

**JURISDICTION** : CORONER'S COURT OF WESTERN AUSTRALIA

**ACT** : CORONERS ACT 1996

**CORONER** : SARAH HELEN LINTON, ACTING STATE CORONER

**HEARD** : 11-13 NOVEMBER 2024  
12 DECEMBER 2024

**DELIVERED** : 23 JULY 2025

**FILE NO/S** : CORC 3409 of 2022

**DECEASED** : CANNON, LYNN MARIE

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*Catchwords:*

Nil

*Legislation:*

Nil

**Counsel Appearing:**

Ms S Tyler assisted the Coroner.

Ms S Teoh and Mr J Kirke (SSO) appeared for the WA Police Force.

Ms A Owen appeared for Senior Constable Baker.

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

Nil

Coroners Act 1996  
(Section 26(1))

## RECORD OF INVESTIGATION INTO DEATH

*I, Sarah Helen Linton, Acting State Coroner, having investigated the death of **Lynn Marie CANNON** with an inquest held at the **Perth Coroner's Court, Central Law Courts, Court 85, 501 Hay Street, Perth**, on 11 to 13 November 2024 and 12 December 2024, find that the identity of the deceased person was **Lynn Marie CANNON** and that death occurred on 5 December 2022 at 24A Hardcastle Avenue, Landsdale, from sharp force injuries to the chest in the following circumstances:*

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## INTRODUCTION

1. Lynn Cannon (Lynn) was a loving mother of two sons, the youngest in a family of five close sisters, a beloved daughter to her mother and a good friend, colleague and carer to many. Tragically, Lynn was brutally murdered by her estranged husband on 5 December 2022, one day after her 51<sup>st</sup> birthday. Lynn had found the courage to leave an unhappy marriage and seek joy in a life without him. He responded with violence. His behaviour was prompted not by love, but by jealousy, hatred and revenge. His selfish and violent actions have deprived her family and friends of the strong, kind and funny lady they loved and cherished and shocked the community.
2. Lynn's former husband, Paul Cannon, was charged and convicted on his plea of guilty of her murder in 2023. He is justly serving a term of life imprisonment. This inquest is not about him. This is Lynn's story.
3. As part of the coronial investigation into Lynn's death, Lynn's family provided information that they had raised with police their concerns about Lynn's welfare on the day she was killed. They knew that her former husband had just become aware that Lynn had found love with a new partner and he had reacted aggressively. He had threatened Lynn with a knife that morning and said he would kill her and her new partner. When they couldn't contact her in the afternoon, after Lynn had gone to his house to drop off some paperwork, they reported their fears for her safety to WA Police. Lynn's sister indicated Lynn had gone to Paul Cannon's house at 3.30 pm and had not been heard from her since. It was unusual for Lynn not to be in contact, so her family were very worried.
4. The first call from Lynn's sister was made to police at 7.30 pm. Lynn was fatally stabbed by Paul Cannon between 8.10 pm and 8.15 pm. The incident was witnessed by Paul Cannon's housemate and overheard by neighbours, who all called emergency services for help. The calls from the neighbours were received by police at 8.15 pm and the housemate called St John Ambulance (SJA) at 8.22 pm after she fled the house. The first SJA paramedic arrived at the house at 8.29 pm. The SJA paramedic went into the house on his own to try to help Lynn, but sadly it was too late to save her, so he held her hand and tried to comfort her as she took her last breath. Other ambulance crews then arrived and assisted the paramedic to deal with Paul Cannon, who had self-inflicted injuries. All of this occurred before the first police car arrived at 8.44 pm.
5. An internal inquiry conducted by WA Police established that police had downgraded the initial priority allocated to the task and redirected initial police enquiries to Lynn's home address rather than to the address that the family had given, which was Paul Cannon's residence.<sup>1</sup> There was also a lack of police assets available and an unusually high volume of calls received that night, which delayed police attendance at Paul Cannon's house.
6. Due to the contact between Lynn's family and police on the day of Lynn's death and the concerns raised about the actions of the police and the adequacy of the police response, the State Coroner determined that the matter fell within the scope of

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<sup>1</sup> Noting that in the initial call by Lynn's sister to police the street number given was incorrect, but this was then corrected by Lynn's sister in another call.

s 22(1)(b) under the *Coroners Act 1996* (WA). Relevant to this matter, this section is enlivened when the issue of causation or contribution by any action of a member of the Police Force in relation to a death arises. As it was a matter falling under that section, a coronial inquest into the death was mandatory.<sup>2</sup>

7. It is important to note that the intention in holding an inquest to consider the actions of the police was not to allocate fault or blame on any particular police officer for Lynn's death, noting the person who was solely responsible for the actions that caused Lynn's death was Paul Cannon. However, the central question to be addressed was whether there was a missed opportunity on the part of the police to save Lynn's life.<sup>3</sup>
8. I held an inquest on 11 to 13 November 2024 and 12 December 2024. Given the outcome of the Supreme Court proceedings against Paul Cannon and the associated limitation under s 53(2) of the *Coroners Act*, the factual circumstances of Lynn's death were not explored in great detail at the inquest, although I have set out some of the detail to assist with understanding the chronology of events. The primary focus of the inquest was how the police responded to the concerns raised about Lynn's welfare on the day of her death.
9. The inquest also considered broader issues around welfare checks and family and domestic violence and WA Police policies and procedures in relation to emergency calls and allocating priorities, to see what lessons could be learned from this sad case and to identify any possible improvements to ensure an appropriate and timely response in cases involving family and domestic violence.
10. Domestic violence is rightly a matter of grave national concern. Looking closer to home, Western Australia has consistently had one of the highest recorded rates of family and domestic violence in the nation. The Government of Western Australia has recognised that family and domestic violence affects the lives of thousands of Western Australian women and children every day. A Family and Domestic Violence Taskforce was convened between September 2023 and March 2024 to help guide Western Australia's efforts to address family and domestic violence. The Court sought independent expert evidence from Dr Alison Evans and Professor Donna Chung, both of whom were involved in the Taskforce, to aid in understanding what has been done since Lynn's death to improve system responses for women facing family and domestic violence and hopefully prevent further deaths.
11. The WA Police Force has also reflected at length on the tragic circumstances of Lynn's death and evidence was heard from officers who investigated the incident from a criminal and internal affairs perspective, as well as two senior officers, State Commander Jodie Pearson APM in relation to WA Police State Communications and Superintendent Levinia Hugo in relation to the work of the Family Domestic Violence Team, who all provided their own insights, from a policing perspective, into the scourge that is family and domestic violence within Western Australia.
12. Significant documentary evidence was tendered as well, which I have also considered in reaching my conclusions.

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<sup>2</sup> Section 22(1)(b) *Coroners Act 1996* (WA).

<sup>3</sup> T 3.

### **BRIEF BACKGROUND**

13. Lynn was born in England and was the youngest of five girls: Christine, Jennie, Jacqui, Pauline and Lynn. She grew up with her sisters in the suburbs of Liverpool. Her childhood was unsettled as her mother was the victim of very serious domestic violence. Unfortunately, due to this exposure to violence in her home life as a child, that type of environment appears to have been normalised for Lynn. Her sisters were very protective of her, but Lynn was still eventually drawn in to a violent relationship of her own.<sup>4</sup>
14. Lynn met Paul Cannon at the tender age of 16 years. He was her first love. She was stricken with Guillain-Barré syndrome, an illness that put her in hospital for over six months, followed by a 12 month period of intensive rehabilitation. It was during the course of her illness that Lynn's family began to have concerns about her relationship with Paul Cannon. He broke up with her when she was gravely ill, at a time when she needed his support most, but then resumed their relationship when she was healthy again. Although Lynn's family raised their concerns with her, Lynn remained fiercely loyal to him and they married in 1996, when Lynn was in her early twenties.<sup>5</sup>
15. By 1999, Lynn was a loving mother to her two sons, Connor and Harry. Her sisters recall that she would shield them from their father's behaviour towards her. Paul Cannon would use foul language and try to degrade Lynn in front of them, but Lynn would send them away to their rooms to play and refuse to respond to his hurtful words in front of them. Connor recalled their father was often drunk and the fights were often about finances or were fuelled by their father's irrational jealousy. There was a lot of screaming and things would be thrown around. Both boys tried to intervene, and they would tell their father to leave the house, but he would respond by telling them to come outside and he would fight them. Lynn encouraged them not to get involved. There is no evidence that Paul Cannon was ever physically violent towards Lynn, before his final brutal acts which led to her death, but it is undisputed that he was frequently insulting and engaged in demeaning verbal abuse towards her over many years. Although the term was not well known back at that time, in hindsight, Lynn's family believe Paul Cannon engaged in coercive control behaviours towards Lynn for the entirety of their relationship. After they separated, he was also often verbally threatening and aggressive.<sup>6</sup>
16. Lynn was described by her family as strong, determined, feisty and tenacious. She was also fiercely loyal, funny and kind-hearted. She was a devoted mother to Connor and Harry and her love for them never wavered, despite her problems with their father.<sup>7</sup> She was hard working and learned the trade of hairdressing so she could help support her family. Paul Cannon, on the other hand, would spend the family's money on gambling, drinking and cannabis.<sup>8</sup>
17. The sisters remained close as they grew up and had families of their own. Over the years, all five sisters emigrated to Australia, with Lynn making the move in about

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<sup>4</sup> Exhibit 3, Tab 2.

<sup>5</sup> Exhibit 3, Tab 2.

<sup>6</sup> Exhibit 3, Tab 2; Exhibit 1, Tab 8.

<sup>7</sup> Exhibit 3, Tab 2.

<sup>8</sup> Exhibit 3, Tab 2; Exhibit 1, Tab 20.

2004. Despite bringing money with them from the United Kingdom, and Lynn working hard in her new profession, they struggled financially due to Paul Cannon's habits. Lynn came to realise that her dream of owning her own home in Australia would be a difficult one while she remained married to Paul Cannon. He also continued his verbal abuse of her in front of their children and friends.<sup>9</sup>

18. In 2015, Paul Cannon and Lynn were in a motor vehicle accident and Paul Cannon hurt his shoulder. He usually worked in construction and rigging, but was unable to work for two years. He became depressed and began to abuse alcohol even more and to use illicit drugs. Paul Cannon never returned to full-time work, so Lynn became the main financial earner in the family.<sup>10</sup> This only worsened the state of the marriage. Eventually, Lynn made the brave choice to end the relationship, after 25 years of a marriage marred by emotional abuse.<sup>11</sup>
19. In 2021, when the lease on their rental was expiring, Lynn decided it was the right time to leave.<sup>12</sup> Lynn used her own money to successfully obtain a mortgage and she began to get her first glimpse of what her new life could be like. The two boys elected to live with their mother, but Paul Cannon didn't have anywhere to live. Connor recalls his parents had a big argument just before they left the rental home and Connor had to intervene. His father then turned his anger on Connor and tried to fight him. During the argument, Paul Cannon slammed a sliding door hard and his hand got caught in the way. He chopped off the end of one of his fingertips and had to go to hospital. He appeared apologetic after this for a time, although he later told a relative that he had been trying to slam the door on Lynn and he blamed her for his injury.<sup>13</sup>
20. Lynn informed her sisters that she and Paul Cannon had agreed to separate but she still allowed him to live with her for a while until he could find somewhere to settle on his own. Her sisters recall that Lynn was "thriving without him dragging her down."<sup>14</sup> Lynn had started new employment as an aged care worker, which she found meaningful and rewarding. She seemed to have a renewed sense of hope about the future. Lynn's sons, Connor and Harry, were also happier than they had ever felt in their lives, and Lynn's mother and the whole extended family were relieved and happy for all three of them.<sup>15</sup>
21. Despite being separated, Paul Cannon continued to harass Lynn for money and a place to stay. Unlike Lynn, his life was not getting better, and it is clear he resented the growing happiness that Lynn found with her independence from him. Paul Cannon apparently still held out hope that they would reconcile and was unable to come to terms with the fact that the relationship had ended. He had told Lynn's sister Christine that he planned to return to the United Kingdom after he received some insurance payouts, but they were still waiting to be resolved.<sup>16</sup> Paul Cannon continued to drink to excess and use drugs, which only worsened his mental state and

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<sup>9</sup> Exhibit 3, Tab 2.

<sup>10</sup> Exhibit 1, Tab 20.

<sup>11</sup> Exhibit 1, Tab 20.

<sup>12</sup> Exhibit 1, Tab 8.

<sup>13</sup> Exhibit 1, Tab 8 and Tab 10.

<sup>14</sup> Exhibit 3, Tab 2.

<sup>15</sup> Exhibit 3, Tab 2; Exhibit 1, Tab 7.

<sup>16</sup> Exhibit 4.

his resentment towards Lynn grew.<sup>17</sup> Lynn eventually told him that he could not live with them anymore, so he found a room to rent in a house in Landsdale. He was a regular customer at a pub and he came to know a worker there had a room to rent in her townhouse. He moved in to the house in October 2021.<sup>18</sup>

22. Lynn's friend, Kelly-Anne, recalled that Lynn enjoyed the fact that with her new job, Paul Cannon found it harder to track her. When she had worked at the hair salon, he turned up often uninvited at her workplace, but as a carer she moved around a lot and this made it harder for him to follow her.<sup>19</sup>
23. Lynn was committed to growing a new, happier life. After they had been separated for almost two years, Lynn started to enjoy a social life and met someone who made her feel loved and who truly cared for her. She was very happy in the new relationship and her sister Jacqui remembers Lynn "giggling about it like a teenager"<sup>20</sup> when she spoke about her new partner, Gary. However, Lynn was clearly concerned about how her estranged husband would react. She was careful to keep the relationship private, for fear of the fallout that might come. She told Gary that her ex-husband was "very bad-tempered, very unpredictable and [he had] threatened physical harm on her, should she move on with another man,"<sup>21</sup> although she never disclosed any incidents of past violence. Gary never met Paul Cannon and had never seen a picture of him. Lynn consciously kept the two men very separate.
24. Connor recalled that about six months before Lynn's death, his father spoke to him and Harry and said he didn't think he could handle it when their mother finally moved on to a new relationship. Paul Cannon intimated he would go somewhere, but did not say where. They mentioned the conversation to their mother, who suggested Paul Cannon might have been talking about suicide, as he had messaged her before to say he planned to kill himself. Connor also always believed if anything were to happen, it would be his father taking his own life. Connor told police he had never believed that Paul Cannon would hurt Lynn, even though he knew his father had threatened to do so many times.<sup>22</sup>
25. Connor recalled that Lynn continued to demonstrate kindness towards his father, often giving him money and taking him food, but Paul Cannon was never grateful. Despite living somewhere else, he would still often come around to Lynn's house uninvited and start fights with Lynn and the two boys. Connor eventually moved down south, so he had some distance from the behaviour, but he understood that his father continued to harass Lynn. Paul Cannon would often ask Lynn who she was meeting when she went out, but she did not tell him due to his jealousy.<sup>23</sup>
26. When Lynn's sister Jacqui asked her when she was going to serve Paul Cannon with divorce papers, Lynn said she was waiting for Paul Cannon to be in a better place, as she didn't want to hurt him. She told Jacqui that Paul Cannon had sent her dreadful messages in which he wrote that he was "hoping she died a horrible death and that he

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<sup>17</sup> Exhibit 1, Tab 20.

<sup>18</sup> Exhibit 1, Tab 12 and Tab 20.

<sup>19</sup> Exhibit 1, Tab 11.

<sup>20</sup> Exhibit 3, Tab 2.

<sup>21</sup> Exhibit 1, Tab 9 [6].

<sup>22</sup> Exhibit 1, Tab 8.

<sup>23</sup> Exhibit 1, Tab 8.

would dance on her grave.”<sup>24</sup> Lynn was not shocked by these awful statements, as it was the same kind of language he had directed towards her during the many years of their marriage. Lynn told her family she recognised he was nasty, but felt they were just words and he would not follow through with them. Sadly, her kindness and forbearance was undeserved. Paul Cannon’s violent words were soon to escalate to violent actions.

27. Paul Cannon’s landlord had observed that Paul Cannon was often upset and angry about the end of his relationship with Lynn. She had met Paul Cannon’s ex-wife, as Lynn would sometime drop past to visit Paul Cannon. The landlord recalled that Paul Cannon was not nice to Lynn and called her names. On one occasion, the landlord came home from work and found Lynn and Paul Cannon in the backyard. Paul Cannon was standing in front of Lynn, yelling at her, and Lynn was crying. Paul Cannon later said to his female landlord, “what happens in this house stays in this house.”<sup>25</sup> Paul Cannon would also tell his landlord that he was going to kill Lynn using swords that he had in his bedroom, although she took this as an idle, albeit disturbing, threat.<sup>26</sup>
28. On 12 August 2022, Paul Cannon sent Lynn a threatening text message in which he wished her dead and, ominously, stated, “*I just wish I was there to watch you die, in agony as a bonus.*”<sup>27</sup> He did not know, at the time of sending that message, that Lynn had begun dating another man. When he gained that knowledge, that threat became real.

### **EVENTS ON 4 DECEMBER 2022**

29. As well as being close with her immediate family, Lynn had also forged close relationships with her extended family. She was a favourite aunt to her nieces and, indeed, had been living with her niece Jasmine for about a year prior to her death. It was at an engagement party for one of her nieces, in November 2022, that Lynn last spent time with a large group of her extended family members. They were planning to meet up again over the Christmas period and there were three family weddings planned for the new year, but sadly Lynn never got to enjoy these celebrations. She did not live to see Christmas 2022.
30. Lynn was living with her son Harry and her niece Jasmine prior to her death. Lynn’s 51<sup>st</sup> birthday fell on Sunday, 4 December 2022. The night before, Lynn had gone out with friends to a wine festival and then a bar in Northbridge. She had met up with her partner at the bar and he then slept over at Lynn’s house. This was unusual, as Lynn had previously told her good friend Kelly-Anne that Gary had not been over to her house because she feared what Paul Cannon would do if he found out she was in a new relationship.<sup>28</sup>
31. The next morning, Paul Cannon arrived unannounced at Lynn’s home. He had apparently come around with a birthday card for Lynn. Lynn’s niece had left the house early and her son Harry was not at home. Lynn and Gary were in bed when they realised Paul Cannon was outside the house. They kept very still in the hope he

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<sup>24</sup> Exhibit 3, Tab 2.

<sup>25</sup> Exhibit 1, Tab 12 [56].

<sup>26</sup> Exhibit 1, Tab 12 and Tab 20.

<sup>27</sup> Exhibit 1, Tab 20, [9].

<sup>28</sup> Exhibit 1, Tab 11.



would think they were not home, but they could hear him outside knocking and turning the locked front door knob. Lynn looked out the window and realised that Paul Cannon was going to the rear of the house. She got out of bed and ran for the back door, as she knew it had a broken latch and was unlocked. Paul Cannon managed to enter the house through the back door. Lynn quickly ushered him back out of the house, but before she did, Paul Cannon became aware for the first time that Lynn was seeing someone new.

32. As Lynn had feared, Paul Cannon reacted angrily and aggressively to the news. He refused to leave and sat out the front of the house, seemingly with the hope he would be able to meet and confront Lynn's new partner. Lynn tried to reason with him, but he flew into a rage. He left the house and went to his car and obtained a metal pole. He then began threatening to damage Lynn's partner's vehicle with the pole. Lynn convinced Paul Cannon that her partner's car was a neighbour's car, so he backed off. Lynn then returned to the house and asked Gary to leave via the back of the house and take her car. He got into her car and drove home while Paul Cannon was still at the house. During this incident Paul Cannon also threatened to harm Lynn, but he did not physically touch her. She was eventually able to calm him down and he left.<sup>29</sup>
33. Connor rang his mother later that day to wish her a happy birthday. She mentioned the incident that morning. Lynn explained that her partner had managed to leave the house by the back door, so she believed Paul Cannon hadn't seen him. Connor recalled she didn't seem overly worried. His father sent him text messages later that day and Connor thought he sounded sad and depressed, but it doesn't appear Paul Cannon mentioned any thoughts of harming himself or anyone else.<sup>30</sup>
34. Lynn also spoke to her niece Jasmine about the events that morning. She said that Paul Cannon had let himself inside via the back door and he had confronted her inside the house. Lynn had shut the bedroom door, but he guessed that someone was inside the bedroom. She confirmed she had a new partner but refused to let Paul Cannon go into the room to confront him. Lynn told Jasmine that Paul Cannon said to her, "I'll put you in a wheelchair and see how he loves you then."<sup>31</sup>
35. When Jasmine returned home at about 2.30 pm, she found the birthday card from Paul Cannon to Lynn in the mail box. The card had been torn up.<sup>32</sup>
36. Later that day, Paul Cannon sent an abusive text message to Lynn in which he made reference to the fact that she was seeing another man and stated, "*I hope to be celebrating your painful death very soon.*"<sup>33</sup>
37. The evidence suggests Lynn was aware they were not simply idle threats, but she was hopeful she could placate him and calm the situation if she responded the way she always had, with kindness and forbearance. I will turn later to the expert evidence about the changing dynamics in family and domestic violence and known 'triggering events', but what is apparent in hindsight is that the new relationship dramatically altered the situation as Paul Cannon no longer felt he had control of

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<sup>29</sup> Exhibit 3, Tab 2; Exhibit 1, Tab 7 and Tab 20; Exhibit 4.

<sup>30</sup> Exhibit 1, Tab 8.

<sup>31</sup> Exhibit 1, Tab 10 [42].

<sup>32</sup> Exhibit 1, Tab 10.

<sup>33</sup> Exhibit 1, Tab 20 [12].

Lynn. However, while Lynn would have been aware of the ever present danger, she perhaps did not have all the tools to appreciate how his rage at losing control would quickly lead to a violent escalation in his behaviour.

38. Jasmine drove Lynn to Lynn's sister Christine's house that afternoon, as Gary had Lynn's car and he lived nearby. Gary collected Lynn from Christine's house. That was the last time Christine saw Lynn alive. Gary took Lynn out to dinner for her birthday. They returned home to Lynn's house at about 8.00 pm and he then drove his own car home. That was the last time Gary saw Lynn in person.<sup>34</sup>
39. Jasmine recalled that Lynn came inside the house alone and they spoke briefly before Lynn went to bed. Everything seemed normal at that time at Lynn's house. In contrast, Paul Cannon's landlord recalled that Paul Cannon had been drinking that night and was very emotional when she came home from the gym at about 9.00 pm. He said something 'really, really bad had happened', but he did not elaborate further.<sup>35</sup> It is now clear he was angrily ruminating on what he had learned that morning.

### **EARLY EVENTS ON 5 DECEMBER 2022**

40. Early on Monday morning, 5 December 2022, Paul Cannon again arrived unannounced at Lynn's home and let himself into the house. When Jasmine got up just before 7.00 am, she noticed the dog was acting strangely and she could smell cigarette smoke. This was unusual, as neither she nor Lynn smoked, and she suspected it signalled Paul Cannon's presence. Jasmine went to warn Lynn, but Lynn was in the bathroom so she did not speak to her. When Jasmine returned to the kitchen, she was confronted by Paul Cannon, who demanded to know where Lynn was in the house. He went to Lynn's bedroom and walked into her ensuite bathroom, where he used her toilet. They then had a confrontation in her bedroom.<sup>36</sup>
41. Jasmine recalled that she could hear yelling coming from the bedroom and she heard Lynn shout out, "Jazzy call the police."<sup>37</sup> Jasmine had rung her mother Christine in a panic and said she didn't know what to do. Then Lynn and Paul Cannon came out of the bedroom and went out the back. Christine rang Lynn and told her that Christine's partner was around the corner and would come to help but Paul Cannon left soon after. Jasmine came out of her room and saw Paul Cannon was sitting outside in his car, which was slowly moving away. He was still shouting abuse at Lynn out of the car window as the car rolled, then he drove off. Jasmine went into Lynn's bedroom and could see that Lynn's handbag was emptied out over the bed. Lynn told Jasmine that Paul Cannon had wanted \$600 that he had previously repaid to her and he had thrown the contents of her bag out during an argument over the money. Lynn also told Jasmine that Paul Cannon had pulled out a large kitchen knife and said, "I'll fucking kill you,"<sup>38</sup> during the argument.<sup>39</sup>

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<sup>34</sup> Exhibit 1, Tab 9.

<sup>35</sup> Exhibit 1, Tab 12.2.

<sup>36</sup> Exhibit 1, Tab 11 and Tab 20.

<sup>37</sup> Exhibit 1, Tab 10 [65].

<sup>38</sup> Exhibit 1, Tab 10 [75].

<sup>39</sup> Exhibit 1, Tab 10; Exhibit 4.

42. Despite this escalation, with the introduction of a weapon, Lynn chose not to call the police.<sup>40</sup> Many people would assume it is automatic to report such behaviour to police. However, the impact of family and domestic violence shapes the response of those subjected to it in many different ways. It is clear that of the reasons why Lynn may not have called the police at this time, it wasn't because Lynn did not view the threat seriously, as when Jasmine asked Lynn whether she thought Paul Cannon might carry through with his threat and hurt her, Lynn replied, "Yes, definitely."<sup>41</sup>
43. Jasmine recalled that Paul Cannon returned a short time later. She saw him in the back garden but did not speak to him. Jasmine was reluctant to leave Lynn alone with Paul Cannon, but she had to go to work. When Jasmine left for work, she sent a message to Lynn asking if Paul Cannon was still there, and Lynn confirmed that he was, although it seems he left a little while later.<sup>42</sup>
44. Christine rang Lynn again at around 8.30 am when Lynn had left the house and was on her way to work. Christine was concerned and tried to encourage Lynn to report the incident. Christine told Lynn that if she didn't act on this now, after Paul Cannon had let himself into the house and threatened her with a knife, "then she would be putting herself and all those around her in more danger."<sup>43</sup> Christine recalled that Lynn agreed. They discussed Lynn obtaining a restraining order against Paul Cannon and also getting a CCTV camera fitted at her home so she could record his behaviour as evidence. Lynn indicated she was open to both suggestions, but unfortunately there wasn't time to put them into action before Lynn's death that same day.<sup>44</sup>
45. Lynn texted her partner about Paul Cannon turning up at her house again. He rang her at 9.23 am and they spoke for around 25 minutes. Lynn's partner recalled she sounded petrified during this conversation.<sup>45</sup>
46. At about 10.30 am that morning, Paul Cannon exchanged some text messages with his landlord. He mentioned being sad and said he was drunk and stoned.<sup>46</sup>
47. It seemed that Lynn had agreed to go and see Paul Cannon in order to give him some vehicle transfer paperwork, as he was taking over ownership of her car. At about 2.00 pm that same day, Lynn went to the house in Landsdale where Paul Cannon was renting a room. Lynn rang her friend Kelly-Anne on the way there and Kelly-Anne told her not to go. Lynn responded that she would be alright because there would be someone else there, apparently expecting his landlord would be home, although this turned out not to be the case. Lynn planned to visit Paul Cannon and then continue on to Kelly-Anne's house. Before they ended the call, Lynn reassured Kelly-Anne she would be fine.<sup>47</sup>
48. After Lynn arrived at the house, an argument ensued. By about 3.00 pm, Lynn and Paul Cannon were arguing loudly enough to be heard by a neighbour. The neighbour

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<sup>40</sup> Exhibit 1, Tab 10.

<sup>41</sup> Exhibit 1, Tab 10 [76].

<sup>42</sup> Exhibit 1, Tab 10.

<sup>43</sup> Exhibit 4 [13].

<sup>44</sup> Exhibit 1, Tab 4.

<sup>45</sup> Exhibit 1, Tab 9.

<sup>46</sup> Exhibit 1, Tab 12.

<sup>47</sup> Exhibit 1, Tab 11.

thought that she heard Paul Cannon threatening to kill himself and Lynn begging him not to do that. Then the arguing ceased for a time.<sup>48</sup>

49. Lynn's partner Gary sent her a text message at 3.05 pm. He knew she always read her messages straight away, but this time she did not.<sup>49</sup> Kelly-Anne rang Lynn at about 3.30 pm and her message also went unread. At some stage, Kelly-Anne rang Lynn's sister Christine, and told her that Lynn had gone to Paul Cannon's house and that she was worried.<sup>50</sup>
50. At about 4.00 pm, the arguing between Lynn and Paul Cannon recommenced and it then escalated over time. A neighbour thought she could hear a female voice saying, "Think about the kids,"<sup>51</sup> and assumed it was Paul Cannon's ex-partner. She also heard Paul Cannon saying he was worried she was going to call the police, as well as mention of another man.<sup>52</sup>
51. Paul Cannon sent a text message to his landlord at 4.05 pm asking her not to come home yet as Lynn was there. The landlord did not think there was anything untoward about the messages. She had knocked off work at 4.00 pm, so she socialised with a friend and then did some grocery shopping to fill in time until about 8.00 pm.<sup>53</sup>
52. Jasmine finished work just before 6.00 pm and she messaged Lynn to ask Lynn if she was coming home that night. Lynn did not respond, which concerned her as Lynn was usually very particular about feeding her dog and would normally let Jasmine know if she needed her to do anything. Jasmine then called her mother at around 6.50 pm and said she was worried as Lynn wasn't home. Jasmine then called Lynn's partner Gary to discuss her concerns. Gary recalled he received a text message from Jasmine at 7.19 pm. He was already concerned that Lynn had not yet read his text message and he became more concerned when Jasmine asked him in the message if he had heard from Lynn. Gary rang Jasmine immediately and they spoke about their mutual concerns for Lynn. After they ended the conversation, Gary spoke to Lynn's sister, Christine, and he confirmed he had not heard from Lynn.<sup>54</sup>
53. Christine had been ringing Lynn's friends. She spoke to Lynn's work colleague, who said Lynn's last client had cancelled so Lynn had finished work at 2.00 pm. When Christine realised Lynn was not working late, she started to panic. She rang Kelly-Anne, who told Christine that Lynn had been planning to go to Paul Cannon's house in the afternoon to sort out some paperwork. Christine stated that she was very concerned at this news as she knew Paul Cannon was an angry man who was capable of causing Lynn harm. She believed Paul Cannon may have taken Lynn hostage, so she rang the police to convey her concerns.<sup>55</sup>
54. Christine first called the police at 7.27 pm. She said she tried to stay calm but was panicking on the inside. Christine rang the police again at 7.55 pm and 7.57 pm to

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<sup>48</sup> Exhibit 1, Tab 16 and Tab 20.

<sup>49</sup> Exhibit 1, Tab 9.

<sup>50</sup> Exhibit 1, Tab 11.

<sup>51</sup> Exhibit 1, Tab 16 [17] and Tab 20.

<sup>52</sup> Exhibit 1, Tab 16.

<sup>53</sup> Exhibit 1, Tab 12.

<sup>54</sup> Exhibit 1, Tab 9; Exhibit 4.

<sup>55</sup> Exhibit 1, Tab 4.

provide more information as she had realised she had provided the wrong street number for Paul Cannon's address.<sup>56</sup>

55. Gary had come to Christine's house, as they lived near each other. After waiting for a while longer and not hearing anything, Christine's partner and Gary decided to go to Paul Cannon's house together to try and find Lynn. They drove to Lynn's house, but by the time they got there at around 9.00 pm, it was too late. Lynn had been fatally stabbed by Paul Cannon between 8.10 pm and 8.20 pm. The first police had only arrived at the house at 8.44 pm, after Lynn had been declared deceased by a paramedic.<sup>57</sup>

### **INITIAL CALL TO POLICE**

56. The Police Incident Report records Christine Holmes (Christine) made a 911 emergency call (noting that these calls are put through to the Australian 000 line and then directed to the appropriate agency) at 7.30 pm. The call was put through by a Telstra operator to the WA Police Force Police Assistance Centre (PAC), which serves as the community's initial contact point for triple zero and general police inquiries. The call was taken by experienced Customer Service Officer Maddison Byrne (Ms Byrne), who was working at the PAC on the night. Christine stated that her sister Lynn had not been seen and was not responding to calls or messages since around 3.00 pm that afternoon.<sup>58</sup>
57. Christine told Ms Byrne that Lynn's ex-partner, Paul Cannon, had come to Lynn's house in Butler that morning with a knife, threatening to kill Lynn and her new partner. Police had not been called at that time and Lynn managed to get him to leave. Christine advised that after Paul Cannon left, Lynn had some errands to run and went to work. She was then going to Paul Cannon's house to drop off forms for a car. Lynn had not been contactable since 3.30 pm, when she was heading to Paul Cannon's house. Lynn was supposed to meet a friend in the afternoon but had not turned up. Christine advised she had seen Paul Cannon being violent to Lynn in the past and Lynn's family were very worried for her safety.<sup>59</sup>
58. Ms Byrne created a CAD (Computer Assisted Dispatch) job for police officers to attend Paul Cannon's house at 23 Hardcastle Avenue in Landsdale (which was later corrected to 24A) as Lynn was known to be going to that address.<sup>60</sup> In the information contained in the CAD task, Ms Byrne recorded that Paul Cannon had turned up with a knife and threatened to kill Lynn and her new partner but police were not called and she had managed to get him to leave. Later, she had gone to Paul Cannon's house to drop off forms. Her last contact was at 3.30 pm when she was heading to his house and she had not been responding to messages or calls since that time. The last portion of the entry read "Caller has witnessed Paul Cannon being violent towards Lynn in the past, they are very worried for her safety."<sup>61</sup>

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<sup>56</sup> Exhibit 1, Tab 9; Exhibit 4.

<sup>57</sup> Exhibit 1, Tab 9; Exhibit 4.

<sup>58</sup> Exhibit 1, Tab 19, p. 1 and Tab 29; Exhibit 2, IAU Report.

<sup>59</sup> Exhibit 1, Tab 19, p. 1; Exhibit 2, IAU Report; Exhibit 3, Tab 3.

<sup>60</sup> Exhibit 1, Tab 19, p. 2.

<sup>61</sup> Exhibit 1, Tab 26, [48].

59. Ms Byrne allocated the incident a Priority 2 (immediate/imminent threat) welfare check. Ms Byrne said she allocated it as a P2 as Lynn's sister had stated that the male had a knife and had been actively threatening to kill Lynn earlier in the day. Ms Byrne gave evidence she formed the impression there "was a sense of urgency to find her and make sure that she was okay due to the ... threat to kill that morning."<sup>62</sup> The fact that Lynn had also been entirely uncontactable for a number of hours was also a factor.<sup>63</sup>
60. She allocated it as an incident type 248 - welfare check, rather than an incident type 29 - Family Domestic Violence incident, based on the information provided that suggested to Ms Byrne the primary concern was for Lynn's welfare as she was missing, and on the known evidence they could not establish that domestic violence was actually occurring at the time of the call. In her evidence Ms Byrne said it was a judgment call that it was a welfare check rather than a domestic violence case, and she acknowledged there was a lot of crossover between the two types of incidents. Ms Byrne commented that if the call had come through in the morning, when Paul Cannon was at Lynn's house with a knife, it would have been a 29 incident as it generally meant an active FDV incident occurring now. The difference appeared to be that now they were primarily trying to find Lynn and check on her welfare, and there was no evidence of active domestic violence occurring at the time of the call.<sup>64</sup>
61. It took approximately 6 minutes for Ms Byrne to obtain the relevant information from Christine and input it into the system. Ms Byrne tried to validate information on Paul Cannon through the police systems, but she was unable to locate him. The CAD task then moved to dispatch at POC at 7.36 pm. Ms Byrne went in a few minutes later and updated Lynn's vehicle details, but the job was already with an officer in POC for allocating by this stage.<sup>65</sup>
62. Ms Byrne recalled being told at 7.48 pm by the radio supervisor that the address had been changed from the Landsdale address to Lynn Cannon's home address in Butler. She told IAU investigators that she was confused and questioned at the time why the address was changed, given they knew Lynn wasn't at home as Christine's daughter was at Lynn's house. They also knew what address Lynn had been going to when last contactable, which was the obvious starting point. However, Ms Byrne had no role in the task by that stage.<sup>66</sup>
63. At the inquest, Ms Byrne confirmed that she also did not agree with the reasoning given for the downgrade to a P3 and she believed it should have remained a P2 for the reasons she allocated it that priority in the first instance.<sup>67</sup>
64. Senior Constable Paul Grant (SC Grant), who was also based at the PAC as a call taker and was involved in this case as he received the calls from concerned neighbours, agreed with Ms Byrne that the initial CAD job was appropriately categorised as a P2. However, he also could not see why it was downgraded after it moved to the POC dispatchers. It was clear from the evidence of Ms Byrne and SC

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<sup>62</sup> T 110; Exhibit 1, Tab 29.

<sup>63</sup> T 110; Exhibit 1, Tab 29.

<sup>64</sup> T 109; Exhibit 2, IAU Report.

<sup>65</sup> T 112, 119; Exhibit 1, Tab 29.

<sup>66</sup> T 116 - 117; Exhibit 2, IAU Report.

<sup>67</sup> T 111, 115 - 116.

Grant that in their role as call takers, they will err on the side of caution when allocating a priority to a task, whereas it appears the dispatchers, who are more conscious of what resources are available when they are trying to dispatch vehicles to respond to a task, take a stricter view of what falls into each priority category.<sup>68</sup>

### **CHANGING THE TASK PRIORITY & ADDRESS**

65. I understand there have been some changes to the names of the relevant areas, where they are located and how they operate, but at the relevant time, the process was that after the CAD job was created and allocated a priority, it then passed from the PAC to staff at the POC (POC) to allocate a police car to attend. Staff at the POC would then review the job and consider the information available and then take steps they consider necessary to allocate resources to the job. Depending on the priority of the task, this was done in conjunction with the local District Operations Supervisor (DOS). Although a radio dispatcher would often consult the radio supervisor before downgrading the priority of a job, it was not mandatory for the supervisor to make such a decision.
66. From 7.36 pm to 8.10 pm, 14 entries were made onto the CAD job by WAPOL staff in the POC and the local DOS relating to information/updates and inquiries being made to try to validate the situation.<sup>69</sup> The CAD priority was downgraded to Priority 3 at 7.38 pm by a police officer at the POC. An entry made 18 seconds later by the Joondalup DOS provided a rationale for the downgrading of the task – recording that there was no direct evidence of imminent threats or harm and it did not require a Priority 2 response.<sup>70</sup>
67. To put this in a context, as at 5 December 2022 the police response priorities were described in policy as:<sup>71</sup>
- i. Priority 1 (P1) – Imminent threat to life. Serious offence/incident in progress URGENT attendance required.
  - ii. Priority 2 (P2) – Serious offence/incident in progress IMMEDIATE attendance required.
  - iii. Priority 3 (P3) – Offence in progress/suspect at scene. Evidence to be preserved. ROUTINE attendance required.
  - iv. Priority 4 (P4) – Incident not in progress NON-URGENT.
68. The policy objective was for a police response to be dispatched to a P1 or P2 task within two minutes and attend the scene within 12 minutes. For a P3, there was no dispatch response time set and the grade of service for attendance was within 60 minutes.<sup>72</sup> The priority of the task will also determine the process for identifying a resource to allocate the job to, in terms of looking within the subdistrict or broadening out to the whole district or neighbouring districts to look for available police vehicles.<sup>73</sup>

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<sup>68</sup> T 45, 225 – 226, 233; Exhibit 1, Tab 31, p. 31.

<sup>69</sup> Exhibit 2, IAU Report.

<sup>70</sup> Exhibit 1, Tab 19, p. 2.

<sup>71</sup> Exhibit 3, Tab 9, p. 2.

<sup>72</sup> T 32, 50; Exhibit 1, Tab 26; Exhibit 2, Tab 12.

<sup>73</sup> Exhibit 3, Tab 9, [39].

69. There was evidence before me that the priority of the task is based on an assessment using the ‘HOT Principle’ (what is the current **H**arm that has already occurred, what is the current **O**pportunity to take action and resolve the matter, what is the current **T**hreat if action is not taken immediately) and is not resource dependent. The staff involved said they were not influenced by considerations of whether a police vehicle would be able to attend the scene within the timeframes set out by police policy, when making the decision to downgrade. If a task is a P1 task, then it will remain a P1 task, even if there is no prospect of a police vehicle attending the scene within two minutes. In that case, a police vehicle will simply attend as soon as they possibly can. The response to police jobs was also said to be “scalable at any one particular time”<sup>74</sup> based on the evolving knowledge of the situation. So the priority of a job might change upon the receipt of new information relevant to the job.<sup>75</sup>
70. Senior Constable Thomas Scudder (SC Scudder), was working at the Police Operations Centre (POC) on the night as the relief dispatcher.<sup>76</sup> His role was to assist the dispatchers in his pod and to take their place when they went on break during their 12 hour shift. Customer Service Officer Paul Solyk (Mr Solyk) was the radio dispatcher responsible for Joondalup district on the day in question in the pod. Both were experienced POC staff members and they worked together on the particular CAD job relating to Lynn.<sup>77</sup> There was also a radio supervisor working with them, Senior Constable Scott Pickering (SC Pickering), and other dispatchers handling the Mirrabooka and Midland districts in their pod.<sup>78</sup>
71. SC Scudder recalled the night was busy and had a lot of outstanding jobs on his screen at the time the CAD task came through, in the order of about 45 jobs waiting to be dispatched across the three districts where he had responsibility. The new CAD task hit his screen at 7.36 pm and the task changed from initial to pending. He didn’t give any thought to the priority, but simply read the job and began to try to find out more information to add to the job. His first action was to try to find a phone number to call Lynn, as that was usually the first thing to do with a welfare check. SC Scudder explained that sometimes a person is not answering calls from family, but will answer a call from police, so it is usual practice to try to call the person when conducting a welfare check. He rang the number included in the CAD job and left a voicemail when she did not answer.<sup>79</sup>
72. Mr Solyk had opened the CAD job at 7.36 pm. His first task was to look at the priority of the job and check the text on CAD to ensure it matched up with the job code and the allocated priority, noting that for a P2, there needed to be a serious offence/incident happening right now. Mr Solyk expressed the opinion that the PAC staff don’t always have a thorough grasp on what priority should be allocated, given the staff tend to be less experienced, so he held the view that call takers were generally over-prioritising tasks at that time. Therefore, his evidence was that he applied his own experience and understanding of the policy to the task.<sup>80</sup> Mr Solyk

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<sup>74</sup> T 50 – 51, 133 -134.

<sup>75</sup> T 51; Exhibit 1, Tab 26.

<sup>76</sup> T 154; Exhibit 1, Tab 31 – SC Scudder is no longer a serving police officer but I have referred to him using his position that he held at that time.

<sup>77</sup> Exhibit 1, Tab 27; Exhibit 2, IAU Report.

<sup>78</sup> T 128 – 129.

<sup>79</sup> T 156 – 159, 162; Exhibit 1, Tab 31; Exhibit 2, IAU Report.

<sup>80</sup> T 142 – 143, 147.



gave evidence that upon his initial assessment, “the text of the job did not match the priority of the job assigned because no immediate incident was occurring.”<sup>81</sup>

73. The job was categorised as a welfare check by the PAC call taker. Mr Solyk did agree with the categorisation given to the task by Ms Byrne. Mr Solyk gave evidence that over his many years of experience dispatching police resources to respond to emergencies, he had seen an increase in family violence matters and mental health issues, and a large number of welfare checks requests regularly came through to police. Welfare checks cover a very broad category of matters and any welfare check has the potential to be a serious incident, with many involving people potentially experiencing suicidal ideation or vulnerable elderly people or children who have gone missing. This case fell within that broad range of a welfare check.<sup>82</sup> Mr Solyk explained the classification of the job as a welfare check didn’t influence his thinking about how serious the matter was, as both welfare checks and family violence are the first types of jobs that will have a car dispatched, due to the propensity for something to go wrong in those cases.<sup>83</sup>
74. The system automatically identifies any available police vehicle and it appeared that all general duties vehicles were tied up with other jobs. The only available unit that showed on the system was a detective vehicle, which could have been dispatched to a P2 but was less likely to be dispatched to a P3. Other evidence available at the inquest indicated this detective vehicle was also actually booked on a job, so it would not have been available if Mr Solyk had attempted to dispatch the vehicle to this job.<sup>84</sup>
75. Mr Solyk’s supervisor, SC Pickering, also recalled the relief dispatcher, SC Scudder, turned to him and said around the time the job first came in as a P2 that he had no one to go to the job, which reinforces that even as a P2, there were no cars available, including the detectives car.<sup>85</sup> SC Pickering gave evidence he remembered “resources were stretched,”<sup>86</sup> which was consistent with this conversation.
76. Mr Solyk could not recall downgrading the priority, but at 7.38 pm the system shows that he downgraded the priority of the CAD job from P2 to P3. He gave evidence that after 15 years in the role, he believes he had developed a sense of what is more important/a higher priority than other jobs, and he would have relied upon this sense to make the decision, although specifically he believed the task did not meet the policy requirements for a priority 2, as there was no evidence of imminent risk. Mr Solyk also stated that the job would only have been downgraded after consultation with the radio supervisor, SC Pickering, as his usual practice was to first ask the radio supervisor if he or she was happy for him to downgrade the job. SC Pickering agreed this would have occurred, although he couldn’t recall the exact conversation.<sup>87</sup>

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<sup>81</sup> Exhibit 1, Tab 27 [32].

<sup>82</sup> T 135,

<sup>83</sup> T 132; Exhibit 1, Tab 27.

<sup>84</sup> T 149; Exhibit 1, Tab 27.

<sup>85</sup> T 160 – 161, 184, 194 - 195; Exhibit 1, Tab 30.

<sup>86</sup> T 192.

<sup>87</sup> T 193.

77. Mr Solyk indicated his usual practice would also be to provide an explanation for the downgrade, although he did not do so in this case. He believes he didn't do so as it had already been done, very shortly afterwards, by Sergeant Matthew Sullivan (Sgt Sullivan).<sup>88</sup>
78. Sgt Matthew Sullivan was working in the role of the DOS at Joondalup Police Station on the night of 5 December 2022, together with Sergeant Brent Keenan (Sgt Keenan). They were assisting the POC and the State Operations Call Centre (SOCC) to coordinate the police response for the cars in the relevant district. Sgt Sullivan and Sgt Keenan had oversight of the police response to jobs in the Joondalup District<sup>89</sup> that night, with a particular focus on dispatching officers to attend the P3 and P4 jobs, although they were also aware of P1 and P2 jobs and were involved in their oversight once dispatched. Sgt Sullivan and Sgt Keenan were aware within seconds of the CAD jobs creation, but there were no cars available in their district, and it would usually be the responsibility of POC staff to dispatch vehicles to a P2 task.<sup>90</sup>
79. Shortly after the priority for the CAD job relating to Lynn was downgraded to P3, Sgt Sullivan became actively involved in that matter, while Sgt Keenan managed the other active jobs in the district. The relief dispatcher at POC recalled that he had heard the Joondalup DOS say over the radio that he was going to downgrade the job, which was a common practice.<sup>91</sup>
80. Sgt Sullivan did not recall having any communication with POC in relation to the downgrade. He recalled that he noticed that no rationale or explanation had been included by POC as to the reason for the decision to downgrade the job. Sgt Sullivan considered it was appropriate for a rationale to be entered, so immediately after it was downgraded by Mr Solyk, Sgt Sullivan made an entry on the CAD job stating "No Direct evidence of Immanent [sic] Threats or Harm. Does not require a P2 response,"<sup>92</sup> along with a notation the job had been downgraded to P3. Sgt Sullivan stated this entry indicated his support for the dispatcher's decision and reflected his own view at the time, based on the current information. Sgt Sullivan explained that he formed the view there were no signs pointing to an immediate risk of harm to Lynn, given she had managed to de-escalate the incident with Paul Cannon in the morning without police involvement and there was insufficient information about what was happening at the current time. In his view, Lynn was "basically an absent person"<sup>93</sup> at that time, and it was appropriately classified as a welfare check. Sgt Sullivan believed the appropriate step was to start gathering more information and then assess further, once more was known.<sup>94</sup>
81. Mr Solyk gave evidence he agreed with the explanation Sgt Sullivan entered for the downgrading of the task; namely, that because there was no incident happening at that moment, it should be a P3 and not a P2.<sup>95</sup> Sgt Keenan gave evidence that he had

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<sup>88</sup> T 131 – 132, 135 – 136; Exhibit 1, Tab 27; Exhibit 2, IAU Report, pp. 20 & 43.

<sup>89</sup> Joondalup District includes the subdistricts of Warwick, Hillarys, Joondalup, Wanneroo, Clarkson and Yanchep – Exhibit 1, Tab 26.

<sup>90</sup> T 90.

<sup>91</sup> T 50, 53, 64, 95, 164 – 166, 193 – 194; Exhibit 1, Tab 26.

<sup>92</sup> Exhibit 1, Tab 19 and Tab 26 [51].

<sup>93</sup> T 53.

<sup>94</sup> Exhibit 1, Tab 26.

<sup>95</sup> Exhibit 1, Tab 27.

also conducted his own risk assessment and agreed that the downgrade to a P3 was appropriate based on the initial information.<sup>96</sup> Similarly, SC Pickering indicated that as an experienced police officer, priority 2 “means we know something is happening right now” whereas there was a lack of information about imminent danger to Lynn, which took it out of that category.<sup>97</sup>

82. Sgt Sullivan explained in his evidence that he did not have the understanding at that early time that Christine and other members of Lynn’s family thought Lynn was effectively being held hostage by Paul Cannon. After speaking to Lynn’s niece Jasmine later, he began to better understand the family’s concerns and as a result, he changed his view regarding the priority response. However, at that stage, based on the limited information before him, Sgt Sullivan considered the CAD job was appropriately classified as a P3 welfare check (noting that welfare checks can also be classified as a P4 when the level of concern is lower). In hindsight, he maintained this was the correct view based upon what the police knew at the time. Sgt Sullivan observed that even if it had been coded as a 29-family violence task, he believes it would not have changed the outcome as both job codes would have been graded the same priority.<sup>98</sup>
83. It was an unusually busy night, compared to the demand that had been expected for a Monday night, and all of the vehicles working in the Joondalup District, plus detectives, were actively tasking at the time Sgt Sullivan began to look at resources for the job. Although the system was showing a detective car available, he knew it was not as it was tied up with a stabbing incident. Therefore, whether it was a P2 or a P3 task, there were no cars available to send. Sgt Sullivan made it clear in his evidence that the lack of available cars, and the inability to meet the goals of service time of 12 minutes for a P2, did not factor into his thinking in supporting the downgrading of the task to a P3 (60 minute response time).<sup>99</sup>
84. After the task had been downgraded and a rationale entered by Sgt Sullivan, Mr Solyk made an entry on CAD at 7.39 pm that no assets were currently available for dispatch.<sup>100</sup> A general call for a vehicle had been made at 7.39 pm, in the hope it might prompt officers who were becoming free to advise of their availability, but there were no police assets available so the job was not allocated.<sup>101</sup>
85. After entering in a rationale on the CAD job for the POC’s downgrade of the task, Sgt Sullivan began gathering information to try to understand the current situation and then make a decision about what to do next, which included ringing Lynn’s family.<sup>102</sup> Sgt Sullivan observed that the DOS role does not formally include responsibility for vetting jobs that come in, but given the closure of the Task Vetting Unit (TVU) that had previously done this, the responsibility for vetting tasks had fallen to the DOS role.<sup>103</sup>

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<sup>96</sup> T 91 - 92.

<sup>97</sup> T 212.

<sup>98</sup> T 54, 56; Exhibit 1, Tab 26.

<sup>99</sup> T 57, 59; Exhibit 1, Tab 26; Exhibit 2, IAU Report, p. 25.

<sup>100</sup> Exhibit 1, Tab 27.

<sup>101</sup> Exhibit 2, IAU Report.

<sup>102</sup> T 52.

<sup>103</sup> T 50; Exhibit 1, Tab 26.

86. Sgt Sullivan sent a text message to Lynn's phone (noting the phone number had been entered in the first CAD job entry) just before 7.45 pm asking her to contact police and confirm she was safe and well if she was able. This is a standard action police use in assisting to locate an absent/missing person. Lynn never responded to this message.<sup>104</sup>
87. After looking up the WA Police Incident Management System (IMS), Sgt Sullivan also made an entry that Paul Cannon was not registered at the address that had been provided (although he entered the address incorrectly himself) and Sgt Sullivan tried to call the number of a person who was registered as living at 23 Hardcastle Avenue.<sup>105</sup>
88. Sgt Sullivan then made a cursory search on IMS for Lynn and Paul Cannon and he found nothing that would elevate risk, in the sense that there was no domestic violence history recorded and no record of the incident that had occurred at Lynn's home in Butler that morning. Sgt Sullivan commented that if there had been recorded domestic violent incidents, it is likely that the job would have remained as a P2 throughout, rather than being downgraded for a time. However, without any previous incidents recorded, and no formal report of the incident that morning, there were no antecedents on the system that raised police concerns.<sup>106</sup>
89. Similarly, SC Scudder gave evidence that if the morning incident had been reported to police, it would have been in the system and two domestic violence incidents in one day would have deemed the incident high risk. It seems though, that the information that the incident had occurred and not been reported, followed by the fact that Lynn voluntarily went to Paul Cannon's home, worked the opposite way in the minds of some of the officers. SC Scudder explained that without a record of police attendance that morning, they had less ability to test the reliability of the account of events, and less ability to understand why Lynn would go to Paul Cannon's house after such an incident.<sup>107</sup>
90. At 7.48 pm the radio supervisor, SC Pickering, changed the address from Paul Cannon's home in Hardcastle Avenue in Landsdale to Lynn's home address in Butler as the first port of call. Mr Solyk stated he would have noticed the change and spoken to the supervisor, but he did not have an independent recollection of this conversation. He assumed it arose due to data interrogation by the supervisor and noted at that stage they knew Paul Cannon was not associated with 23 Hardcastle Avenue, so it would not be unusual to send a car to the missing person's address.<sup>108</sup>
91. SC Pickering explained as radio supervisor, he had to conduct a triage process and prioritise jobs while also trying to vet jobs and try to give them out to local government or other agencies, if they did not fall within the police remit. He had checked the IMS and previous CAD jobs for 23 Hardcastle Ave, with no result. This was relatively unusual, as in his experience there would usually be something on the system connecting the person to the address, so SC Pickering had doubts that it was the correct address for Paul Cannon. He noted there was no information on the CAD

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<sup>104</sup> Exhibit 1, Tab 26; Exhibit 2, Tab 3.

<sup>105</sup> Exhibit 1, Tab 26.

<sup>106</sup> Exhibit 1, Tab 26.

<sup>107</sup> T 185 - 186.

<sup>108</sup> T 139; Exhibit 1, Tab 27.

job to confirm that anyone had checked Lynn's address, and the only information appeared to be that her family had not heard from her since 3.30 pm. Checking her home address was the usual "first port of call, procedure-wise" for a welfare concern, so he considered it appropriate that her home be checked first.<sup>109</sup>

92. Sgt Sullivan had not been consulted about the change (noting he had only just made an entry in relation to the lack of connection between Paul Cannon and the Hardcastle address). He gave evidence he probably wouldn't have made the change to the address, but he also considered it was a standard action when looking for an absent/missing person to attend their home address in the first instance, so he wasn't surprised when he saw the change.<sup>110</sup>
93. SC Scudder supported the change of address on the night, explaining that there are times when a person has argued with family and will return home and turn their phone off, leading to a welfare check request. Once the address changed, it fell within the Clarkson sub-district and a Clarkson car was allocated to the job.<sup>111</sup>
94. SC Scudder was still looking for additional information, but there were no records that assisted SC Scudder on the police database. He explained that he was looking for information about restraining orders or a criminal history suggestive of violence, but there was nothing that assisted him to understand further the context of the relationship between Lynn and Paul Cannon. While he accepted that there was evidence from the family in the CAD job about their concerns there was a history of violence, SC Scudder explained that sometimes information from callers was unreliable, so it was usual practice to try to find police intelligence to support the critical decisions that had to be made. His ability to make other calls and make further enquiries was limited due to the need to assist the other two districts he was responsible for that night.<sup>112</sup>
95. Mr Solyk went on a break between 7.48 pm and 8.00 pm. While he was on his break, at 7.54 pm, Sgt Sullivan rang Christine to ask her for more information about the report she had made to police. Christine confirmed that she had still not heard from Lynn. Christine provided her daughter Jasmine's contact details, as Sgt Sullivan wanted to talk to Jasmine about the incident that morning. Mr Solyk returned from his break around this time and still had no available cars to dispatch. Although his system showed one detective car available, it was not actually free and was tied up with a job. He did not have a vehicle available until 8.25 pm, although he kept checking.<sup>113</sup>
96. Christine rang the police emergency number again at 7.55 pm in order to correct the street number for the address at Hardcastle Avenue. She had ascertained the correct street number from Lynn's son, Harry, and wanted to pass it on. The call taker at PAC was unable to find the CAD task, possibly as the address had been changed from the Hardcastle Ave address to the Butler address. Christine asked if the PAC officer could transfer her to Joondalup Police Station, as she had spoken to Sgt Sullivan a bit earlier. She was told this wasn't possible, and Christine said she would

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<sup>109</sup> T 195 – 197, 207.

<sup>110</sup> T 62; Exhibit 1, Tab 26 and Tab 26.2.

<sup>111</sup> T 165.

<sup>112</sup> T 169 – 170, 179, 184.

<sup>113</sup> Exhibit 1, Tab 26 and Tab 27.

just call Joondalup Station directly and hung up. Christine rang Joondalup Police Station at 7.57 pm and spoke to a male officer, who said he would update the information on the CAD task. However, this did not occur.<sup>114</sup>

97. Christine did not know the name of the police officer she spoke to, but it was later ascertained through the IAU investigation that she spoke to Senior Constable Andrew Baker (SC Baker). SC Baker did not recall taking the call, but he accepted at the inquest it must have been him. SC Baker indicated he would ordinarily have gone straight into CAD and entered the new information. However, he did not. Much later in the evening, SC Baker took another call from one of Lynn's family members, and added some information they provided to the CAD task, and he accepted this is what he should have done when he took the earlier call. SC Baker did not know why he failed to enter the information provided by Christine, but I accept the most likely reason was that he must have been distracted and overlooked it.<sup>115</sup>
98. Sgt Sullivan made some more entries in the CAD job in relation to Lynn's car details and did some searches on other systems to see if Lynn's car had been recorded anywhere near the Landsdale address, but nothing relevant was found. Sgt Sullivan then rang Jasmine at about 8.00 pm.<sup>116</sup>
99. Jasmine confirmed that Lynn was not at home and that Jasmine had witnessed Paul Cannon with a knife that morning. The conversation between Sgt Sullivan and Jasmine took about half an hour. It's not clear why it took so long. Sgt Sullivan gave evidence that he was trying to gain 'situational awareness' and he was asking Jasmine specific details about the day's events, being direct but also trying to be empathetic, and it took him some time to elicit the information that he needed. It seems clear that Sgt Sullivan was trying to understand how serious the situation had been that morning, given it had not been reported to police. Jasmine was very heightened during their conversation, but he managed to establish that Paul Cannon had threatened to harm himself and Lynn with the knife and Lynn had been genuinely scared. Information was provided at the inquest that Jasmine was not aware until that conversation that a police vehicle had not yet been sent to Paul Cannon's house, and she was understandably upset when she realised.<sup>117</sup> Christine recalled that Jasmine said she had been shouting at the police and asking them if they had sent a car to Paul Cannon's Landsdale address, as she was scared about what might be happening to Lynn.<sup>118</sup>
100. While Sgt Sullivan was still talking to Jasmine, Mr Solyk dispatched a car that had become available in Clarkson, NB109, to Lynn's home in Panama Road, Butler, at 8.25pm. It was a general duties vehicle and the officers were sent to the address to conduct a welfare check.<sup>119</sup>
101. After concluding his call to Jasmine, Sgt Sullivan made an entry into CAD at 8.30 pm with information that Jasmine had provided in relation to the incident that morning and the confirmed correct street address for Paul Cannon in Hardcastle

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<sup>114</sup> Exhibit 2, IAU Report, Tab 19 and Tab 20; Exhibit 4.

<sup>115</sup> T 239 - 240; Exhibit 1, Tab 28.

<sup>116</sup> Exhibit 4.

<sup>117</sup> T 84 - 85; Exhibit 1, Tab 19, p. 3 and Tab 26 and Tab 26.2.

<sup>118</sup> Exhibit 4.

<sup>119</sup> Exhibit 1, Tab 27.

Avenue. Sgt Sullivan gave evidence the CAD job relating to Lynn had been one his main focuses at the time as he tried to gather more information and assess the situation for the level of immediate risk. After speaking to Jasmine and obtaining her direct account of the events of the morning, which described very concerning behaviour by Paul Cannon, and having confirmed that Lynn had not been home and obtained Paul Cannon's correct address, Sgt Sullivan now held serious and genuine concerns for Lynn's safety.<sup>120</sup>

102. As a result of his heightened level of concern, Sgt Sullivan called SOCC and spoke with intelligence officer Senior Constable Tim McKeown. Sgt Sullivan conveyed his genuine concerns for Lynn, whom he now deemed at imminent risk. He thought they needed to upgrade and escalate the situation. Sgt Sullivan explained in his statement that he called SOCC as they have additional resources at their disposal, such as phone triangulations and public broadcasts, that might assist in locating Lynn quickly. This call appears to have concluded around 8.38 pm.<sup>121</sup>
103. Jasmine was still at Lynn's house, so she knew Lynn hadn't come home. Sgt Sullivan stated he realised by the end of the call to Jasmine that there was no need to send a vehicle to Lynn's house, as it was clear she wasn't there, and that was part of the information he conveyed in the call to SOCC. However, a police car had already been sent to Lynn's home. Sgt Sullivan made a phone call to the car that was heading to Lynn's house and told them to go to Paul Cannon's house instead. He wasn't aware the officers had already arrived at Lynn's house at the time he made the call. The officers had knocked on the door and then called Jasmine, who had advised she had just left and Lynn was not at the house. They began to head to Hardcastle Avenue.<sup>122</sup>
104. At 8.38 pm, Sgt Sullivan made a number of entries in CAD. He noted his escalating concern for Lynn's safety in CAD and his belief there was an imminent risk. He also recorded that he had redirected a police car that was on its way to Lynn's home in Butler to Paul Cannon's home in Lansdale instead. This was car NB109, which had been dispatched to Lynn's house by Mr Solyk at 8.25 pm. Mr Solyk gave evidence he would not have been turning his mind at that time to the appropriateness of the address, as it was simply his role at that stage to dispatch a car to the address nominated by his supervisor.<sup>123</sup>
105. Another police car, NX101, had booked off from another job and at 8.27 pm they self-dispatched to attend the P3 job at 24A Hardcastle Avenue. As they were heading there, they were cleared from this job by POC at 8.38 pm and redirected to a P2 welfare check in Marmion, that related to a Lifeline call from someone threatening suicide. However, Sgt Sullivan overheard the call and intervened over the radio, overruling the call from POC and directing NX101 to continue on to Hardcastle Avenue at 8.42 pm. They were the first police car to arrive at 24A Hardcastle Avenue, arriving at 8.44 pm. However, even at the time the police officers had begun

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<sup>120</sup> T 76 - 79.

<sup>121</sup> Exhibit 1, Tab 26 and Tab 26.2.

<sup>122</sup> T 64, 79; Exhibit 1, Tab 26.

<sup>123</sup> T 74 - 78; Exhibit 1, Tab 27.

to head to the address, it was already too late to help Lynn. They were only present to arrest Paul Cannon and to begin the steps involved in investigating Lynn's death.<sup>124</sup>

### **THE ATTACK**

106. In the meantime, Lynn had been alone with Paul Cannon at his house for approximately four and a half hours when his landlord arrived home. Shortly after, two neighbours heard two females screaming and a male yelling and they were both sufficiently concerned to call emergency services at 8.15 pm. One reported to police that they had heard fighting that had escalated over the course of the afternoon, and when a third person had joined in it had gotten worse. By the end of the call, the neighbour reported the third person had just left. Not knowing exactly what was actually happening, the PAC call taker, SC Grant, classified the task as a family violence incident and allocated it a priority 3. Nothing came up on CAD to suggest there was another task in the system relating to the same, or similar address, to alert him to the concerns that had already been raised in relation to Lynn's welfare.<sup>125</sup>
107. What is now known is that Paul Cannon's landlord had arrived home about 8.10 pm. She found the front door was locked. As she unlocked and opened the front door, she could see lights were on in the courtyard but did not hear any voices. The landlord walked inside her home and looked out into the courtyard, where she saw the horrifying sight of Paul Cannon standing over Lynn while holding two knives from the kitchen. Lynn was on the couch in a defensive position with her hands and one leg up in front of her. She looked like she had a bruise under her left eye. Paul Cannon turned to the landlord and said, "What the fuck are you doing here? I told you not to come home, fuck off."<sup>126</sup> Lynn was alive and crying at this stage. The landlord told Paul Cannon to leave Lynn alone and to put the knives down. He ignored her.<sup>127</sup>
108. The landlord slowly opened the patio doors and Paul Cannon made a grab for her, so she stepped back out of reach. At this time, while Paul Cannon was distracted, she saw Lynn try to stand up from the outdoor couch. However, Paul Cannon then turned, grabbed Lynn by the hair and stabbed her repeatedly to the chest with a large knife while yelling, "*I told you I was going to kill you.*"<sup>128</sup> Lynn tried desperately to protect herself, but he did not stop.<sup>129</sup> The shocked and terrified landlord fled the house, got in her car and called triple zero for help. She was put through to SJA. The neighbours had also overheard the screaming, which is when they rang police.<sup>130</sup>
109. The landlord explained to the SJA call taker that she was in her car outside her house and she had just seen her housemate stab his wife inside the house. She was told not to go back inside and to wait until police arrived. She told the operator she had seen Lynn lying on the floor, surrounded by blood. She called out to Lynn but received no response. The landlord could not see Paul Cannon anywhere nearby but confirmed he

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<sup>124</sup> T 64 – 65, 79, 139, 150; Exhibit 1, Tab 26 and Tab 27; Exhibit 2, Tabs 3 to 7.

<sup>125</sup> T 221 - 225; Exhibit 1, Tabs 13 to 16, Tab 20; Exhibit 2, Tab 19; Exhibit 5.

<sup>126</sup> Exhibit 1, Tab 12 [125].

<sup>127</sup> Exhibit 1, Tab 14 and Tab 15.

<sup>128</sup> Exhibit 1, Tab 20 [16].

<sup>129</sup> Exhibit 1, Tab 7.

<sup>130</sup> Exhibit 1, Tab 20.



was still inside the house. She repeatedly asked for police to be sent and was reassured they would be informed. A SJA paramedic arrived soon after.<sup>131</sup>

### **SJA ATTENDANCE**

110. SJA Clinical Support Paramedic Shane Toovey (Mr Toovey) was on duty and doing administrative work in his allocated vehicle at the Shell Service Station on Ocean Reef Road in Wangara when, at 8.25 pm, he received an emergency priority 1 task. The triple zero call had been received by SJA Operations Centre at 8.22 pm and it was allocated to him within a few minutes. The information provided was that someone's housemate had stabbed their wife and there was blood everywhere. The offender was listed as Paul Cannon and his Landsdale address was provided.<sup>132</sup>
111. Mr Toovey happened to be relatively close to the address, as he had just cleared another case in the area. He was working as a single crew, so he drove there alone under priority 1 conditions, with the expectation other SJA staff would join him at the scene. He arrived at 8.29 pm and was the first emergency services responder on scene. Mr Toovey saw neighbours out the front and they pointed him to the house at 24A Hardcastle Avenue. Mr Toovey went to the back of his vehicle to grab his ECG monitor and work bag and at that time he was approached by Paul Cannon's housemate, who was still on the phone to the SJA operator. She seemed very distressed and possibly intoxicated. She told Mr Toovey that she had seen Lynn stabbed and then run out of the house. She confirmed the offender was still inside with the patient. The housemate gave Mr Toovey her house keys but said she didn't want to go inside again.<sup>133</sup>
112. Mr Toovey called the SJA Operations Centre to obtain an ETA for when police would arrive, as he assumed they were on their way. He wasn't told that SJA had not been able to get through to the police (for reasons that are explained later), but was simply told they couldn't provide him with an estimated time. Mr Toovey knew that under his workplace policies, he should wait for the police, but he was very concerned for Lynn.<sup>134</sup>
113. Mr Toovey waited a minute or two, made a quick scene safety assessment and then very bravely decided to enter the house without police support. He was concerned that there was a chance Lynn was still alive and needed urgent medical treatment. He devised an exit plan by asking the housemate to stay at the front door and hold the door open for him. He told her, "If I come running back out, and you see someone chasing me, shut the door behind me."<sup>135</sup> He then left his bag at the front door and, at 8.35 pm, Mr Toovey entered the house alone.<sup>136</sup>
114. Mr Toovey entered slowly and called out "Ambulance, ambulance"<sup>137</sup> to alert anyone inside that he was not police. Mr Toovey got to the end of the dark hallway and found Lynn lying in a corner at the end of the hallway on her back with her legs

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<sup>131</sup> Exhibit 1, Tab 12; Exhibit 2, IAU report; Exhibit 3, Tab 4.

<sup>132</sup> Exhibit 1, Tab 21 and Tab 22.

<sup>133</sup> T 248 - 249; Exhibit 1, Tab 21 and Tab 22.

<sup>134</sup> T 250.

<sup>135</sup> T 251.

<sup>136</sup> Exhibit 1, Tab 20 and Tab 21.

<sup>137</sup> T 251.

up, in a large pool of blood. Mr Toovey moved her legs down and as he did so, he saw Lynn take a last gasping breath. He later explained in evidence this was likely an agonal breath as her system was shutting down. Mr Toovey then looked around and observed Paul Cannon seated in a chair nearby with a small bloodied kitchen knife on the ground near his feet. There was also another larger knife in a pool of blood outside. Paul Cannon's eyes were closed and he appeared drunk and in a semi-conscious state, with visible self-inflicted cuts to both his wrists.<sup>138</sup>

115. Mr Toovey satisfied himself that Paul Cannon posed no threat to him and after he removed the knife that was inside the house, he immediately turned his attention back to Lynn. He quickly ran back to the front door and grabbed his bag and monitor, then returned to the house to assess Lynn. He dragged Lynn in to the kitchen, as he needed more light and room to assess her. Then, using an ECG monitor, he established her heart showed no electrical activity and she showed no other signs of life. He saw what he estimated to be six individual stab wounds to Lynn's chest and concluded she had suffered fatal chest injuries. He realised at that moment that it was too late to save Lynn. When he was asked about the severity of the injuries at the inquest, and whether he felt if he had been able to go in earlier he could have saved her, Mr Toovey responded, "Unfortunately not. The injuries that Lynn received were far too great."<sup>139</sup>
116. Mr Toovey said, "I looked at Lynn, I brushed the hair out of her eyes. Her eyes were open to me. I told her I'm sorry, and that she's safe now, and I declared her deceased."<sup>140</sup> At 8.40 pm, five minutes after he first arrived, the paramedic had declared Lynn deceased.<sup>141</sup> He then sat with Lynn for a couple of minutes and wrestled with his conscience about what to do next, before he stood up and walked over to Paul Cannon and began assessing Paul Cannon.<sup>142</sup> Another paramedic crew arrived at this time. As there was nothing they could do for Lynn, the newly arrived paramedics turned their attention to assisting Mr Toovey with Paul Cannon. They applied some dressings to his wounds then waited for police, who arrived shortly after.<sup>143</sup>
117. Mr Toovey impressed everyone in the courtroom with his bravery, empathy, dedication and skill. He put his own life at risk to try to save Lynn's life and also acted according to his training, and against instinct, to care for Paul Cannon despite knowing the terrible thing Paul Cannon had done. Mr Toovey has earned the gratitude of Lynn's family, who have gained some comfort from knowing that he was there with Lynn when she took her final breath. Sadly, I am aware that the toll of this case, and others, has led Mr Toovey to retire from SJA. Whilst his choice is understandable, it is the community's great loss. I am also aware that Mr Toovey was recently awarded an Ambulance Service Medal in the King's Birthday Honours for 2025. The honour is well deserved.

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<sup>138</sup> T 253; Exhibit 1, Tab 20 and Tab 21.

<sup>139</sup> T 256.

<sup>140</sup> T 254.

<sup>141</sup> Exhibit 1, Tab 20 and Tab 21

<sup>142</sup> T 254.

<sup>143</sup> Exhibit 1, Tab 21.

**POLICE ATTENDANCE**

118. The first police officers did not arrive at the scene until 8.45 pm, five minutes after Lynn had formally been declared deceased by Mr Toovey and after a second paramedic team had arrived. It is clear WA Police were aware from 8.15 pm that events were unfolding at the Hardcastle Avenue address, but the seriousness of the situation wasn't realised for some time.
119. At 8.15 pm, one of the neighbours on Hardcastle Avenue had reported a disturbance to police, which was described as a female yelling 'get off' with possibly a male voice present. The address was unclear, but a second call taken around the same time from another neighbour indicated the disturbance was at 24A Hardcastle Ave and the neighbour believed the argument sounded violent.<sup>144</sup> Both had CAD jobs created, that were each given a priority 3 rating, one being classed as a family violence incident and the other as a disturbance. At 8.17 pm, a call for an available vehicle was made, however once again no assets were available. Mr Solyk had seen the jobs come in on CAD and made an entry at 8.21 pm that no cars were currently available.<sup>145</sup>
120. Police Constable Leah Gardner (Const Gardner), was stationed at Clarkson Police Station and working a shift with Police Constable Sophia Walton (Const Walton) and Police Cadet Ryan Stocks on the night of 5 December 2022. They were in car NB109 and were allocated the task to do the welfare check on Lynn at her home address. Const Walton recalled the task suggested that Lynn's family held concerns for her welfare after her former partner had threatened to kill her with a knife earlier that day.<sup>146</sup> At 8.43 pm they attended Lynn's home in Panama Road, Butler. They knocked on the door but no one answered. Const Gardner called Lynn's niece, Jasmine, who advised she had just left the house and that Lynn was not there. Jasmine had gone to her sister's house as she was scared to be home alone.<sup>147</sup>
121. In the meantime, SJA Operations Centre staff had been attempting to notify WA Police of the incident and the urgent need for police to attend 24A Hardcastle Avenue. When SJA require police assistance, they dial a number that is specifically configured for PAC to recognise the calling agency and direct the call to be answered by the call takers who answer triple zero calls. However, the calls will queue if PAC staff are busy servicing other calls.
122. According to SJA records, this is the timeline of events for their calls relating to the incident at 24A Hardcastle Avenue:<sup>148</sup>
- i. 8:22 pm SJA received a 000-call from the housemate requesting assistance for Lynn, who had been stabbed.
  - ii. 8.24 pm the call was entered for dispatched as a priority 1 and it was allocated to CSM Toovey at 8.25 pm. He arrived at the scene at 8.29 pm.
  - iii. 8.25 pm - an unanswered call was placed to the PAC designated line – the call lasted 5 minutes 24 seconds before it was abandoned.

<sup>144</sup> Exhibit 2, IAU Report and Tab 19.

<sup>145</sup> Exhibit 1, Tab 27; Exhibit 2, IAU Report.

<sup>146</sup> Exhibit 1, Tab 18.

<sup>147</sup> Exhibit 1, Tab 17.

<sup>148</sup> Exhibit 2, Tab 27.2.

- iv. 8.27 pm – an unanswered call was placed to the PAC designated line – the call lasted 13 minutes 57 seconds before it was abandoned.
  - v. 8.30 pm – CSM Toovey rang to request an ETA for police – they still had not been able to be advised due to the call being unanswered so there was no ETA.
  - vi. 8.31 pm – a call was placed to the designated line relating to assistance required for a suspicious death in Wagin – the call was answered after 7 minutes 15 seconds and the incident involving Lynn was also mentioned by the SJA operator, but no further details were provided to police at that time.
  - vii. 8.31 pm – an unanswered call was placed to the PAC designated line – the call lasted 7 minutes 14 seconds before it was abandoned.
  - viii. 8.35 pm – an unanswered call was placed to the PAC designated line – the call lasted 7 minutes 24 seconds before it was abandoned.
  - ix. 8.36 pm – an unanswered call was placed to the PAC designated line – the call lasted 1 minutes 19 seconds before it was abandoned.
123. SJA staff then gave up calling the designated line and rang triple zero at 8.39 pm. The call was answered after 1 minute 5 seconds, at 8.40 pm.<sup>149</sup>
124. When the call was answered, SJA Operations Centre requested urgent police backup at 24A Hardcastle Avenue, indicating they had found a female deceased and a male stabbed. The SJA crew were considered to be in imminent danger and SJA had called a Code Black. SJA had been trying to notify the police since 8.22 pm, but had been unable to get through on the designated line, so they reverted to making an emergency call.<sup>150</sup> Both Sgt Sullivan and Sgt Keenan gave evidence that if they had known about the SJA information at an earlier stage, it would have obviously changed the urgency of the need for a response at an earlier time, although they were still limited by the need to find an available car.
125. At 8.41 pm a telephone call had also been received by one of the Joondalup DOS, Sgt Keenan, from officers in Yanchep police car NY101 who were at Joondalup Health Campus. They had been advised by SJA staff at the hospital that SJA had crews at the scene in Landsdale in relation to a double wounding. This was the first time Sgt Keenan or Sgt Sullivan became aware that a serious incident had occurred at Hardcastle Avenue. The information was added to CAD, so it was seen by the POC staff, and the task was upgraded back to P2. The Detective Sergeant at SOCC was also notified.<sup>151</sup>
126. While Const Gardner was on the phone to Jasmine, she heard a call over the radio for a P2 job at 24A Hardcastle Avenue, Landsdale. The call was to assist the SJA officers with a female that was deceased and a male who was unconscious. Const Gardner recognised the address as Lynn's ex-husband Paul Cannon's address, as it was listed on the CAD job as the next address to attend in an attempt to locate Lynn. The radio broadcast also advised the deceased person was believed to be Lynn. Sgt Sullivan also rang the car and told them to go to Hardcastle Avenue. The three police officers immediately drove to the address in Landsdale.<sup>152</sup> Two other police cars

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<sup>149</sup> Exhibit 2, Tab 25 and Tab 27.2.

<sup>150</sup> Exhibit 2, Tab 6 and Tab 19.

<sup>151</sup> T 67; Exhibit 1, Tab 3 and Tab 27; Exhibit 2, IAU Report.

<sup>152</sup> Exhibit 1, Tab 17.

were already there, along with the ambulance, by the time they arrived at the scene at about 9.03 pm.<sup>153</sup>

127. The first police officers at the scene were the officers in car NX101. First Class Constable Reddie arrested Paul Cannon for murder. Paul Cannon was then taken by ambulance to Royal Perth Hospital (with a police officer accompanying him) for treatment for his self-inflicted injuries. Analysis of blood taken at the hospital indicated he had been drinking alcohol and had taken cannabis at some stage. He required surgery, but survived.<sup>154</sup>

### **CAUSE AND MANNER OF DEATH**

128. Forensic Pathologists Dr Jodi White (Dr White), and Dr Kirralee Patton performed a post mortem examination on 12 and 13 December 2022. They observed multiple sharp and blunt force injuries to the head, torso and limbs. There were several sharp force injuries to the lungs, with associated lung collapse and blood within the chest cavity (haemothorax). There were sharp force injuries to the heart, with associated blood within the sac surrounding the heart (haemopericardium). Toxicology showed only paracetamol. At the conclusion of all investigations, the forensic pathologists formed the opinion the cause of death was sharp force injuries to the chest. I accept and adopt their opinion as to the cause of death.
129. Dr White was asked whether she could express an opinion about whether there was any prospect Lynn could have survived her injuries if immediate medical treatment had been provided. Dr White was unable to comment on the specific timing or sequence of the injuries, but did express the opinion the injuries were very severe and would have led to Lynn's death "within a few to several minutes."<sup>155</sup> This was consistent with the evidence of the paramedic, Mr Toovey.
130. On 30 August 2023, Paul Cannon appeared in the Supreme Court of Western Australia and was convicted on his plea of guilty to one count of murder. He was sentenced on the factual basis that he had formed an intention to kill Lynn, at least by the time of the attack, after finding out that she was seeing another man. The learned sentencing Judge imposed a term of life imprisonment with a minimum non-parole period of 19 years.<sup>156</sup>
131. I find Lynn died from multiple sharp force injuries to the chest, which I also find were deliberately inflicted by Paul Cannon with a knife. On the basis of his conviction of the offence of murder, I find Lynn died by way of unlawful homicide.

### **IAU INVESTIGATION**

132. Following Lynn's death, officers from the WA Police Internal Affairs Unit (IAU) conducted an investigation into the conduct of nine police officers and two customer service officers who were involved in the taking of the calls from Lynn's family and allocation of the CAD task, including assessing its priority and adding relevant information. Detective Sergeant Reeve Shelhot (Det Sgt Shelhot), was the

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<sup>153</sup> T 79; Exhibit 1, Tab 17.

<sup>154</sup> Exhibit 1, Tab 20; Exhibit 2, IAU Report and Tab 19.

<sup>155</sup> Exhibit 6.

<sup>156</sup> T 15; Exhibit 1, Tab 20.

investigating officer and he prepared the Final Investigation Report, dated 18 June 2024. Det Sgt Shelhot gave evidence about his report at the inquest.<sup>157</sup>

133. In summary, the allegation that was investigated against each police officer and customer service officer was whether they breached the WA Police Force Code of Conduct to work to the best of their ability with competence, integrity and transparency in relation to particular actions they took, or failed to take, in this case. Put another way, the purpose of the IAU investigation was to determine whether any of the 11 WA Police Force employees either neglected their duties by not complying with policies or procedures or the Code of Conduct or whether they neglected their duties in failing to respond appropriately to welfare concerns.<sup>158</sup>
134. The IAU investigation did not review the conduct of any of the police officers who attended the homicide scene or dealt with the criminal investigation leading to the prosecution of Paul Cannon, as there were no concerns raised in relation to these aspects of police involvement. The focus of the investigation was also not on potential resourcing issues, other than how they impacted upon the decision-making of the individual staff subject to investigation.<sup>159</sup>
135. All eleven staff members involved were interviewed and the IAU investigators also reviewed relevant material such as the CAD tasks, recordings of radio dispatching calls and emergency calls and any emails or other electronic record of information obtained or actions taken.<sup>160</sup>
136. The conclusion of the IAU investigation was that the allegations were not sustained against all but one of the WA Police staff. One police officer, SC Baker, was found to have breached the Code of Conduct and neglected his duties by failing to appropriately record information obtained from a telephone call from Lynn's sister, Christine, in relation to the welfare check for Lynn. When interviewed, SC Baker had indicated he could not remember the call, but other evidence established he was the person who answered the call at 7.57 pm. He was found to have neglected his duties by not updating the CAD task information. He was sanctioned and received a managerial notice, which is a written warning that is intended as an educational tool to remind the officer of the expected standard. He accepted the notice and no further action was taken.<sup>161</sup>
137. In reaching those conclusions, the IAU investigation effectively found that the downgrading of the CAD task from priority 2 to priority 3 was within the WA Police policy framework, based upon what was known at the time.<sup>162</sup>
138. The IAU report identified that there was an unanticipated surge in demand for police resources on 5 December 2022, which challenged the ability of WA Police to respond to all jobs where attendance was required. No root cause was identified for the surge, noting these surges can relate to one-off events and may not reoccur the following week/month/year. WA Police receive 34,612 triple zero calls and nearly a

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<sup>157</sup> Exhibit 2, IAU Report..

<sup>158</sup> T 29; Exhibit 2, IAU Report.

<sup>159</sup> T 30.

<sup>160</sup> T 30 – 31.

<sup>161</sup> T 32 – 33, 40, 240 - 241; Exhibit 2, IAU Report.

<sup>162</sup> T 31.

million phone calls annually for assistance. A trend of surges in summer months, when people are out and about more and the combination of alcohol and heat often leads to an increase in police incidents. The police use previous data to forecast how many calls they are likely to receive in the future for resourcing purposes. The forecast for this particular night, based upon previous events, was around 89 expected triple zero calls, but in fact around 230 calls were received that evening.<sup>163</sup>

139. The surge in demand, with more than double the number of calls received from members of the public seeking assistance than expected, put a strain on the police resources and the ability of the staff at POC to dispatch vehicles to respond to the tasks. The demand for resources in the Joondalup district was high. The IAU investigation looked at the vehicle availability in the District at the relevant time and confirmed that every vehicle was tied up with a task, all of a similar priority, and it was not possible to divert the vehicles to the job related to Lynn.<sup>164</sup>
140. The IAU investigation also concluded that the classification of the job as a welfare check, rather than a family and domestic violence task, was reasonable based on information that the primary concern was to locate Lynn and check on her welfare. In any event, Det Sgt Shelhot explained that even if that was incorrect, it wouldn't necessarily have made a difference to the priority given to the task, as within each category of job there is a broad scope for different priority ratings to be given, so it wouldn't have automatically changed from a priority 3 if it had been classed as a family and domestic violence incident instead.<sup>165</sup>
141. Since Lynn's death there has been a change to the policy in relation to family and domestic violence incidents in terms of downgrading a priority, that does not apply to welfare checks, but at the time of this incident there was also no difference in that regard for either task.<sup>166</sup>
142. The other significant area of concern was the change of the address for the CAD job from Paul Cannon's home in Hardcastle Avenue, Landsdale, to Lynn's home address in Butler. Lynn's family were very distressed because they knew she wasn't at home through Jasmine, and could have told the police this was the case (as Jasmine did when she was eventually spoken to by Sgt Sullivan and Const Gardner). The IAU investigation did not consider this issue at any length, other than to observe it was a subjective decision based upon standard procedure for a missing person. Det Sgt Shelhot observed that police officers are routinely required to make judgment calls based upon their experience and knowledge, as well as standard procedures, and the decision-making was not unreasonable when considered within that framework.<sup>167</sup>
143. As noted above, Ms Byrne considered her allocation of a Priority 2 was appropriate. SC Grant also indicated during an interview as part of the IAU investigation that he would probably have put the job on initially as a P2 as well, because of the mention of a fight with a knife and the fact that Lynn had then gone to Paul Cannon's house, that since then no one had been able to contact her, and no one was certain where

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<sup>163</sup> T 33 – 34, 41; Exhibit 2, IAU Report; Exhibit 3, Tab 9.

<sup>164</sup> T 38, 41 - 42.

<sup>165</sup> T 34 - 35.

<sup>166</sup> T 35.

<sup>167</sup> T 37 – 38.

Lynn was at that time.<sup>168</sup> In that context, SC Grant expressed the opinion the police should have been looking to find her more, rather than downgrading the task while making more inquiries.<sup>169</sup>

### **DISBANDING OF TVU**

144. Some evidence was given by witnesses based at POC in Midland working alongside with the Police Assistance Centre that the disbanding in August 2021<sup>170</sup> of the former TVU at POC had adversely impacted upon the District Operations Supervisor (DOS) role as the TVU staff would previously vet jobs that had not been closed. General evidence of the POC and DOS witnesses was that the closure of the TVU had also increased their workload.<sup>171</sup> SC Grant also worked at the TVU before it was disbanded, and he recalled quite a high percentage of jobs were diverted as the jobs were not a police issue or didn't require an immediate police response. Many of tasks involved welfare checks, and so the TVU would make calls to next of kin and neighbours, to try to resolve the matter without police attendance<sup>172</sup>. The current situation now is the Police Assistance Centre are based in Midland and SOCC are based in Perth<sup>173</sup>.
145. SC Scudder noted that in the past, jobs that were lower than a P1 or P2 priority would go through the TVU, and the POC staff didn't have to consider dispatching to them until they had been vetted. He recalled a lot of the jobs went away through the vetting process. However, after the TVU was disbanded, all of the jobs had to be looked at by POC staff, with the vetting effectively falling to the relief dispatcher, along with any work being done by the DOS from the local district.<sup>174</sup>
146. Mr Solyk explained that when the TVU closed down, the workload of dispatchers increased, because they would do more vetting of the tasks to be allocated themselves. He explained that on a busy night (and Monday 5 December 2022 was an unusually busy Monday night), a dispatcher does not have the time to do the kind of active inquiries that are required to properly vet a task.<sup>175</sup> The relief dispatchers, such as SC Scudder, had some time to make some inquiries, but their availability to do so is dependent on the relief dispatchers competing tasks, noting that they look after two or three districts, and at times provide relief to dispatchers so they may have a comfort break.<sup>176</sup> While vetting tasks was not a formal responsibility of the District DOS, Sgt Sullivan explained that due to the closure of the TVU, that responsibility has also fallen to the District DOS role, alongside their other responsibilities.<sup>177</sup>
147. Mr Solyk gave evidence that in the 15 years since he started work as a dispatcher, the number of jobs has effectively doubled from around half a million jobs a year to around a million jobs a year. He attributes the dramatic increase in part to not vetting

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<sup>168</sup> T 45.

<sup>169</sup> T 45 – 46; Exhibit 1, Tab 32, pp. 31 -32.

<sup>170</sup> T 227

<sup>171</sup> T 137

<sup>172</sup> T 228

<sup>173</sup> T 128

<sup>174</sup> T 174.

<sup>175</sup> T137

<sup>176</sup> T 137 – 138.

<sup>177</sup> Exhibit 1, Tab 26, page 6.



the request at its source, essentially to determine whether it is appropriately a matter for the police or establish details that make the priority rating more accurate. Mr Solyk believes if there was proper vetting initially, it would reduce the number of priority matters coming through, so there would be a better chance to allocate resources to them in a timely manner.<sup>178</sup> Mr Solyk gave evidence at the inquest that he wished there had been more resources available to him, as he would then have potentially had a vehicle to send to the P3 task.<sup>179</sup>

### **COMMENTS ON POLICE CONDUCT**

148. There was evidence before me that police will often head to a job with “the absolute bare bones”<sup>180</sup> of information and the preliminary information often “doesn’t represent what is actually happening at all.”<sup>181</sup> Therefore, it is often the information that is built over time by further enquiries and the gathering of intelligence while officers are making their way to the scene that can help the attending officers to hopefully have some appreciation of the reality of what they are about to walk into, before they enter the scene.<sup>182</sup>
149. Mr Solyk, the POC dispatcher on the night, accepted that Ms Byrne entered effectively all the information she had been given on the night from the emergency call, but there were obviously still some unknowns at that time. It seems Ms Byrne had the benefit of actually speaking with Lynn’s sister Christine, so she no doubt sensed from her tone and the way she delivered the information, Christine’s genuine fear for Lynn. That is part of role to judge the emotional state of the caller. Mr Solyk, on the other hand, only had the text of that information to guide him.<sup>183</sup> While hearing the call, as well as reading the text might be useful, that is not how the work is divided, and even after hearing the other evidence about what had been conveyed, it seems the general view of the POC and Joondalup DOS staff was that the available information from Christine at the initial stages still only warranted a P3 at the time.<sup>184</sup>
150. In terms of judging the priority, the comment was made that “we’ve got to judge it on the information we’ve got at that time” and not everything can be made a priority or then “nothing is a priority.”<sup>185</sup> There was some evidence that since the new policy has come into effect, which limits the authority to downgrade a priority to the Senior Sergeant at SOCC, there are a lot more P2’s, which then means if there are not enough resources, the dispatchers have to stratify the P2’s by reading the information on the jobs and determining which P2 task appears to be more urgent.<sup>186</sup>

#### *Resources*

151. The POC radio dispatcher, Mr Solyk, indicated in his statement that on the relevant night, between 6.30 pm and 8.30 pm, there were 23 pending jobs and 6-10 active

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<sup>178</sup> T 141 - 142.

<sup>179</sup> T 144.

<sup>180</sup> T 19.

<sup>181</sup> T 19, 32.

<sup>182</sup> T 19.

<sup>183</sup> T 145; Exhibit 2, Tab 19.

<sup>184</sup> T 146.

<sup>185</sup> T 20.

<sup>186</sup> T 153.

incidents, but only 6 or 7 tasking vehicles available to dispatch to those jobs. On a Friday or Saturday night, they would have more cars on, but given this was a week night, that was the allocated resources, based upon the projected number of jobs on a Monday night. The number of jobs was unexpectedly high for that night and exceeded the available police resources. All of the available vehicles were tasked during the period Lynn's job came in, and there weren't any police resources available to allocate to the job based on the priority rating. Mr Solyk gave evidence this can happen at certain times. It was unusual to redirect a vehicle, even for a P2 job, and once it was downgraded to a P3, that wouldn't occur. If the priority warranted it, Mr Solyk indicated they could look for vehicles outside the district, but it would depend on the availability of their resources and the situation would need to be extremely urgent.<sup>187</sup> Mr Solyk was asked if in hindsight he felt anything could have been done differently on the night, and he expressed the wish that there had been more resources available to dispatch, as this would have meant he could have sent a car to the job sooner, noting he still felt it was appropriately a P3 task at that time, based on what was known. However, on a quiet night, Mr Solyk indicated a car could often be dispatched to a P3 job within a matter of minutes.<sup>188</sup>

152. As I have explained, on this particular night, enquiries established all of the general duty vehicles available for tasking and the two detective vehicles on duty across the Joondalup District were allocated to other tasks. The Yanchep vehicle was tasked with a mental health incident from 6.26 pm to 9.25 pm. The Joondalup Vehicle was tasked with a sudden death from 6.28 pm to 10.27 pm. The other vehicles were tasked with a serious assault, a robbery, a burglary involving stolen firearms, two family violence incidents and a burglary that involved a deprivation of liberty. It was noted that in normal practice, a tasking vehicle would not be diverted from these incidents to attend a priority 3 incident, or be taken from a job if they were still completing the task, unless it was a matter of urgency. Obviously, with the benefit of hindsight, Lynn's situation was an emergency, but that was not appreciated at the time, and all of the vehicles were involved with serious incidents. A review by State Intelligence Command concluded that, the actions and decisions made in relation to allocating resources to tasks that required police attention on this night seemed appropriate at the time.<sup>189</sup>
153. It is obvious that if the WAPOL staff involved at POC and Joondalup Police Station had known what was actually happening between Paul Cannon and Lynn that afternoon, they would never have downgraded the priority, as there was clearly an imminent risk that Paul Cannon would harm Lynn or himself, based upon what the neighbours had overheard during the afternoon and the known circumstances of Paul Cannon's deteriorating behaviour.<sup>190</sup> It is clear now that Lynn's family's fears that he was holding her there against her will and threatening to cause her harm were accurate.
154. SC Pickering also gave evidence that if they had more vehicles and more available resources, that would change the way they could respond to incidents like this. He noted that the recent policy change in relation to downgrades only being permitted by

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<sup>187</sup> T 129 - 130; Exhibit 1, Tab 27.

<sup>188</sup> T 144.

<sup>189</sup> Exhibit 2, Tab 20.

<sup>190</sup> T 136.

a senior sergeant had made “job attendance times blow out a fair bit.” Whilst SC Pickering accepted that it is definitely a safeguard against a similar incident occurring, he noted it meant there were more high priority matters that must be triaged and managed, against the same limited resources.<sup>191</sup>

155. The author of the IAU report observed that in terms of the working environment, the officers from POC described “working twelve-hour shifts in a sterile environment with four computer screens. The screens are split into sections, allowing several computer programs and applications to be monitored concurrently. POC staff have described situations during peak periods where at least one channel may have thirty to fifty CAD tasks waiting to be dispatched and incoming tasks needing to be prioritised. Their work requires attention to detail and the environment can be described as dynamic and stressful.<sup>192</sup> At least one of the POC witnesses described going home with a headache after a shift, from the demands and stress of the work.
156. Similarly, the role of the DOS requires a juggling of many different tasks in order to coordinate and direct the policing activities within the district and ensure they maximise the deployment of the district’s resources.
157. Ultimately, the general position of the police was that everybody did the best that they could with the information available to them at the time.<sup>193</sup>
158. Sgt Sullivan commented that although in hindsight he still felt the initial downgrading of the job to a P3 was correct, he wished there were extra resources on the ground so he could send cars to jobs when people are calling for them, rather than having to wait for cars to become free. Sgt Sullivan gave evidence that the most frustrating thing for him is having multiple jobs still on the system and having no police cars to send to them. From his perspective, Sgt Sullivan also expressed a view that the WA Police would benefit from bringing back the Task Vetting Unit/District Control Unit, given that much of the responsibility for vetting tasks has now fallen to the District DOS. Sgt Sullivan had commented during his IAU interview that it was extremely fortunate on the relevant night that they had two DOS on shift at Joondalup, which had allowed him to make the calls and other enquiries that he undertook, as often there was only one DOS on shift and he would not have been able to take the steps that he did if he had been alone.<sup>194</sup>

### **REVIEW OF THE SOCC**

159. State Commander Jodie Pearson APM (Commander Pearson), gave evidence at the inquest as the current Commander of the State Intelligence and Command portfolio, which includes the State Communications Division, State Command Division and Forensic Division. Encompassed within that the State Communications Division is the SOCC (which includes the POC now) and the PAC. At the time of these sad events, the PAC and POC were co-located in Midland and the SOCC was a separate business unit in a Maylands, but since POC has been integrated into the SOCC, and they are based together in a different location, separate to the PAC.<sup>195</sup>

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<sup>191</sup> T 205 - 206.

<sup>192</sup> Exhibit 2, IAU Report, p. 39.

<sup>193</sup> T 25.

<sup>194</sup> T 68 – 71, 83; Exhibit 1, Tab 26.2; Exhibit 2, Tab 26.

<sup>195</sup> T 257; Exhibit 3, Tab 9.

160. In terms of the DOS role, Commander Pearson explained that eight of the Metropolitan Police Districts have a DOS team. The DOS staff connect the Metropolitan District Supervisors, SOCC and PAC staff, and provide oversight of critical and routine incidents that occur within their district while coordinating efficient and effective resource deployment. SOCC has ownership and responsibility to manage all P1 and P2 tasks, although the DOS is aware of them, and the DOS focusses on the P3 and P4 tasks.<sup>196</sup>
161. Commander Pearson indicated in her report that the WA Police Force receive over 1.4 million calls annually. The highest volume job category of incidents that police receive through the triple zero and 131 444 numbers are incidents categorised as ‘disturbances’ (job code 28). These can range from antisocial behaviour in a shopping centre to a large scale disturbance like a pub brawl. The second highest is ‘welfare checks’, which was explained earlier in this finding as a broad category that at its heart involves a concern that someone isn’t where they should be/there is a serious concern for an individual’s safety. In 2023, WA Police received over 70,000 welfare check requests, averaging 5800 individual jobs per month. The third largest category of job are family and domestic violence call-outs, comprising around 65,000 jobs per year, based on 2023 statistics.<sup>197</sup>
162. Commander Pearson explained that the TVU, that was referred to by a number of the witnesses who worked at POC or in the DOS role, was introduced for the 2011 Commonwealth Heads of Government (CHOGM) security operation and eventually moved to the State Communications Division in 2019. The TVU had no impact on priority 1 and priority 2 tasks, but TVU staff were intended to review P3 and P4 tasks and assess whether police needed to attend a task and, if attendance was necessary, determine the priority for police attendance and add relevant information to the task to assist attending officers.<sup>198</sup>
163. It is apparent the role of the TVU was well regarded by the staff working in the POC and DOS roles and benefited the frontline response by reducing the number of active tasks requiring police attendance (around 24% of non-urgent CAD tasks were closed by TVU) and adding additional information or frontline police. However, Commander Pearson explained that no other jurisdiction has the equivalent of the TVU and the WA Police Force determined that the large staff investment in the unit (which had 1 Senior Sergeant, 4 Sergeants and 48 Constables) was not warranted, so it was closed in August 2021.<sup>199</sup>
164. Commander Pearson explained that it was envisaged that uniformed call-takers, radio dispatchers, radio supervisors, and DOS staff would all contribute to the task vetting duties on lower priority tasks after the TVU was closed. That appears to be what has occurred, although that additional burden on the individual staff seems to have been keenly felt. However, it was made very clear at the inquest that there is no plan to reinstate the TVU.<sup>200</sup>

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<sup>196</sup> Exhibit 3, Tab 9.

<sup>197</sup> T 259; Exhibit 3, Tab 9, pp. 11 - 12.

<sup>198</sup> T 281; Exhibit 3, Tab 9.

<sup>199</sup> Exhibit 3, Tab 9.

<sup>200</sup> T 283 – 284, 289; Exhibit 3, Tab 9.

165. Following Lynn's death, on behalf of the WA Police Force, Commander Pearson directed the State Communications Division to conduct a systematic review of its end-to-end processes to:<sup>201</sup>
- i. identify gaps and inefficiencies in the current call taking and dispatch procedures;
  - ii. identify opportunities for optimising future police responses to similar incidents; and
  - iii. ensure that the entire process is supported by agency-endorsed frameworks and decision-making support systems.
166. As a result of the review, changes were made to the dispatch priority procedure to revise the definitions for incident types and dispatch priorities, which Commander Pearson indicated would enhance the clarity and efficiency of police responses. Commander Pearson explained the updated policy categorises incidents based on their urgency, ranging from imminent risks to life to local responses. The amendment came into effect on 30 September 2024 and was accompanied by a comprehensive training package and amendments to the PAC and SOCC Knowledge Base.<sup>202</sup>
167. In her report, Commander Pearson identified that based on the new definitions, the information provided in Christine's initial call to police at 7.30 pm that there was a risk of injury to Lynn, would likely cause a call taker to determine the job required a P2 response. Importantly in the context of this case, once the PAC call taker determined that priority response, under the new procedures, a written justification assessed by a senior supervisor is required for any downgrade. Further, the downgrade can only be approved if circumstances of the incident change.<sup>203</sup>
168. This change was referred to in the evidence of a number of the POC and DOS staff, where they noted that since 30 September 2024, only a Senior Sergeant or above at SOCC can downgrade a CAD task priority.<sup>204</sup> Commander Pearson indicated the new procedures provides clear directives and requirements concerning the downgrading of priority 1, 2 and 3 CAD tasks to the senior officers with that decision making authority, and as a result it is expected that there will be greater consistency, oversight and accountability when a decision is made to downgrade a CAD task. It will also minimise the subjective element of downgrades.<sup>205</sup> Commander Pearson gave evidence that she considers the change will add a "safety net"<sup>206</sup> to what is always, by necessity, a dynamic process.
169. Commander Pearson acknowledged at the inquest that the flow on effect of the new process was a greater number of priority 2 jobs, which has an impact on the front line, but explained that she was working to support the human decision-making around the process to ensure that the outcome is functional while also achieving its aim to reduce subjectivity in decision-making. Improvements to the technology used by police, as well as ensuring that all possible resources are available for tasking of jobs, are part of this process.<sup>207</sup>

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<sup>201</sup> Exhibit 3 Tab 9, p. 12.

<sup>202</sup> Exhibit 3, Tab 9.

<sup>203</sup> Exhibit 3, Tab 9, p. 14.

<sup>204</sup> Exhibit 1, Tab 27; Exhibit 3, Tab 9, p. 15.

<sup>205</sup> Exhibit 3, Tab 9.

<sup>206</sup> T 263.

<sup>207</sup> T 264 - 265.

170. Lynn's sisters were consulted as part of the review, and Commander Pearson identified that they were unaware at the time they were contacting police that the police response time for a priority 3 incident (which in 2022 was a routine response) was 60 minutes. They advised that if they had known the police response time, they would have sent a family member to check on Lynn. Instead, they quite understandably assumed police were going to get there more quickly than they might have been able to attend themselves.<sup>208</sup>
171. To address such concerns, the PAC Knowledge Base has been updated to require call takers to inform callers of the approximate response times for different incident priorities. For example, for priority 3 responses, which are typically attended within 60 minutes, call takers will communicate this timeframe to the caller, ensuring they are aware of when to expect police assistance. The call takers will also advise that if the situation escalates, the callers should dial 000 immediately and advise them of the change.<sup>209</sup>
172. Noting that in this case, Lynn's family would not have been given this information as the priority was downgraded after the initial call, the new policy states that where an incident dispatch priority downgrade has been authorised by the senior supervisor, the caller for the incident shall be advised of the new police response time.<sup>210</sup>
173. Commander Pearson explained that this new approach aims to manage caller expectations more effectively and improve transparency regarding police response times.<sup>211</sup> If this policy had been in place on 5 December 2022, I am confident the Christine would have responded to the news the priority of the task had been downgraded with immediate concern, which might well have led to a reconsideration of that decision, after more information was provided.
174. One other change that arose from the review was amendment to the Police Manual procedures for tasking of police resources when responding to an incident requiring an immediate (P2) or urgent (P1) police response, to ensure that a radio supervisor/dispatcher will explore resources from both within and external to the district.<sup>212</sup>
175. The issue of the unanswered SJA calls was another matter considered in Commander Pearson's review. The Key Performance Indicator for Triple Zero calls is that 90% of calls are answered within 20 seconds. All calls for assistance are presented to the PAC via a queue system, where lower numbers indicate higher priority. SJA has a direct line into the PAC, which is assigned a priority lower than triple zero calls. As a result, when there are a large volume of triple zero calls coming in, the designated SJA line is queued behind those higher priority calls.<sup>213</sup>
176. An internal police review examined the SJA Calls to PAC on 5 December 2022 related to Lynn. The police review identified two unanswered calls, but the SJA

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<sup>208</sup> Exhibit 3, Tab 9.

<sup>209</sup> Exhibit 3, Tab 9, p. 15.

<sup>210</sup> Exhibit 3, Tab 9.

<sup>211</sup> Exhibit 3, Tab 9.

<sup>212</sup> Exhibit 3, Tab 9.

<sup>213</sup> T 273 – 274.

review identified five unanswered calls to WA Police on the designated agency number, with the first call made at 8.25 pm and the last at 8.36pm, before they called triple zero instead. Instead, it appeared to identify the first call to the designated number was queued from 8:31:45 until it was abandoned at 8:39:00; the second call was placed to triple zero at 8:39:40 and was answered at 8:40:14. It seems the earlier calls were not identified in the police review, although it appears to have been accepted that there were issues at PAC at this time, and many calls were being queued.<sup>214</sup>

177. During the period from 8.30 pm to 8.45 pm, the review identified there were 6 agents present taking agency calls (along with other types of calls) such as the first call made by SJA, and 11 taking triple zero and 131444 calls, with 5 others taking only 131444 calls as they were not yet qualified to take the priority calls. Only one staff member had called in sick, so the roster was not significantly depleted. However, in that same time period, 99 calls were put through to PAC, 46 were answered and 53 were abandoned. About half of the calls that were abandoned were triple zero or urgent calls.<sup>215</sup>
178. A critical information log showed a call spike occurred between 7.30 pm and 8.45 pm, with 89 calls forecast for the night but 230 calls were actually received. In particular, between 8.00 pm and 8.20 pm, there were 113 calls received. There were four major incidents on the night, with three suspicious deaths reported (including Lynn's) and a fire at the Yongah Hill Detention Centre. It's clear that the night was much busier than anticipated and the PAC was unable to cope with the demand. At 8.40 pm, a team leader logged on to start taking triple zero calls to assist the other call takers.<sup>216</sup>
179. I note that as a result of this incident, there were discussions between the WA Police Force which resulted in SJA updating their Operational Guidelines which relate to contacting other Emergency Services for assistance to read :<sup>217</sup>

*Triple Zero to Police*

*For potentially life-threatening emergencies, where the direct police line is not answered promptly, dial triple zero and request Police – this call will have a higher priority of being answered. On completion of the call ensure the Duty Manager is aware.*

180. Further, SJA now have one of their paramedics co-located at PAC to ensure seamless communication and coordination between the two agencies during emergencies. Commander Pearson explained that in a similar situation, the paramedic would be able to immediately verbally advise that there is an urgent situation that requires police attendance. SC Grant, who still works at PAC, gave evidence the call takers speak to the SJA officer regularly and find having easy access to a SJA staff member very helpful to obtain additional information.<sup>218</sup>

<sup>214</sup> Exhibit 2, Tab 25.

<sup>215</sup> Exhibit 2, Tab 25.

<sup>216</sup> Exhibit 2, Tab 25.

<sup>217</sup> Exhibit 2, Tab 27.2.

<sup>218</sup> T 230; 274; Exhibit 3, Tab 9 [118].

181. At the time of the incident, police did not have any documented history of family violence between Lynn and Paul Cannon, although they were provided with some background information by Christine in the first call, and then later Jasmine gave a direct firsthand account of what she had witnessed. It is now accepted that in the days leading up to Lynn's death, Paul Cannon had visited her home whilst armed and made threats, but these incidents were not reported to police at the time they occurred. Evidence was provided that if the incidents had been reported on 4 December 2022 and the morning of 5 December 2022, the following actions could have been taken by police:
- i. Both incidents would have met the criteria for P2 classification as family violence incidents;
  - ii. If he had been located, it is likely that Paul Cannon would have been arrested and potentially charged for making threats while armed;
  - iii. Even though Paul Cannon may then have been released on bail, he could have been placed on protective bail conditions, a restraining order and/or a police order could have been issued;
  - iv. If he wasn't located, efforts would have continued to be made to find him and he would be on a "high priority" list for his local police station;
  - v. A CAD alert could have been placed on Paul Cannon's Landsdale address as well as Lynn's address in Butler;
  - vi. Protective advice could have been given to Lynn and a duress alarm could have been installed on her phone.
182. It should be noted that, based upon what is known in other cases and in this case, the above options may not have kept Lynn safe. It is also acknowledged by the WA Police that "there are many reasons and hurdles which may prevent persons from reporting Family Violence."<sup>219</sup> However, when considering the police response to this case, the notification of police of the earlier incidents and the actions they could have taken are relevant as it shows what police can do if they are aware of family violence concerns and can factor that information in when making risk assessments and responding to incidents. Commander Pearson commented that the "absence of prior reports underscores the challenge faced by call takers and dispatchers, who must make critical decisions without the full picture."<sup>220</sup>
183. To assist them in this difficult task, Commander Pearson advised that in August 2024, the WA Police Force introduced dedicated Family Violence Sergeants (FV Sergeants) within the SOCC. The FV Sergeant's role is to oversee and review all FV tasks, ensuring that these incidents are correctly classified and prioritised in CAD. The FV SOCC Sergeants provide 24-hour 7 days per week operational support and guidance to all districts' response to real time family violence incidents. They work in collaboration with the Department of Communities to provide multi-agency response to family violence incidents as they occur.<sup>221</sup>
184. Commander Pearson indicated the FV Sergeants are considered by the WA Police Force to be an important component of the Family Violence Response Model (FV Response Model). They are there to support responding officers and supervisors

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<sup>219</sup> Exhibit 3, Tab 9 [122].

<sup>220</sup> Exhibit 3, Tab 9 [124].

<sup>221</sup> Exhibit 3, Tab 9 [125].



managing family violence incidents and they can also assist in ensuring the safety of all parties is addressed by considering whether options such as a police order or a telephone family violence restraining order might be indicated, as well as providing information and safety planning for victims and children, including consideration of access to firearms.<sup>222</sup>

185. It is well established that there may be many reasons why a person may not wish to report a family violence incident to police. However, there was considerable evidence from the police officers involved in this case to the effect that if the incident in the morning had been reported to police, that information would have significantly altered their approach to the CAD job received that evening.<sup>223</sup> SC Grant gave evidence that police officers can place a ‘premise hazard’ alert against a specified address on CAD, which will tell any PAC call taker that there is a known hazard at the address, such as known family violence. The call taker must read the alert and then acknowledge it before continuing with creating the CAD job, which ensures that key information is included in both the information recorded and in assessing the nature and priority of the task.<sup>224</sup>
186. I note in Lynn’s case, given the incident was initially classified as a welfare check, it’s not clear if a FV Sergeant would become involved in such a case. However, I acknowledge that in a more general sense it is a significant addition to the way SOCC manages these kinds of incidents.
187. Commander Pearson also provided information about technology upgrades and efforts to better collaborate with partner agencies which are being progressed by the State Communications Division to improve the efficiency of the call taking at PAC and help them quickly process calls to manage the queue. The combined call centre, housing experts from partner agencies such as Communities, health services and SJA is an example of the integrated approach that is hoped to enable call takers to direct incidents to the right team, based on the nature of the emergency and improve response times. Other possible innovations include self-dispatch capabilities, integrated transcription of calls and leveraging automation, allowing for the diversion of non-urgent calls where appropriate or redirection to a more appropriate agency. An automated text message to callers in certain categories of cases is also being considered, which would reduce the possibility of misinformation or misunderstanding if further follow up calls are made. However, there are financial constraints and other challenges in integrating these systems across external agencies, which requires additional coordination, funding and long-term planning to overcome these barriers.<sup>225</sup>
188. Commander Pearson acknowledged in her report that numerous points of intervention existed before Lynn was fatally stabbed, where different actions taken might have influenced the outcome for Lynn and altered the events that followed. In reviewing this incident, the WA Police have tried to consider what changes could be made to create opportunities for different decisions to be made in another such case.<sup>226</sup> Commander Pearson expressed the opinion the changes made a result of the

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<sup>222</sup> Exhibit 3, Tab 9 [126].

<sup>223</sup> For example, T 204.

<sup>224</sup> T 231 - 232.

<sup>225</sup> Exhibit 3, Tab 9 [127] – [140].

<sup>226</sup> Exhibit 3, Tab 9, p. 16.

review prompted by Lynn's death "mark a significant step toward optimising police response management" and highlighted the importance of restricting the ability to downgrade CAD tasks to ensure "greater consistency, accountability and a thorough understanding of the risks and operational requirements, reducing the likelihood of subjective downgrades."<sup>227</sup> Commander Pearson also observed that CAD tasking procedures have been revised to better prioritise and redirect high-priority tasks. There is also a focus on diverting non-police related tasks, and non-urgent tasks, away from the CAD and SOCC, ensuring that in the future police can focus on incidents where they have primary responsibility and reducing wait times for attendance to all police CAD tasks.<sup>228</sup> In addition, there have been important changes to improve communication with callers, so that people calling for help have a good understanding of the estimated response time, and are kept informed if that time frame is changed.<sup>229</sup>

### **WA POLICE FAMILY VIOLENCE TRAINING**

189. Police officers who gave evidence at the inquest were asked if they have observed changes in their training in relation to family and domestic violence callouts. Witnesses agreed they have noticed changes in the training and response, including the checks and balances put in place, and training in relation to the line of questioning of both the suspect and victim in family and domestic violence incidents to ascertain the true situation, and to ensure safeguards are put in place. Family and domestic violence training was described at the inquest by a witness as "a very intense process."<sup>230</sup> The training police officers receive emphasises that collateral information helps in the decision-making that police are required to undertake, with police officers explaining at the inquest that "we can only respond to the information we have at hand."<sup>231</sup> The evidence at the inquest established that police resources are limited, and police therefore cannot treat every matter as possibly being a "worst case scenario,"<sup>232</sup> so the more reliable information available, the better police are able to properly assess the risk and make the most appropriate decisions.
190. Many of the officers who gave evidence confirmed they have witnessed during their careers a positive change in the way the WA Police Force trains its officers in relation to family and domestic violence issues.<sup>233</sup> However, it is clear there is more work to do.
191. Superintendent Levinia Hugo (Supt Hugo) has worked at the Family Violence Division (FVD) of the WA Police Force since October 2022 and plays an important role in the development of policy and guidelines for the agency "to support victims and hold suspects to account."<sup>234</sup> Superintendent Hugo provided a written report and spoke to the report at the inquest, with a focus on addressing what strategies WA Police have initiated, or intend to initiate, to respond to family and domestic violence concerns. Her evidence assisted me in considering whether recommendations are

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<sup>227</sup> Exhibit 3, Tab 9 [143].

<sup>228</sup> Exhibit 3, Tab 9.hugo

<sup>229</sup> T 275.

<sup>230</sup> T 24.

<sup>231</sup> T 24.

<sup>232</sup> T 24.

<sup>233</sup> T 72.

<sup>234</sup> Exhibit 3, Tab 1, p. 2.

required or whether the WA Police have appropriately taken steps to learn from Lynn's death.

192. Supt Hugo advised that, prior to Lynn's death, the WA Police Force was already concentrated on enhancing its response to calls for assistance and the FVD has systematically reviewed and mapped all national inquests and Royal Commission outcomes against WA Police's current policies, procedures and training. This review of relevant inquiries nation-wide is to ensure the implementation of recommendations specifically related to family violence that may have relevance in WA. One example is the Queensland inquest into the deaths of Hannah Clarke and her three young children, which resulted in 87 recommendations, 78 of which have been considered in the context of Western Australia and mapped by the WA Police to ensure that lessons are learned from those tragic deaths. In Supt Hugo's opinion, the FVD has, in this way, significantly improved the agency response to family violence.<sup>235</sup>
193. Supt Hugo provided some examples of the changes that have been implemented, such as the implementation of the Family Violence Team (FVT) Rotational Model, which involves rotating police officers through the FVT in order to improve frontline knowledge of downstream processes and improve standards of initial response to family violence incidents.<sup>236</sup>
194. A significant change is that on 9 May 2023, about six months after Lynn's death, the WA Police implemented the '*Western Australia Police Force Family Violence Training and Assessment Strategy 2023 – 2025*'. The Strategy focusses on five levels of training, starting with Customer Service Officers, Cadets and Call Takers and going up through the ranks of police officers to include supervisors to Inspectors, then at the current highest level the FVT staff, who have ongoing contact with victim-survivors after the crisis event. The training included oversight recommendations by the Ombudsman of Western Australia, who has a function reviewing family and domestic violence fatalities, as well as the learnings taken from inquests involving family violence.<sup>237</sup>
195. Another change that came into effect after Lynn's death is that the Policy FV-01.02 *Response to Family Violence* was reviewed and rewritten, with the new version coming into effect in February 2023. Supt Hugo advised the policy rewrite took account of lessons learned from WA Police's experience in responding to family violence incidents, which included the review into Lynn's death. As a result, the current version of the policy clearly sets out the procedure that attending officers should follow where it is reasonably practical at each point of their investigation of a family violence incident.<sup>238</sup> In addition, in November 2023, the FVD implemented a 'Family Violence Response Model' to assist police officers to investigate family violence incidents and "ensure consistency and effectiveness in responding to these

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<sup>235</sup> T 298; Exhibit 3, Tab 1; *Inquest into the death of Hannah Ashlie Clarke, Aaliyah Anne Baxter, Laianah Grace Baxter, Trey Rowan Charles Baxter, and Rowan Charles Baxter*, Bentley DSC, delivered 29 June 2022 - [https://www.courts.qld.gov.au/\\_data/assets/pdf\\_file/0010/723664/cif-hannah-clarke-aaliyah-baxter-laianah-baxter-trey-baxter-and-rowan-baxter.pdf](https://www.courts.qld.gov.au/_data/assets/pdf_file/0010/723664/cif-hannah-clarke-aaliyah-baxter-laianah-baxter-trey-baxter-and-rowan-baxter.pdf).

<sup>236</sup> Exhibit 3, Tab 1.

<sup>237</sup> T 309 – 313; Exhibit 3, Tab 1.2

<sup>238</sup> Exhibit 3, Tab 1.

sensitive situations.”<sup>239</sup> The model is a one-page flowchart, which outlines a series of actions that should be taken, based on the evolving circumstances of a family violence incident and factoring in the decisions made by responding officers. Where family violence is established, officers are encouraged to make a police order before leaving the scene and continuing any further investigative actions, noting that it provides an additional layer of protection irrespective of the outcome of the investigation.<sup>240</sup>

- 196.** Similar to the strategies discussed by Commander Pearson, Supt Hugo discussed ways to engage with other agencies that play a role in family violence incidents and improve information sharing and support. An operation was initiated during the festive season in 2022-2023 designed to enhance services for victims of family violence while many partner agencies were not fully operating, given office closures and leave over the festive season. Department of Communities resources were co-located with police at the SOCC, enabling senior leadership to actively aid frontline personnel and victims and value-add information to attending officers on the frontline. A similar operation was then actioned over the Easter 2024 period, where again there would be an impact on available services due to holiday leave. As a result of identified benefits from these operations, WA Police has allocated six Sergeant positions at the SOCC to offer operational support and guidance to frontline supervisors and primary first responders attending family violence incidents. These are dedicated family violence Sergeants whose role it is to provide prompt, real-time assessments in family violence cases. The positions commenced on 6 August 2024, not long before this inquest, so the impact is still being monitored, although anecdotally it appears well supported.<sup>241</sup>
- 197.** There is also guidance available for frontline officers on the 1FORCE application that is accessible on all officers’ mobile phones across the State, which guides officers’ decision making and assists them to assess risk and to consider options in responding to family violence incidents.<sup>242</sup>
- 198.** Supt Hugo also advised the State Government has funded Communities to provide a seven day service within the Family Domestic Violence Response Team, which is located in every district, although at the time of the inquest this was yet to be fully implemented and was 7 days/week but not 24 hours a day.<sup>243</sup> From a technology point of view, Supt Hugo also indicated the WA Police have initiated a new project intended to develop a shared data dashboard with Communities to promote timely exchange of information, ultimately planned to be rolled out at a frontline level. Similarly, information sharing has been improved between the Department of Justice and WA Police to enable identification of breaches of orders or conditions imposed by the courts in family violence circumstances, and with the Department of Health to enhance data sharing.<sup>244</sup>
- 199.** Relevant to Lynn’s case, Supt Hugo specified in her report that WA Police acknowledge the challenges faced by women survivors of family violence in

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<sup>239</sup> Exhibit 3, Tab 1, p. 7.

<sup>240</sup> Exhibit 3, Tab 1.

<sup>241</sup> T 304 – 305, 313 - 314; Exhibit 3, Tab 1.

<sup>242</sup> T 314 - 316.

<sup>243</sup> T 305; Exhibit 3, Tab 1.

<sup>244</sup> Exhibit 3, Tab 1.

reporting incidents to authorities. It is known that “in Western Australia, significant underreporting of family violence exists due to cultural and language barriers, fear of legal repercussions, and concerns about trust and safety.”<sup>245</sup> Supt Hugo referred to the importance of intervening “at an earlier stage in order to provide victim-survivors opportunities to have a choice” in the type of response that a report of family violence may generate.<sup>246</sup>

200. Traditional reporting methods like telephone calls or visiting police stations can be daunting as they immediately trigger police intervention. I understand that a major concern in reporting family violence is that the victim survivor doesn’t necessarily want to have the perpetrator arrested or charged, for varied reasons. However, if a crime is reported to police, they must investigate that crime.
201. To address these issues, WA Police, in collaboration with the Centre for Women’s Safety and Well-Being and Edith Cowan University, aim to enhance reporting opportunities for family violence women survivors. The project will engage with various groups affected by family violence regarding the efficacy of police station as the primary venue for reporting family violence, noting that police are legislatively bound to investigate. Supt Hugo explained that a primary focus of the project is to find out from victim-survivors *how* they would like to report family and domestic violence and it will explore whether there may be additional broader options for reporting family violence. This project is ongoing and incorporates personal experiences such as insights from the review into Lynn’s death, amongst others, and recommendations from the WA Police Commissioner’s Family Violence Advisory Group.<sup>247</sup>
202. Supt Hugo indicated in her report that, when considering the options for the project, WA Police already has identified a number of initiatives which might provide alternative pathways for reporting. Noting the concepts of these initiatives are still in their infancy, the proposals include:<sup>248</sup>
  - i. A multi-agency Community Call Centre with a different number to the usual emergency number, which would allow individuals to connect with specialised call takers, experienced in family violence and mental health, who would be able to offer advice, support and information, but the call may not necessitate police intervention.
  - ii. Multi-agency Family Violence and Advocacy Centres, which would build upon the current model of the Multi-Agency Investigation and Support Team and would be based across the state. They would be designed to provide trauma-informed, multi-disciplinary support in a child-friendly environment, offering comprehensive care for victims and children affected by family violence.
  - iii. An anonymous reporting platform in collaboration with ‘Safe to Say – Crime Stoppers’ specifically aimed at family violence, similar to the platform developed

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<sup>245</sup> Exhibit 3, Tab 1, p. 13.

<sup>246</sup> T 301 - 302.

<sup>247</sup> Exhibit 3, Tab 1 – The advisory group includes members from legal services, the family violence support sector and members with lived experience of family violence. The group assists WA Police by advising on new initiatives and identify opportunities where WA Police can improve existing services.

<sup>248</sup> T 301 – 303; Exhibit 3, Tab 1.

to address sexual abuse. This platform will afford anonymity to family, friends and victims who are seeking some information pertaining to family violence.

203. The introduction of the call centre and advocacy centres would be aimed at enhancing victim safety, ensuring access to support services and encouraging more reporting for family violence. Offering alternative pathways for reporting family violence aligns with community preferences for how survivor-victims wish to report or seek assistance and is part of a trauma-informed approach. To overcome cultural and language barriers, family violence information referral cards have also been developed in consultation with relevant community members and feature a QR card that allows individuals to access language appropriate resources.<sup>249</sup>
204. Supt Hugo commented in her evidence that in trying to create all of these options for victim-survivors, she is still conscious of the need to “try and keep the perpetrators in focus, because they very easily go behind the curtain”<sup>250</sup> when the focus moves to the victim-survivors. Questions such as, ‘Why didn’t she leave?’ or in Lynn’s case, ‘Why did she go to his house?’ are examples of this shift in focus, which takes the responsibility and focus away from people like Paul Cannon. The question should instead be, ‘What has he done to prevent her from leaving or ending contact?’<sup>251</sup>
205. Therefore, in considering risk assessment, there needs to be a spotlight put on the perpetrator which includes looking at the risk and behaviours that are from the perpetrator’s perspective. Ensuring there is robust exchange of information between agencies will give a clear picture of whether the perpetrator’s behaviour is escalating and improve risk assessment, capturing both factors from the victim-survivors perspective as well as things happening for the perpetrator. Supt Hugo gave health as a good indicator of this kind of focus. It could include looking at the reasons why both a victim-survivor might engage with medical services (for unexplained injuries, for example) or why a perpetrator may be seen by doctors (for alcohol or mental health issues) that could assist in forming a picture of increasing risk in a domestic relationship. Information sharing in that space may require legislative change, given the rules around patient confidentiality, but Supt Hugo noted that they are working to provide Health with information from WAPOL that may help them to identify red flags, for example in the case of firearm licences.<sup>252</sup>
206. Moving forward, the WA Police Force is collaborating with the non-profit organisation Stopping Family Violence and Curtin University on an ongoing project to develop a tool to index the risk a person poses within the family violence relationship. Known as the Harm Assessment Risk Matrix (HART), it is intended to be a tool to accurately identify individuals capable of committing serious harm and allow for targeted intervention and support and assist towards a multi-agency approach.<sup>253</sup>
207. In conclusion, Supt Hugo emphasised that while police officers have, and will continue, to sometimes make mistakes as human beings, it is the focus of her team to try and “give them tools in their toolkit to be able to do the best job that they can

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<sup>249</sup> Exhibit 3, Tab 1.

<sup>250</sup> T 305.

<sup>251</sup> T 305 – 308.

<sup>252</sup> T 305 – 307, 320.

<sup>253</sup> T 305 - 308; Exhibit 3, Tab 1.

do”<sup>254</sup> when faced with the complexities of family and domestic violence incidents. Supt Hugo gave evidence that the FDV Team are conducting random family violence health checks to review how various districts have managed specific family violence incidents, including viewing the written reports and the associated body worn camera footage, to consider how the officers have performed in providing a family domestic violence informed response and then providing support to officers if there are improvements that can be identified. Supt Hugo acknowledged there can be culture issues, often associated with compassion fatigue, in a particular district and these reviews are able to identify and address such concerns at an early stage. However, overall she has seen a “remarkable improvement”<sup>255</sup> in the process of conducting these reviews, which suggests the training is having a positive effect.

208. Supt Hugo noted there has been a rise in family violence reporting, but acknowledged that there is still a significant hidden problem. In her estimation, possibly only around 20 per cent of the population report family violence incidents to police, and it is known the level of underreporting is particularly systemic for culturally and linguistically diverse women (CALD), because they are isolated and the perpetrators will often use immigration, culture or religion as a tool to prevent victim-survivors seeking help. To assist with CALD communities, WAPOL has created referral cards that are given to both the victim survivor and perpetrators with a QR code on the back that allows for the information to be translated into 20 CALD languages, six Aboriginal languages and Auslan. The FDV Team have also held a CALD conference with relevant CALD community groups and members of the public to disseminate information about how the police and other agencies can support them.<sup>256</sup>
209. Ultimately, Supt Hugo explained that addressing family and domestic violence is about safety and developing trust in conjunction, so that the people who are experiencing family and domestic violence trust the police and other agencies that if they do ask for help, there is help to be given. Further, Supt Hugo emphasised the importance of making it clear to victim-survivors that it is their choice that will guide what help they receive. Supt Hugo commented that pathways to reporting is still one of the most important areas where more work is required, so that the size of the problem can be fully understood and support can be provided to those women, like Lynn, who are currently hidden from view until things have escalated to the point of no return. Lynn spent years protecting herself, her sons and other family in the best way she knew how, but in the end those safety planning measures were no longer enough to keep her safe. It is important that other women and their supporters have the confidence and the means to reach out for help in the way that works best for them, before it is too late.<sup>257</sup>

### **CONSULTATION WITH LYNN’S FAMILY**

210. Lynn’s family have been actively involved in this inquest from a very early stage. It has been an understandably draining and traumatic experience for Lynn’s family and friends but they have engaged with the process in a constructive and meaningful way, with the hope that they would learn answers and direct avenues for change.

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<sup>254</sup> T 309.

<sup>255</sup> T 319.

<sup>256</sup> T 308, 321 - 322.

<sup>257</sup> T 320, 324 - 325.

They critically directed aspects of the investigation into the police response and provided important background about Lynn and Paul Cannon's relationship, as well as factual evidence about the fateful days leading up to Lynn's brutal murder. Lynn's sister Jacqui Darley (Jacqui) was a key contact point for Lynn Cannon's family, but all of her sisters, along with extended family members and support network were involved in the inquest process and they attended the inquest hearing itself.

211. I have set out at the start of this finding much of the background information that Lynn's family has provided to the Court. It is clear that Lynn was a very loved mother, sister and daughter and that her death has left a hole in her family. Most of her family last saw her in November 2022, only a few weeks before her death, at a family member's engagement party. She was happy and excited for the future. Days before her death she celebrated her 51<sup>st</sup> birthday with her new partner. All of these are happy memories. However, they are tarnished forever but what came next. Lynn was frightened on the morning of 5 December 2022, after Paul Cannon barged in to her house and threatened her with a knife, but she stayed strong for the sake of her niece. Her family believed this might be the impetus for Lynn to take steps to report Paul Cannon's controlling and aggressive behaviour to the authorities, something she had avoided until then. Sadly, she didn't get the chance.
212. The circumstances of Lynn's death have greatly added to her family's pain at losing her, knowing that she was alone for hours with the man who eventually killed her. They were told later by police that Lynn's phone had been smashed, along with her smart watch, so she had not been able to call for help herself. Although they tried to get help to her, it came too late. Lynn's family are left to wonder, "Did she ever know that there were people who were concerned for her safety and were trying desperately to arrange help?"<sup>258</sup>
213. Jacqui explained in a detailed statement to the Court the circumstances leading up to Christine's report to the police, and the genuine fears her family held for Lynn's safety. Lynn's family believe they conveyed appropriately the level of urgency they felt, but their concerns were minimised by everyone other than the first call taker. They were dumbfounded when they eventually realised that the priority had been downgraded. It is clear that if they had known that the police were not going immediately to Paul Cannon's house, they would have taken their own steps to try to find her urgently.<sup>259</sup>
214. Lynn's family also believe that the police have attempted to deflect responsibility. They note that even with the early incorrect street number, Lynn's car would have been clearly visible from the road if police had gone to Hardcastle Avenue. They would likely have also been alerted to the right house by the neighbours, or even have heard the sounds of the screaming for themselves. Even when Paul Cannon's landlord phoned emergency services and SJA attended, the police did not come. Lynn's family have gained comfort from the bravery of Paramedic Shane Toovey, who put his own life at risk to be with Lynn in her final moments, but they consider it inexcusable that police did not arrive at the scene until after Lynn was declared

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<sup>258</sup> Exhibit 3, Tab 2

<sup>259</sup> Exhibit 3, Tab 2.



deceased, well over an hour after Christine first called them for help and after repeated calls by SJA directly to the POC were not answered.<sup>260</sup>

215. Lynn comes from a family of strong women and, despite their profound grief, they have united to use their strength to seek answers from the police as to what went wrong, and to drive change so that lessons are learned from these terrible events. It is too late for their beloved sister Lynn, who was let down by the system, but they do not want this to happen again to another woman and her family.<sup>261</sup>
216. Jacqui spoke as the final witness at the inquest. After sitting through the evidence, she stated that Lynn's family had come to the inquest hoping that those who had been responsible for downgrading Lynn's priority "might have the humility to admit they made a mistake,"<sup>262</sup> as unless mistakes are acknowledged, how do we bring about change? They note that the witnesses involved have explained why they feel their decision-making was sound, based upon what they knew at the time, but therein "lies the danger of subjectivity."<sup>263</sup> Some comments about the lack of documented family violence history and questions about why Lynn would have gone to Paul Cannon's house if she knew she was in danger also flagged for them the need for this kind of reductive thinking to change.<sup>264</sup>
217. However, Jacqui also highlighted that in their search for answers, she and Christine met with Supt Hugo and were given an opportunity to see the training now being given to officers in relation to family and domestic violence. They note that part of the training includes awareness of coercive control and the eight stages that can lead to partner homicide, which they can attest to having seen it play out before them in the life of their sister. They wonder why these signs were not recognised by some of the officers involved in Lynn's case that fateful night. They support the intensive training now being offered by Supt Hugo and the FVD staff, and encourage these officers to engage with this training and learn from the past.<sup>265</sup>
218. Generously, Lynn's family have also expressed their gratitude for some of the changes that have been implemented since losing Lynn, as detailed by Commander Pearson and Supt Hugo, in particular the need for a senior sergeant to approve any priority downgrade and the notification to families of delays when attending a job. They acknowledge that Supt Hugo and her team are working hard to reduce the number of domestic violence incidents in this State. They have been working with Supt Hugo to aid her understanding of how a victim-survivor's support network may not know how to report incidents when they are not the victim, which has informed the work on the 'Safe to Say' platform, giving other family and friends a way to reach out and access information without breaching the confidentiality of a loved one.<sup>266</sup>
219. One death in association with family and domestic violence is too many, and we still have so many more than one. This year police statistics show that there were 3379

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<sup>260</sup> Exhibit 3, Tab 2.

<sup>261</sup> T 380; Exhibit 3, Tab 2.

<sup>262</sup> T 380.

<sup>263</sup> T 380.

<sup>264</sup> T 380 – 381.

<sup>265</sup> T 381 – 382.

<sup>266</sup> T 323.

domestic violence assaults recorded across Western Australia in March, which amounts to an average of 109 domestic violence assaults a day and is an increase of 86% on the same month's statistics in 2018. Further, those numbers reflect the small percentage of incidents that are reported, with the hidden number believed to be significantly higher. Media reports rightly describe our nation as being gripped by a domestic violence crisis.<sup>267</sup>

220. Jacqui poignantly noted that “Lynn no longer has a voice, but we are here to speak for her.” They have identified indifference, complacency and a lack of urgency in Lynn’s case that needs to be corrected within the members of the WA Police Force. However, most importantly, they correctly identify that we “need to put the spotlight on the perpetrator. We need to change their way of thinking. Their partner is not their possession.”<sup>268</sup> That is a bigger task that involves more than just the WA Police Force. It requires a whole of government, and indeed a whole community, change in attitude and approach to how we view family and domestic violence. In my view, even this term somewhat minimises the conduct, as it seems to distinguish it from the seriousness we view this kind of violence in any other setting.
221. To aid my understanding of what is being done on a broader community level, I was assisted by the expert evidence of Dr Alison Evans (Dr Evans) and Professor Donna Chung (Professor Chung).

### **EXPERT EVIDENCE OF PROFESSOR CHUNG & DR EVANS**

222. Dr Evans is the Chief Executive Officer for the Centre for Women’s Safety and Wellbeing, which is the peak body for domestic and family violence services for women and children, as well as providing sexual assault support services and community-based women’s health services, in Western Australia. The Centre leads a lot of the advocacy work, as well as the policy and legislative reform efforts, on behalf of victim-survivor services. Dr Evans’ organisation, along with some lived experience experts and subject matter experts, called for crisis talks in the family and domestic violence space, which led to the establishment of the Family and Domestic Violence Task Force, of which Dr Evans was a member.<sup>269</sup>
223. Until recently, Professor Chung was the Chair of the Board for the Centre for Womens’ Safety and Wellbeing and is a Distinguished Professor of Social work at Curtin University. Professor Chung was also a member of the Family and Domestic Violence Task Force as a subject matter expert.<sup>270</sup>
224. Dr Evans and Professor Chung worked collaboratively, at the request of the Court, to prepare a joint report dated 12 December 2024, and they spoke to that report on the same date during the final day of the inquest hearing. Their evidence was directed to informing the Court in relation to family and domestic violence dynamics and to gain a better understanding of risk factors and red flags in family and domestic violence cases and how we all might foster a preventative or safety role in the community. Specific to Lynn’s case, Dr Evans and Professor Chung also helpfully explained

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<sup>267</sup> T 382; <https://thewest.com.au/news/crime/alarming-wa-police-data-shows-staggering-domestic-violence-rates-are-highest-on-record-c-18621370>.

<sup>268</sup> T 382.

<sup>269</sup> T 332 – 333.

<sup>270</sup> T 334.

some of the dynamics that might have been at play in her relationship with Paul Cannon that may have influenced Lynn's decisions not to report his threatening behaviour and to go to his house despite her fear of him.<sup>271</sup>

225. Professor Chung described some strategies and approaches known as 'safety work' that women in violent relationships will often use to de-escalate the situation or avoid a situation altogether by 'keeping the peace' at all times. In their report, Professor Chung and Dr Evans explained that safety work "refers to the strategies and tactics which women deploy to keep themselves and others safe."<sup>272</sup> Further, the "behaviours are labelled in this way as they are highly gendered responses in intimate relationships where women are socially expected to manage the emotional health of the relationship including the feelings and reactions of their partners."<sup>273</sup>
226. Professor Chung and Dr Evans theorised that Lynn was probably engaging in safety work when she went to Paul Cannon's home on the afternoon of her death to give him the transfer papers to her car, in the hope that this would appease him and stop him from returning to her home and coming into contact with her niece and other people like her sons. "It was a tactic of trying to keep everyone safe from his actions by enabling him to have what he requested."<sup>274</sup> It may have also been, in part, a response to direct threats from Paul Cannon, either towards Lynn or others.<sup>275</sup>
227. Professor Chung explained further that "there can be a whole range of reasons why people then might attend the property in ways that seem to the outside world naïve or strange or odd,"<sup>276</sup> but this is because there are often a lot of pieces of information that are underpinning their coercive behaviours "that cause that pull to make contact to try and de-escalate."<sup>277</sup> Professor Chung and Dr Evans noted that where there are abusive dynamics in a relationship, the victim-survivor is often hopeful that an appeasement will lead to less abuse and reduce fear, but "at the core of domestic and family violence is the perpetrator's relentless need for power and control over their partner so the resolution of incidents will not deescalate or fundamentally alter the situation as the problem lies with the abuser's ongoing need for control over others."<sup>278</sup>
228. In the past, Lynn's efforts to calm and appease Paul Cannon had appeared to her to be successful in managing immediate risk, so it seems she followed the same pattern. However, Professor Chung suggested that Lynn likely underestimated the pathological jealousy that Paul Cannon was exhibiting in terms of his distress and abuse and violence in response to finding out Lynn had a new partner. Professor Chung explained that "re-partnering is often a very strong red flag where the perpetrator has been someone with a history which is associated with control."<sup>279</sup> In the context of Lynn's relationship with Paul Cannon, which was characterised by coercive control behaviours, his discovery she had a new partner would have

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<sup>271</sup> T 336.

<sup>272</sup> Exhibit 3, Tab 10, p. 1.

<sup>273</sup> Exhibit 3, Tab 10, p. 1.

<sup>274</sup> Exhibit 3, Tab 10, p. 1.

<sup>275</sup> T 336- 337, 344; Exhibit 3, Tab 10.

<sup>276</sup> T 344,

<sup>277</sup> T 344,

<sup>278</sup> Exhibit 3, Tab 10, p. 1.

<sup>279</sup> T 337

signalled to him that he was losing control over Lynn and his behaviour then escalated beyond what Lynn had experienced in the past.

229. Professor Chung observed that “post-separation is the most dangerous time for women, both immediately but also over the longer term for a number of women, where their ex-partner has exhibited a range of jealous and controlled and coercive behaviours.”<sup>280</sup> Therefore, while the literature shows there is clearly a heightened risk to women at the immediate point of separation, re-partnering can reignite the level of risk. When the woman re-partners, there is a focus both on the loss of control but also the realisation of the unlikelihood of the relationship reconciling, even though any hope of reconciliation may have always been unrealistic.<sup>281</sup>
230. Professor Chung also explained that with controlling males, there is “something particular about sexual jealousy that is often a basis on which they ruminate.”<sup>282</sup> If they are taking drugs and alcohol then this can increase that rumination and things become very heightened. Knowing that Paul Cannon had been drinking alcohol excessively prior to Lynn’s arrival, it can now be seen how Paul Cannon’s recent knowledge of Lynn’s new relationship, combined with his drinking, meant his escalation in behaviour could have been predicted, even though there was no documented history of physical violence at that stage. Professor Chung observed that “we also know that the severity and extent of violence will increase under the influence of alcohol and drugs.”<sup>283</sup>
231. Professor Chung noted that “there’s a kind of unconscious bias, or an unconscious assumption, that if someone is dangerous there will be a record of it somewhere, and that isn’t the case necessarily.”<sup>284</sup> She commented that there is a large group of perpetrators who will not have any record of past behaviour because a lot of the behaviour is coercive and/or goes on behind closed doors, so it is not recorded. Therefore, to make the unconscious assumption that if there is no evidence from previous history then it is not that serious or the risk is small is a false conclusion. Professor Chung stated that “when someone has a known history of coercive, jealous, abusive behaviour, we can’t afford not to take it seriously because of the implications.”<sup>285</sup> Professor Chung and Dr Evans hypothesised that Lynn may not have wanted to inflame the situation, and possibly put not only her own safety but also her sons’ safety at risk, by involving courts and escalating her response.<sup>286</sup>
232. Professor Chung commented in her evidence that although there may be no criminal history, there may be a history of mental health issues or drug and alcohol admissions with health services, that can assist in raising a red flag, but that requires access to the health services records. It seems clear that Paul Cannon was abusing alcohol in the lead-up to these events, and he had other serious health issues that were negatively affecting his mental health.<sup>287</sup>

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<sup>280</sup> T 338.

<sup>281</sup> T 337 – 339.

<sup>282</sup> T 338.

<sup>283</sup> T 341.

<sup>284</sup> T 341.

<sup>285</sup> T 340.

<sup>286</sup> Exhibit 3, Tab 10, p. 2.

<sup>287</sup> T 340 - 343.

233. In their report, Professor Chung and Dr Evans noted that in general, the pattern of the perpetrator's contacts with the victim-survivor and their family and friends can be initially remorseful in appearance, with the intention that the victim-survivor will reconcile with them. When this does not occur the contacts are generally increasingly abusive and threatening.<sup>288</sup>
234. Professor Chung observed that particular behaviours that were red flags in Lynn's case were Paul Cannon's re-presenting to Lynn's home uninvited twice in two days, and the evidence that Paul Cannon had brought a knife to Lynn's home on the second occasion and threatened her with it. These were significant warning signs that Paul Cannon was exhibiting an increasing need to coerce and the risk level was escalating.
235. Noting there was information from the neighbours that Paul Cannon may have been making threats to harm himself early in the afternoon, Professor Chung commented that this is also quite a common post-separation feature and it can be "used as a pull to bring the person back and to gain some control over that person. Threat to suicide can lead people to feel sorry for them and move them into a 'mental health emergency approach', which obscures the abuse and control and the rumination of jealousy that is actually underpinning the crisis. It's also a tactic used sometimes once people have killed ....their former loved ones," as part of a pattern of murder-suicide, as occurred in this case (at least in the sense that Paul Cannon self-harmed after murdering Lynn), so threats of self-harm should raise significant concern as it is a real sign of escalation in danger.<sup>289</sup>
236. Professor Chung suggested that GPs, mental health practitioners and drug and alcohol service providers need to be empowered to be able to conduct intentional screening for men who are presenting in crisis, even where they don't have a criminal history, to ensure that risk factors for family and domestic violence are considered as part of the picture and then be able to access appropriate information sharing networks where the risk is considered high.<sup>290</sup>
237. Professor Chung acknowledged that it can be difficult for police or any emergency responder to understand the situation as "often what happens in domestic and family violence is .... you're kind of, working with half a deck of cards all of the time. You don't know the full picture."<sup>291</sup> Therefore, anything that assists the police to quickly gain additional information from other sources can be very important.
238. Professor Chung and Dr Evans identified some situations that can be flagged as immediately elevating risk for individuals. Distilled down, Professor Chung and Dr Evans identified a number of relevant questions for police dispatchers and police officers to put that will help identify these concerning situations and help determine whether there are red flags present that there is imminent risk of harm. They are:<sup>292</sup>
- i. Are the parties separated? (Post separation is a time of very high and often increasing risk)
  - ii. Is the person threatening to harm the ex-partner or others?

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<sup>288</sup> T 342; Exhibit 3, Tab 10, p. 2.

<sup>289</sup> T 344 - 345.

<sup>290</sup> T 367 - 369.

<sup>291</sup> T 346 - 347.

<sup>292</sup> Exhibit 3, Tab 10, pp. 2 - 4.

- iii. Do they have access to weapons?
- iv. Do you know if they have used weapons previously against any person?
- v. Do you know if they have self-harmed in the past year?
- vi. Do they regularly use alcohol or other drugs?
- vii. Are there any current or upcoming court cases that are known to be happening?

Professor Chung and Dr Evans emphasised that in cases where the caller ‘does not know’ the answer, that should be distinguished from a ‘no’ answer.

239. With the benefit of hindsight, consideration of Lynn’s case indicates many of these factors were present and proper questioning may have elicited a positive response from Christine or Jasmine when reporting concerns to police, and assisted in assessing the imminent risk of harm. Paul Cannon was exhibiting extreme jealousy, was using alcohol and drugs (which increased his risk of rumination), had continuing unemployment issues that affected his self-esteem and was escalating in his behaviour. For safety purposes, Lynn’s family knew she would typically let them know where she was and keep in contact, so the fact that she was not able to be contacted was also a red flag.<sup>293</sup>
240. Professor Chung and Dr Evans were asked whether in Lynn’s situation, given the obvious red flags, it should have been a question for police whether they could confirm that she was **not** in imminent danger, rather than whether she **was** in imminent danger? Their response was that there are various myths and unconscious assumptions in perceptions about what constitutes danger in intimate partner violence and post separation coercion, violence and abuse that could have been at play in this case and led to the focus being on a ‘welfare check’ rather than a fear that an offence had occurred or was imminent. These perceptions can mean that victim-survivors feel like they have to wait to be attacked to prove that the person was dangerous. They noted that “a lack of a pro-active and pre-emptory response in policing domestic and family violence has been noted in research, particularly in situations where the victim is seen as ‘not speaking up about what happened’”. The general impression of the police officers involved that Lynn would not have gone to Paul Cannon’s house if she believed she faced a serious threat is a clear example of that type of thinking.<sup>294</sup>
241. Commander Pearson advised that the State Government Family Violence Taskforce, of which the WA Police Force is a key member, is currently developing a reform plan built around four key pillars, which emphasise the need for adequate risk assessments, case coordination and specialist response that are appropriately resourced. The plan calls for the embedding of collaborative practices, ensuring victim-survivors consistently receive sensitive and safe responses, while perpetrators are held accountable across all parts of the system.<sup>295</sup>
242. Professor Chung and Dr Evans, as members of the Taskforce, note that the Taskforce was “established in response to another devastating year of deaths due to family and domestic violence. We know that these deaths are only the tip of the iceberg. We

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<sup>293</sup> Exhibit 3, Tab 10.

<sup>294</sup> Exhibit 3, Tab 10, pp. 4 - 5.

<sup>295</sup> Exhibit 3, Tab 9.

know that every day, every hour, all around the State, women and children are living in fear and that they are at risk of being killed.”<sup>296</sup>

243. Professor Chung and Dr Evans are supportive of the steps the Taskforce, through the outcome of the Family and Domestic Violence (5 year) System Reform Plan, is taking towards a cohesive all-of-government response to family and domestic violence, with the first Inaugural progress report released the day before Professor Chung and Dr Evans gave their evidence.<sup>297</sup>
244. Dr Evans explained at the inquest that it was determined at the Family and Domestic Violence Taskforce that the key areas of focus would be on risk assessment, risk management, information sharing, and then the workforce development and capability that is going to be required to support those various workforces to do that effectively.<sup>298</sup> Risk-relevant information sharing between agencies and consistency in responses are key parts of the system reform.<sup>299</sup> Dr Evans spoke very positively about the work that is currently being done collaboratively to focus on reforming the family and domestic violence system in Western Australia to ensure that all the relevant agencies are working together much more effectively.<sup>300</sup> However, as indicated by the fact that it is a five year plan, all of these changes will take time.
245. Professor Chung observed that even in other jurisdictions where information sharing between agencies is better advanced, there is still a lot of missing information. Therefore, Professor Chung emphasised that “in the absence of having all that available information ... you’re better off to assume a higher risk than you are to presume a lower risk, because of the inherent danger of what’s happening. So if in doubt prioritise it higher, not lower ... don’t use the absence of information to deprioritise.”<sup>301</sup> Put another way, “the importance of knowing what you don’t know is equally important.”<sup>302</sup> What happened in Lynn’s case, where there was no recorded history of prior violence, is a tragic case in point.
246. In that regard, Professor Chung and Dr Evans pointed in their report to the importance of obtaining anecdotal history from family members or other people in the victim-survivor’s support network in the absence of documented history. Professor Chung commented that there may be a family dynamic influencing the decisions being made that is understood by the people closest to the victim-survivor, but not readily understood by an external observer. In Lynn’s case, her sisters had a deep understanding of the dynamics in Lynn’s relationship with Paul Cannon and why she might appear to have behaved counter-intuitively by not reporting the incident in the morning involving the knife and then choosing to go to his home afterwards. They understood the patterns of coercion in Lynn’s relationship history, as well as her usual protective behaviour by always remaining in contact with them. Weight needs to be given to this historical knowledge in the absence of other ‘objective’ evidence that might be found in the police database.<sup>303</sup>

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<sup>296</sup> Exhibit 3, Tab 10, p. 5.

<sup>297</sup> T 350; Exhibit 3, Tab 10.

<sup>298</sup> T 351.

<sup>299</sup> T 352 - 353.

<sup>300</sup> T 362.

<sup>301</sup> T 347.

<sup>302</sup> T 348.

<sup>303</sup> T 348 – 349.

247. Flowing from that, Dr Evans and Professor Chung emphasised the need to empower family members, friends and supporters of victim-survivors, and indeed the wider community, to play their part in changing the response to family and domestic violence. This is particularly important from a prevention perspective. Dr Evans spoke of the need to send a strong message to the community that they have a role to play and the corollary to that is the need to find a way to help members of the community to develop the necessary skills to take on that role and play that part. This involves ensuring that all people have the necessary information around safety-planning, risk assessment and identifying red flags, not just the women experiencing the family and domestic violence. Dr Evans expressed the opinion we need to be much more proactive in terms of producing and disseminating that information. Current campaigns around coercive control and ‘16 days in WA’ are all part of this process, but Dr Evans expressed the view there is much more to do, and there will need to be significant resourcing to achieve that goal.<sup>304</sup>
248. A Lived Experience Advisory Group is a key part of the process, noting that while “it is true that family and domestic violence is everyone’s responsibility, the importance of specialisation must never be forgotten, and survivor voices must always be centred.”<sup>305</sup>
249. Other areas of focus include resourcing the specialist family and domestic violence services that support women and children who are experiencing safety concerns and ensuring those services are able to help these women and children access pathways into housing during the current housing crisis.<sup>306</sup>

## **RECOMMENDATIONS**

250. I have made some reference to the Family and Domestic Violence Taskforce and the Family and Domestic Violence (5 year) System Reform Plan that has come from that Taskforce. I am informed an Implementation Oversight Group has been established to drive, oversee and monitor implementation of the System Reform Plan, to strengthen responses to family and domestic violence in Western Australia. It is, however, still early days, with a phased approach to implementation planned from 2024 to 2029. The State Government has committed to twice yearly reporting on the implementation progress. I have been provided with a copy of the Inaugural progress report,<sup>307</sup> which was released in December 2024, but have not seen any further report.
251. The Australian Institute of Criminology (AIC) report that in 2023–24, 43 women were victims of intimate partner homicide, compared with 34 in 2022–23. While we have seen a general decline in homicides over the past three decades, the AIC reported a 28% increase in the rate of women killed by intimate partners in 2022–23, and a further 25% increase in the rate in 2023–24 (AIC, 2024).<sup>308</sup>

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<sup>304</sup> T 362 – 363.

<sup>305</sup> Exhibit 3, Tab 10, p. 6.

<sup>306</sup> T 365 - 366.

<sup>307</sup> Exhibit 3, Tab 10; <https://www.wa.gov.au/organisation/departments/family-and-domestic-violence-system-reform-plan-implementation>.

<sup>308</sup> *The Domestic, Family and Sexual Violence Commission Yearly Report to Parliament* (Aug 2024), Commissioners foreword, p. 5.



252. Research indicates that intimate partner homicides are predictable, and thereby, preventable, as very few happen without warning signs.<sup>309</sup> Professor Chung and Dr Evans referred to the “increasing recognition of the need to build whole-of-system interventions for perpetrators of domestic and family violence,”<sup>310</sup> noting that this includes mainstream services, and not just specialist services. It includes increasing community education and empowering families and friends. “There is a pressing need equip members of the broader community with the information needed to support an individual’s safety or to hold a perpetrator’s problematic behaviours to account.”<sup>311</sup> Put simply, it is a community wide problem, not just an individual family problem or a policing problem. We are all a part of the solution.
253. Professor Chung and Dr Evans observed that currently in Western Australia, approaches to Bystander intervention are ad hoc and piecemeal. They strongly support a state-wide, planned and coordinated approach that is sufficiently resourced and evaluated for impact. A recent rapid review recognised that governments should prioritise investment in more targeted education and skills-building for family, friends, neighbours and co-workers as bringing a broader circle of people into the situation creates more intervention pathways. Professor Chung and Dr Evans state that, “Embedding family and domestic violence within the community will unlock a significant area of prevention.”<sup>312</sup>
254. Dr Evans gave evidence that there needs to be resourcing directed to dissemination of this information into the community and making it easily accessible to people seeking it out.<sup>313</sup> A more proactive and well-resourced approach to bystander intervention is an essential strategy in preventing domestic violence homicide, but Professor Chung and Dr Evans observed that it is important to recognise that this will increase demand for services even further.
255. When appropriately resourced, specialist crisis services are also shown to support not only immediate safety, but to also lay the groundwork for safety to be sustained. Therefore, Professor Chung and Dr Evans have emphasised the current funding crisis for specialist crisis services, which are “unable to keep up with demand and escalating risk to such a point that their staff are overwhelmed,” meaning some victim-survivors may not receive a response. Dr Evans referred to the “moral injury”<sup>314</sup> that staff at these services experience in such difficult circumstances when they are unable to meet the demand for services. Dr Evans called for better resourcing of frontline specialist Family and Domestic Violence Services, who can provide immediate assistance to victim-survivors and their support network and also work with the various agencies involved to ensure ongoing safety measures are put in place. This requires immediate significant funding uplift in frontline areas along with analysis to determine the unmet demand in family and domestic violence crisis

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<sup>309</sup> Exhibit 3, Tab 10, p. 7 – Australian Domestic and Family Violence Death Review Network Australia’s National Research Organisation for Women’s Safety (AFVDR & ANROWS). (2022). Australian domestic and family violence death review network data report: Intimate partner violence homicides 2010-2018 (2<sup>nd</sup> ed.: Research report 03/2022). ANROWS.

<sup>310</sup> Exhibit 3, Tab 10, p. 8.

<sup>311</sup> Exhibit 3, Tab 10, p. 9.

<sup>312</sup> Exhibit 3, Tab 10, p. 9.

<sup>313</sup> T 362.

<sup>314</sup> T 366.

response, recovery and healing with a view to developing a pathway to fund ongoing demand on a sustainable basis.<sup>315</sup>

256. I am aware that the Commissioner of Police recently appeared before the Legislative Assembly Estimates Committee, along with the Hon. Minister for Police, and funding for ongoing Family and Domestic Violence Initiatives was discussed. It was noted that there is an increased number of reports and increased involvement of police in family and domestic-violence related issues, but it is still believed that only around 20% to 30% of victim-survivors are reporting their violent situation incidents to police, so police are working to encourage the remaining 70% to come forward and report that to police in different ways, so family violence can be better understood by the community. Resourcing of the police was discussed in this context, as well as the high number of triple zero calls police receive that are not policing-related matters, which has an impact on resourcing, but the WA Police Force is focussing on improving its capability through the SOCC to try to keep victims safe.<sup>316</sup>
257. It is clear that the WA Government is aware of the need to reform the approach of our agencies, including the WA Police Force, to family and domestic violence and is supporting change through the implementation of the Family and Domestic Violence System Reform Plan. It is still early days, but it is important to acknowledge that the WA Government has thus far indicated a willingness to follow through with program of reform. Responsibility for the implementation of the plan rests with the Department of Communities, not the WA Police Force, although the police are obviously involved. It is difficult, in the circumstances, for me to formulate any further specific recommendation in this regard.
258. However, I wish to add my support to the need for the implementation of the reform plan to be fully funded, and it must include ensuring that there is ongoing sustainable funding for the government and non-government specialist support services that not only provide crisis support to victim-survivors, but also ongoing support and advocacy. They are often left at the end of the line when funding is allocated, as they do not have the same presence as the larger government agencies, but their work on the ground, providing immediate assistance and an ongoing support network to victim-survivors is vital. I support Dr Evans' comments that there needs to be an immediate significant funding uplift in frontline areas, along with analysis to determine the unmet demand in family and domestic violence crisis response, recovery and healing with a view to developing a pathway to fund ongoing demand on a sustainable basis.<sup>317</sup>
259. I note that the System Reform Plan includes a focus on Safe accommodation initiatives, which is obviously one way that these services contribute, but their overall work in providing information, support and advocacy for victim-survivors and their families and supporters is central to ensuring that we, as a community, are best placed to ensure that women have the best options available to them to seek help and receive ongoing support, separate to moments of crisis.

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<sup>315</sup> T 364 – 365; Exhibit 3, Tab 10, p. 9.

<sup>316</sup> <https://www.parliament.wa.gov.au/hansard/daily/esta/2025-07-01>.

<sup>317</sup> T 364 – 365; Exhibit 3, Tab 10, p. 9.

260. Further, I note that two recent recommendations were made following the death of another woman in a family domestic violence context, and the WA Police Force have supported the recommendations. One has already been implemented, but the other requires funding to ensure that face-to-face training developed by the Family Violence Division can be provided to all frontline police officers. I add my support to this recommendation, and to the need for appropriate funding to be allocated by Treasury.<sup>318</sup>

### **CONCLUSION**

261. It is important to note, once more, that the person responsible for Lynn's death is Paul Cannon. His behaviour has been condemned by the courts and the community in the strongest terms and he is rightly serving a term of life imprisonment for his brutal crime. Nothing arising from this inquest can bring back Lynn to her family.
262. The WA Police Force expressed its condolences to Lynn as an agency and it has been acknowledged publicly by the Commissioner of the Police that the WA Police Force as a whole let Lynn down that night. The conduct of the individual officers involved were considered by the Internal Affairs Unit and only one was found to have acted outside the scope of policy and training, and that was dealt with by way of a managerial notice. The evidence before me at this inquest does not suggest that the IAU investigation was wrong and any individual's conduct caused or contributed directly to Lynn's death. I acknowledge that the staff were working in a high pressure, stressful environment with many competing demands. Due at least in part to these various pressures, I am satisfied that there was a general failure amongst most of the staff involved in this case to recognise the escalating risk that Paul Cannon presented to Lynn's safety, apart from the initial call taker.
263. I am satisfied there were key indicators that Lynn's safety was at imminent risk at the time leading up to her death, noting Paul Cannon's coercive and controlling behaviour was clearly escalating in the final days of Lynn's life. Lynn and her family were coming to understand that the safety strategies she had previously used to keep herself and her loved ones safe were no longer effective, but before she could formally report his behaviour, she was brutally murdered. Her family realised on the afternoon she went missing that something was seriously wrong, but those risks were not recognised and acted upon quickly enough by the police when the request for help was made by her sister Christine.
264. There seems little doubt, with the benefit of hindsight, the individual police officers involved would have reacted differently and made different decisions if they had fully understood the seriousness of the situation unfolding at Paul Cannon's house that afternoon/evening, and if they had the benefit, as we do in hindsight, of all of the relevant information in this case. While they still believe they made the right choices on the night, based upon the information before them, they appeared to agree that more information may have led to different choices. It would not have changed the fact that there were no cars immediately available to send to Paul Cannon's address, but it is possible there would have been a police car available to be sent to the house prior to 8.15 pm, which is the critical time for Lynn, if the priority had remained

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<sup>318</sup> Inquest into the death of NW, [2024] WACOR 51, Coroner Jenkin.

higher and there had been less focus on going to Lynn's home rather than Paul Cannon's home.

265. There was eventually a realisation by the Joondalup DOS who spoke to Lynn's niece that the situation was more serious than first believed, but by then it was too late. If police officers had arrived at Paul Cannon's Lansdale address prior to, or at the time of, Paul Cannon's landlord arriving home, it can only be speculated as to what might have happened next. It is important to recognise that domestic violence homicides can occur even when the police are involved, but in this case, we will never know as police arrived too late on the scene to have any chance to intervene. The ability of police officers to attend was clearly impacted by a lack of frontline resources. There was an unanticipated surge in demand for police resources, with close to three times the number of triple zero calls received that night than forecast. This meant that there were no resources available when the first call came in, even when it was still classed as a priority 2 job. I understand the WA Police Force are actively working on ways to ensure that they can focus on their frontline response to immediate safety risks, while re-directing other requests that are more properly directed to other agencies, to reduce the huge number of emergency calls police now receive each day and the burden this places on finite resources.
266. As I noted at the inquest, there appear to have been a number of missed opportunities to try to send police officers earlier to Paul Cannon's address in Landsdale, which could potentially have changed the trajectory in this case. However, I agree with the submissions made on behalf of WA Police that it could not be said that any one particular officer's conduct is responsible for the lack of an earlier police response, and the decisions made need to be considered within the context of the unanticipated demand that night. Further, we know that the injuries that Paul Cannon eventually inflicted on Lynn in front of a witness were unsurvivable, so it is possible that he may have acted in the same way if police had got there sooner. Nevertheless, from the perspective of Lynn's family, the small possibility that earlier police attendance might have changed the course of events means everything to them.
267. I wish to acknowledge the advocacy of Lynn's family. Despite their grief and anger, they have willingly worked with the police and this Court to understand what went wrong and strive for positive change. They have assisted Supt Hugo with their knowledge of Lynn's lived experience, along with their own perspectives, to try to improve the police response to family and domestic violence, particularly in the context of better training and improved communication between callers and police communications staff. It is clear that if they had fully understood the lack of ability for an immediate police response, they would have taken action themselves, but they were not given all of the information on the night.
268. I also extend my particular thanks to Supt Hugo and Professor Chung and Dr Evans for assisting me in gaining a better understanding of the complexities of family and domestic violence and what is being done in Western Australia to try to implement urgently needed system reform. Their assistance has been invaluable.
269. In concluding my findings in this tragic case, I note the recent reported comments upon retirement of the Hon John McKechnie AO KC, who in his many years of

public service has been exposed to many of the worst incidents of family and domestic violence in this state:<sup>319</sup>

*Laws won't help it. More police won't help. We need a fundamental change in the community attitude to domestic violence.*

270. Every person in the community has a role to play in putting an end to family and domestic violence. We must each be able to say with confidence:<sup>320</sup>

- I do not tolerate violence or violence supportive attitudes.
- I see stopping family and domestic violence as mine and everyone's responsibility.
- I know how to promote respect and challenge violence supportive attitudes.

271. Only when we as a community can say this with confidence will we have done the work we must do, to address the damage that family and domestic violence is doing to our community. We must all be inspired to work in Lynn's memory to do more.



S H Linton  
Acting State Coroner  
23 July 2025

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<sup>319</sup> <https://www.abc.net.au/news/2025-07/05/ccc-john-mckechne-reflects-on-40-years-in-public-service/105494948>.

<sup>320</sup> Strengthening Responses to Family and Domestic Violence – System Reform Plan 2024 to 2029, p. 7.