; however, on the night of her death she did not display any symptoms that might have justified [Constables] Natoli and Mitchell apprehending her under the *Mental Health Act*.
>
> …
>
> Despite the IMS alert, [Ms] Marquis did not exhibit any behaviours that might have raised the concerns of the officers at the time they were dealing with her. There were certainly no grounds for them to apprehend her under section 156 of the *Mental Health Act*.

Was it appropriate for police to leave Ms Marquis unattended outside the police station?

55. As to this question, it was the outcome of the IAU investigation that it was not appropriate as the two constables had breached the Code of Conduct. Nevertheless, it was clear that the question was not an easy one for those involved in the IAU investigation to answer. As Acting Inspector Swannell said at the inquest: "*I know there was a great deal of deliberation about sustaining any finding against them*."[24]

56. Although a coroner must always give close consideration to the outcome of an IAU investigation with respect to the death the Court is investigating, a coroner is not bound by the conclusions that have been reached.

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[21] Exhibit 1, Tab 15.1, IAU Report dated 23 September 2022, p.13
[22] *Mental Health Act 2014* (WA), s 156(1)(b)(i) and (ii)
[23] Exhibit 1, Tab 15.1, IAU Report dated 23 September 2022, p.15
[24] Ts 12.2.24 (Acting Inspector Swannell), p.42

57. Superintendent Robert Anderson (Superintendent Anderson), the officer in charge of the WAPF Coronial Inquest Coordination Division, gave evidence at the inquest. The role of this unit includes overseeing the police action with respect to a death the subject of a coronial investigation and provide input as to whether any improvements can be made.[25]

58. Although Superintendent Anderson had no involvement in the coronial investigation squad or IAU investigations, he had familiarised himself with the circumstances of Ms Marquis' death.

59. At the inquest, Superintendent Anderson was asked:[26]

> So, in your opinion do you think the officers in this case should have been disciplined for breaching the Code of Conduct? --- My personal belief is no, they shouldn't.
>
> And why is that? --- Because with the time, place, circumstances they were facing they did everything that they thought was right. They presented and gave her a duty of care. They offered to take her home, and they offered to sit with her. Now she declined that, but I don't think they purposefully and deliberately or mischievously breached our Code of Conduct. They were doing their duty that night. They stopped a car that was being driven by Petra Marquis who was intoxicated, over the limit. You know, they've done everything right. Through no fault of their own, through potential – through the potential lack of experience and not having dealt with something like that again, and there were officers with 20 years' service who have gone straight to specialist areas who have never dealt with scenarios like that … and I think the officers, what they did that night, was everything they should have done, and with the benefit of hindsight they will never do it again … They trusted that the partner was going to turn up and he did turn up, but they didn't know, nor should they have known how bad poor Petra Marquis was actually suffering. They could never have known that, and I feel sorry for them.

60. I am of the view that these observations by Superintendent Anderson are soundly based. It is not in contention that the behaviour of the two constables in their interactions with Ms Marquis were "*compassionate and caring*" right up to the point where she walked out of the police station.[27]

61. With respect to those interactions, I agree with Superintendent Anderson's observation that: "*I hate to say it, but I think the reality is that there are some officers out there that wouldn't have considered those things. Potentially.*"[28]

[25] Ts 12.2.24 (Superintendent Anderson), p.51
[26] Ts 12.2.24 (Superintendent Anderson), p.57
[27] Exhibit 1, Tab 15.1, IAU report dated 23 September 2022, p.15
[28] Ts 12.2.24 (Superintendent Anderson), p.54

62. In determining the question of whether it was appropriate for the two constables to leave Ms Marquis outside the police station by herself, their conduct towards Ms Marquis before she left the police station is relevant.

63. Constable Natoli stated:[29]

> At various points during my interaction with Ms Marquis I recall making the following offers:
>
> a. I asked if she would like a lift home;
>
> b. I told her that we could take her anywhere she wanted to go;
>
> c. I asked her if she had money for a hotel;
>
> d. I asked her if she needed us to call her a taxi;
>
> e. I asked her if she wanted to use the phone (but she said no because she texted her ex-husband); and
>
> f. I offered to wait out the front with her (but she said no because her ex-husband was going to be there in 10 minutes).

64. At the inquest, Constable Mitchell explained:[30]

> I believe that the fact that her, you know, ex-husband was no more than 10 minutes away from picking her up helped reassure [us] that, you know, there is very little time for anything to happen and she is at the police station, which you would imagine is a safer place to be.

65. I accept these accounts by the two constables and note that this evidence from Constable Natoli is largely corroborated by the CCTV camera footage within the police station.

66. The shift the two constables were working that night was due to finish at 1.00 am on 9 June 2022.[31] As Ms Marquis had left the police station at 12.37 am, a contention could be made that either constable ought to have checked if Ms Marquis had been collected by her ex-partner at or about 1.00 am when they completed their shift.

67. Even if a check had been made on Ms Maquis at or about 1.00 am, and had CPR commenced immediately, the prospect of her making a full recovery would have been extremely low. The grave consequences of oxygen deprivation to a person's brain are measured in minutes. At another inquest in 2020, Associate Professor Paul Bailey, an emergency physician specialising in cardiac arrest and ex-Medical Director of SJA, stated:

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[29] Exhibit 1, Tab 7.2, Statement of Constable James Natoli dated 12 January 2024, pp.4-5
[30] Ts 12.2.24 (Constable Mitchell), p.38
[31] Ts 12.2.24 (Constable Natoli) p.9

"*Hanging is an infrequent but devastating cause of cardiac arrest, with outcomes worse than cardiac arrest of presumed cardiac aetiology.*"[32]

68. The Associate Professor noted that between 2015 and 2019, the 1018 persons in Western Australia found after unwitnessed hangings and who were in cardiac arrest, 331 had CPR. Of those 331 persons, 79 had return of spontaneous circulation (ROSC) at hospital arrival. However, only four of those patients were discharged from hospital, with their quality of life not known.[33]

69. As to the proposition that a check on Ms Marquis ought to have been made by either constable when they had completed their shift, in accordance with the ***Briginshaw*** principle and being mindful not to insert hindsight bias, I am not satisfied this should have been done.

70. I am also satisfied that given the circumstances known to the constables and the assistance that had already been offered to Ms Marquis by Constables Natoli and Mitchell, it was not necessary for one of them to remain with Ms Marquis outside the front of the police station until she had been picked up by her ex-partner. To find otherwise would involve the impermissible application of hindsight bias.

71. Accordingly, I am satisfied that in all the circumstances, the decision by the two constables to leave Ms Marquis outside the police station by herself was appropriate.

72. In making that decision, I have noted the lack of experience of these two police officers. Constable Natoli had graduated from the police academy in November 2020. As with all police graduates, he was then placed on an 18-month probationary period as a constable which ended on 25 May 2022. Consequently, on the night of Ms Marquis' death, it was only two weeks since he had completed his probation.[34]

73. Constable Mitchell was even less experienced. He had only graduated from the police academy in May 2022. As at early June 2022, he was only two weeks into his probationary period as a constable.[35]

74. My observations regarding the partnering of inexperienced police officers for operational duties are dealt with in more detail later in this finding.

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[32] ***Inquest into the death of Jordan Robert Anderson*** [2020] WACOR 44, p.38
[33] ***Inquest into the death of Jordan Robert Anderson*** [2020] WACOR 44, p.38
[34] Ts 12.2.24 (Constable Natoli), pp.6-7
[35] Ts 12.2.24 (Constable Mitchell), pp.31-32

IMPROVEMENTS SINCE MS MARQUIS' DEATH [36]

75. As would be expected of all public service entities, the WAPF is always on the pathway of continual improvement with respect to its operations. As there is ordinarily a gap of some duration between the date of the death requiring a mandatory inquest and the inquest's date, an entity connected to the death will often implement changes that are designed to improve practices and procedures before the inquest is heard.

76. In his report to the Court, Superintendent Anderson outlined the changes to policy and guidelines that have been made since June 2022. He advised that since Ms Marquis' death, the Duty of Care polices and guidelines for police officers have been reviewed on two occasions, resulting in a reduction to the number of individual policies relating to police officers' duty of care. This has simplified these policies and guidelines.[37]

77. As to action undertaken to prevent the type of situation occurring again with respect to Ms Marquis' death, the Duty of Care policies now reinforce police officers' duties and responsibilities. This revised policy reminds police officers of their duty of care obligations and to give particular consideration to the needs of an apprehended person, and any issues surrounding their release.[38] Superintendent Anderson stated:[39]

> In particular, police officers must ensure that their duty of care to any person is fulfilled at the point of release from custody. The level of assistance will depend on several factors and the potential risk presented. Police officers should pay particular attention to the vulnerability of the person based on:
>
> a. presentations, for example mood, speech, appearance etc.;
>
> b. warnings and alerts on the Incident Management System; and
>
> c. environmental conditions at time of release (for example late at night/weather).

78. This policy was broadcasted on 25 January 2024 and reinforced with WAPF personal.[40]

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[36] Exhibit 1, Tab 31, Report on Duty of Care Policies and Guidelines of Superintendent Robert Anderson dated February 2024, Exhibit 1, Tabs 32.1 – 32.9, various annexures to Superintendent Anderson's Report

[37] Exhibit 1, Tab 31, Report on Duty of Care Policy and Guidelines by Superintendent Robert Anderson dated February 2024

[38] Exhibit 1, Tab 31, Report on Duty of Care Policy and Guidelines by Superintendent Robert Anderson dated February 2024, p.4

[39] Exhibit 1, Tab 31, Report on Duty of Care Policy and Guidelines by Superintendent Robert Anderson dated February 2024, p.4

[40] Exhibit 1, Tab 31, Report on Duty of Care Policy and Guidelines by Superintendent Robert Anderson dated February 2024, p.4, Exhibit 1, Tab 32.9, Update to DC01.00 Duty of Care

79. Nevertheless, there will be occasions when there may be a risk to a person's wellbeing that a police officer has no control over. As identified by Superintendent Anderson, these will include situations when a person refuses assistance and where there is no legitimate reason to further detain that person. In those circumstances they are free to leave. It was also recognised that, "*there will always be scenarios where a person chooses to take a course of action post interaction with police that is beyond that officer's control*."[41]

80. I commend the WAPF for the improvements that have been made to its police officers' duty of care obligations.

QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF MS MARQUIS

81. Having carefully considered the documents comprising of exhibit 1 and the oral evidence of the witnesses at the inquest, I am satisfied that the supervision, treatment and care of Ms Marquis by the two constables on the night of 8 and 9 June 2022 was appropriate. Notwithstanding the findings of the IAU investigation, I am not satisfied either constable was required to do anything more than what they did prior to, and at the point of, releasing Ms Marquis from the police station.

82. I am also satisfied that given the constables' interactions with Ms Marquis and her general behaviour on the night, it would have been impossible for either constable to foresee the actions taken by Ms Marquis to end her life shortly after she left the police station.

PROPOSED RECOMMENDATION

83. I was concerned to hear evidence at the inquest regarding the inexperience of the two constables. Although I was satisfied they acted appropriately in their dealings with Ms Marquis, police officers with more operational experience may have taken a different approach regarding Ms Marquis' ongoing supervision until she was picked up by her ex-partner.

84. Constable Natoli's evidence at the inquest was that the first time he was partnered with a probationary constable was within two weeks of completing his own probationary period.[42] Constable Mitchell's evidence caused me even greater disquiet. He said that since coming off probation in November 2023 (i.e. three months before the inquest), "*the majority of*

[41] Exhibit 1, Tab 31, Report on Duty of Care policies and Guidelines by Superintendent Robert Anderson dated February 2024, p.4
[42] Ts 12.2.24 (Constable Natoli), p.8

the times I'm on the road, I'm the senior officer in a car."[43] I asked Constable Mitchell:[44]

> And how do you feel about that situation being still relatively inexperienced yourself as a constable? --- It can be uncomfortable at times.
>
> Yes? --- There is a lot of access to supervision around which is helpful, but obviously it's not there in the moment making the decisions for you.
>
> Yes. And often you have to make decisions on the spur of the moment, don't you? --- That's correct, your Honour.

85. This inquest is not the first one I have encountered where inexperienced police officers have been partnered for operational duties. One of those was the ***Inquest into the deaths of Trisjack Preston Simpson and Mervyn Drage*** [2021] WACOR 36. At that inquest, one constable was halfway through their 18-month probationary period and their more senior partner had only completed their probationary period five months prior to the incident. This constable expressed similar concerns regarding his role as the senior officer to what I heard from Constables Natoli and Mitchell.

86. Despite submissions from the WAPF that questioned whether my proposed recommendation was obtainable, I made the following recommendation in my findings for the above inquest:[45]

> That the Western Australian Police Force introduces a policy to the effect that, whenever possible, probationary constables performing operational duties should be partnered with a police officer with a post-probationary operational experience of at least one year.

87. After my findings were published, the Minister for Police wrote to the Court by letter dated 16 December 2021 in response to this recommendation (and others I had made in my findings for that inquest). The Minister advised of the recruitment, over a four-year period, of an additional 950 police officers over and above the attrition rates. This meant the rapidly increasing numbers of probationary constables "*will temporarily skew*" the ratio of probationary constables to other police officers thereby, "*hampering any implementation of the Coroner's recommendation.*"[46] My recommendation was therefore not adopted by the WAPF.

88. With the passage of time since that letter (approximately 3½ years), it was my view that the temporary "skew" would no longer be in existence.

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[43] Ts 12.2.24 (Constable Mitchell) p.32
[44] Ts 12.2.24 (Constable Mitchell) p.32
[45] ***Inquest into the deaths of Trisjack Preston Simpson and Mervyn Drage*** [2021] WACOR 36, p.47
[46] Letter from the Hon. Paul Papalia, Minister for Police, to the Court dated 16 December 2021, p.1

Consequently, the implementation of the same recommendation should now be more achievable.

89. By email dated 31 May 2024, the Court notified counsel for the WAPF of my proposed recommendation and invited a submission from the WAPF as to its view regarding this recommendation being made in the findings for this inquest.

COMMENTS RELATING TO THE PROPOSED RECOMMENDATION

90. By letter dated 7 June 2024, Deputy Commissioner Kylie Whiteley (Deputy Commissioner Whiteley) provided submissions on behalf of the WAPF in response to my proposed recommendation.[47]

91. Deputy Commissioner Whiteley confirmed that my recommendation from 2021 had not been implemented. She described this recommendation as a "*significant policy change, mandating minimum supervision standards.*"[48] With respect, this is not an accurate description of my recommendation from 2021. It was never intended to "*mandate*" minimum supervision standards as my recommended minimum supervision standard was only applicable when circumstances allowed it. Or put another way, "*whenever possible*", as set out in the recommendation.

92. Deputy Commissioner Whiteley stated that the WAPF, "*acknowledges probationary constables are still developing and require ongoing support throughout their probationary period, and should be afforded adequate supervision.*"[49]

93. However, Deputy Commissioner Whitley went on to add that the supervision of a probationary officer, "*is now augmented with enhanced traditional supervision, and remote support through the use of technology*."[50] And she cited examples of the enhanced traditional supervision and technological supports.[51]

94. I was already aware of most of these developments. However, I was unaware that experienced police officers recruited internationally must still undertake a probationary period in Western Australia.[52]

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[47] Letter from Deputy Commissioner Kylie Whiteley to the Court dated 7 June 2024
[48] Letter from Deputy Commissioner Kylie Whiteley to the Court dated 7 June 2024, p.2
[49] Letter from Deputy Commissioner Kylie Whiteley to the Court dated 7 June 2024, p.2
[50] Letter from Deputy Commissioner Kylie Whiteley to the Court dated 7 June 2024, p.2
[51] Letter from Deputy Commissioner Kylie Whiteley to the Court dated 7 June 2024, p.2
[52] Letter from Deputy Commissioner Kylie Whiteley to the Court dated 7 June 2024, p.2

95. I also note that the enhanced traditional supervision and technological supports outlined by Deputy Commissioner Whiteley will not always offer practical assistance to an inexperienced police officer having to make a "spur-of-the-moment" operational decision. These decisions would not be infrequent.

96. Deputy Commissioner Whiteley referred to the WAPF's Policy HR-13.09 (the Policy) that relates to probationary constables. The passages from the Policy quoted in her letter included the following:[53]

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

97. Only last month I presided over another inquest that involved two probationary constables who were partnered together for operational duties.[54] On 12 April 2022, they were the only on-duty officers at a police station located in a country town when they were required to respond to a complaint concerning a man. This man died some hours later after his interaction with the two probationary constables. From my reading of the second paragraph in the Policy cited above, that partnering may not have complied with the Policy. However, it would appear from Deputy Commissioner Whiteley's letter that this paragraph was only added to the Policy in August 2022 (four months after the man's death).[55]

98. With respect to my proposed recommendation, Deputy Commissioner Whiteley advised that the WAPF maintained the same position it took in 2021, namely, "*that the current policy regarding the rostering and supervision of probationary constables is appropriate and therefore does not support the proposed recommendation being made*."

99. Having considered the response by the WAPF and having tailored my recommendation accordingly, I am of the view that a rostering guideline (instead of a policy) should be introduced by the WAPF so that, whenever possible, probationary constables performing operational duties are partnered with a police officer with a certain level of post-probationary operational experience. As police officers recruited from outside of

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[53] Letter from Deputy Commissioner Kylie Whiteley to the Court dated 7 June 2024, pp.2-3
[54] ***Inquest into the death of Stephen Kenneth Sherwood*** CORC 18 of 2022 heard on 14 May 2024
[55] Letter from Deputy Commissioner Kylie Whiteley to the Court dated 7 June 2024, p.3

Western Australia are also required to complete a probationary period, I am satisfied that this guideline need not apply to them if they have already had an appropriate level of prior operational experience in another jurisdiction.

100. I have also decided that a lower length of post-probationary operational experience for the more senior police officer would make the proposed recommendation more achievable. I have therefore reduced this level from one year to nine months' post-probationary operational experience.

101. It is my firm view that every effort should be made to avoid, where possible, what occurred with the partnering of the two constables on the night of Ms Marquis' death. That partnering for operational duties meant a constable who had only very recently completed their probationary period was partnered with a constable who had only just commenced his probationary period. If efforts are not made, whenever possible, to avoid the outcome of inexperienced police officers being partnered for operational duties, then I fear it will only be a matter of time before there is a person "*held in care*" by police whose death was "*caused, or contributed by,*"[56] the inexperience of police officers who were responsible for the care of that person.

102. It is always better to make a proactive change with an aim to reduce the risk of a future death, rather than having to make a reactive change to reduce the risk of another death from occurring again.

103. In light of the apparent misunderstanding of my recommendation from 2021, I will again stress that my revised recommendation is not to have a procedure implemented that must have probationary constables who are performing operational duties partnered with a police officer with a post-probationary operational experience of at least nine months. My recommendation is for a "*rostering guideline*" that stipulates such a partnering should occur "*whenever possible*". It is not my intention, and nor was it in 2021, to introduce a measure "*mandating minimum supervision standards*".[57]

104. Superintendent Anderson stated the WAPF is "*committed to providing the best service and care to the community of Western Australia*".[58] The introduction of a rostering guideline that reflects my recommendation would be a meaningful step towards achieving that commitment.

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[56] *Coroners Act 1996* (WA) s 22(1)(c)
[57] Letter from Deputy Commissioner Kylie Whiteley to the Court dated 7 June 2024, p.2
[58] Exhibit 1, Tab 31, Report on Duty of Care Policies and Guidelines by Superintendent Robert Anderson dated February 2024

105. I am therefore of the view that the following recommendation is appropriate:

Recommendation

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

CONCLUSION

106. Ms Marquis was a lady with long-standing mental health issues. In the period before her death, she sadly encountered significant life stressors. These stressors included (i) a previous attempt to end her life, (ii) a separation from her long-term partner and (iii) a miscarriage of a baby that she was longing to have.

107. Facing the inevitability of losing her motor driver's licence for a lengthy period of time and affected by alcohol, Ms Marquis made an impulsive decision to end her life, shortly after being released from the custody of two constables. She used the ropes from a flag pole at the front of the police station to hang herself. Unfortunately, due to poor lighting in the area and that part of the police station being closed, she was not discovered until more than five hours later. Despite extensive CPR from attending police officers and then by ambulance officers, Ms Marquis could not be revived.

108. The impact of Ms Marquis' death upon the two constables who interacted with her on this night was clearly evident from the way they gave evidence at the inquest. I am satisfied that the manner in which they dealt with Ms Marquis on the night was appropriate and I am satisfied they had no way of knowing what Ms Marquis was about to do after she had left their care.

109. I have made a recommendation with respect to the partnering of inexperienced police officers for operational duties. I had previously made a recommendation regarding this subject matter in 2021, which was not adopted by the WAPF. It is my fervent hope that the changes I have made

to the second recommendation will persuade the WAPF to reconsider its position regarding this important area.

110. On behalf of the Court, I extend my condolences to Ms Marquis' family and loved ones for their sad loss.

PJ Urquhart
Coroner
12 June 2024