



Western

Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 27/17

*I, Barry Paul King, Coroner, having investigated the death of **Mary Josephine Van Der Walt** with an inquest held at the **Perth Coroner's Court** on **4 July 2017**, find that the identity of the deceased person was **Mary Josephine Van Der Walt** and that death occurred on **23 April 2014** at **Royal Perth Hospital** from **ligature compression of the neck** in the following circumstances:*

Counsel Appearing:

Ms F Allen assisting the Coroner

Mr B G Humphris appearing on behalf of the Western Australia Police

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INTRODUCTION

1. Mary Van der Walt (the deceased) died on 23 April 2014 at Royal Perth Hospital (RPH).
2. The deceased suffered from depression and anxiety. She had also been diagnosed with borderline personality disorder.
3. When last seen at the Inner City Community Mental Health Service (the ICCMHS) on 16 April 2014, the deceased appeared to be in a positive frame of mind,¹ but early in the morning on 21 April 2014 she hanged herself after calling '000' to say that she had found a body at her home.
4. A senior constable (the senior constable) and a constable (the constable) attended her home about 20 minutes later and found her hanging in a courtyard. The senior constable cut her down, possibly causing her head to strike the ground. The constable called for an ambulance.
5. The senior constable determined that the deceased had no pulse, and he used a torch to determine that the deceased's pupils did not react to light. He was satisfied that the deceased had died, so neither police officer commenced cardiopulmonary resuscitation (CPR).
6. Ambulance paramedics attended about six minutes after the constable called for an ambulance. They administered CPR and adrenaline and, after about 15 minutes, the deceased's spontaneous circulation returned.
7. The ambulance officers took the deceased to Royal Perth Hospital, where she was put on life support in the intensive care unit. It soon became apparent that she had suffered irreversible brain damage.

¹ Exhibit 1, Tab 2

8. Life support was withdrawn on 23 April 2014 and brain stem testing showed brain death shortly thereafter. The deceased was kept on a ventilator to allow for organ donation on 26 April 2014.²
9. On 4 July 2017 at the Perth Coroner's Court, I held an inquest into the deceased's death.
10. The focus of the inquest was on the training provided to police officers to equip them to respond to situations, such as that with the deceased, where a person is unresponsive and not breathing.
11. The documentary evidence adduced at the inquest comprised:
 - a. a brief of evidence,³ including a report prepared by Senior Constable Claire Lyons of the Coronial Investigation Unit of the Western Australia Police (WAPOL);⁴
 - b. copies of the Police Operations Centre call-taker instructions, namely:
 - i. 'Sudden Deaths' advice;⁵
 - ii. 'Collapsed Persons Guide';⁶ and
 - iii. 'Sudden Death Guide';⁷and,
 - c. an email dated 3 July 2017 from Professor Bryant Stokes, clinical professor of neurology.⁸

² Exhibit 1, Tab 11

³ Exhibit 1

⁴ Exhibit 1, Tab 2

⁵ Exhibit 2(a)

⁶ Exhibit 2(b)

⁷ Exhibit 2(c)

⁸ Exhibit 3, placed at Exhibit 1, Tab 10(c)

12. Oral evidence was provided by:
 - a. the constable;
 - b. Deon Brink, General Manager, Clinical Services, St John Ambulance WA (SJA);⁹ and
 - c. Superintendent Anthony Flack, Head of Faculty, Operational Skills and Training, Western Australia Police Academy;¹⁰
13. I have found that the cause of death was ligature compression of the neck and that the deceased died by way of suicide.

THE DECEASED

14. The deceased lived with a flat-mate in a unit in Maylands.¹¹
15. The deceased was born in South Africa on 5 December 1985, making her 28 years old at the time of her death. She experienced a difficult childhood due to her relationship with her step-father, who did not accept her and abused her verbally. In 2013 she disclosed that she had been sexually abused by a cousin in April 1994.¹²
16. The deceased attended primary school and high school in South Africa before moving to London to complete her final year. She moved to Western Australia in July 2005 and completed a Certificate 2 in art and design.¹³
17. The deceased worked for a company known as Boardies and then went on to work for an internet service provider. She later worked for a superannuation fund on a six-month contract, but when the contract ended,

⁹ ts 30 – 34

¹⁰ ts 24 – 37 per Flack, A

¹¹ Exhibit 1, Tab 2

¹² Exhibit 1, Tab 2

¹³ Exhibit 1, Tab 2

she struggled to find work. She obtained casual work at a retail shop over the Christmas holidays in 2013, and she continued to seek work when that job ended.¹⁴

18. The deceased had been in a four-year relationship with a man, who at one stage she was engaged to marry, but the relationship ended when he began taking illicit drugs. She was then in a close, but on/off relationship with another man, and it seems that they were still at least friends at the time of her death.¹⁵
19. In 2009 the deceased was diagnosed with depression. In 2012 she was admitted to RPH for psychiatric assessment following a suicide attempt, apparently by overdose.¹⁶ She was diagnosed with suicidal ideation and heart palpitations secondary to anxiety. From October 2012 she saw a general practitioner in Subiaco who prescribed the antidepressant desvenlafaxine. In mid-2013 she began attending the ICCMHS in Perth, where she received ongoing treatment from a continuing care team, including psychological therapy from a clinical psychologist (the psychologist).¹⁷
20. The deceased saw the psychologist 21 times between 23 October 2013 and 16 April 2014. According to the psychologist, the deceased showed positive and negative mood changes with overall slow and gradual improvement, with the exception of marked mood deterioration and near relapse on 2 April 2014 in the context of reactivity to psycho-social stresses. In the last session with the psychologist on 16 April 2014, the deceased described herself as 'doing contentedly' with a desire to change the way she was for the better and to see the best in herself so that it could be projected at interviews.¹⁸

¹⁴ Exhibit 1, Tab 2

¹⁵ Exhibit 1, Tab 2

¹⁶ Exhibit 1, Tab 11

¹⁷ Exhibit 1, Tab 2

¹⁸ Exhibit 1, Tab 2

21 APRIL 2014

21. At 1.19 am on 21 April 2014 the deceased called '000' and informed the operator that she had found a body at her address in Maylands. The operator transferred her to Police Emergency, but during the transfer the deceased disconnected. The police call-taker got the deceased's address and attempted to call her, but she did not answer.¹⁹
22. The police call-taker created a computer aided dispatch (CAD) request for officers to attend the deceased's unit. The CAD request stated: X TELSTRA OPERATOR – FEMALE REQ POLICE TO MAYLANDS, MENTIONED SOMETHING ABOUT A BODY AND THEN HUNG UP WHILE BEING TRANSFERRED TO POLICE. MOBILE RINGS OUT ON CALLBACK.²⁰ The numerical code on the CAD request was '338', signifying a sudden death.²¹
23. The senior constable and the constable responded to the CAD request and at 1.41 am arrived at the deceased's unit in their police vehicle. The unit was dark, and their loud knocks on the front door brought no response. They went through an open carport and a side gate to enter the back yard, using their torches to see in the dark. As they went around the corner they found the deceased hanging by the neck with an electrical extension cord tied to beams on a pergola. Beside the deceased was a chair lying on its side.²²
24. The senior constable checked the deceased's wrist for a pulse and noticed that she was warm to touch, but he detected no pulse. He asked the constable to contact Police Communications to arrange for SJA to attend, and he used a knife on his multi-tool to cut the electrical cord to lower the deceased. He did not wait for the constable to assist him as he considered that time was of the essence.²³

¹⁹ Exhibit 1, Tab 2A

²⁰ Exhibit 1, Tab 2A

²¹ ts 27 per Flack, A

²² Exhibit 1, Tabs 3A and 4

²³ Exhibit 1, Tabs 3A and 3B

25. Though the senior constable was attempting to lift the deceased to take the strain off the cord as he cut it, the cord cut more quickly than he expected and the deceased dropped suddenly. He struggled with her weight and lowered her as gently as he could, but it was possible that her head hit the brick paving as she went down.²⁴
26. The senior constable then loosened the electrical cord and felt again for a pulse on the deceased's neck. He noted that her lips were blue and that her pupils did not react to light. He concluded that the deceased had died and, when the constable concurred, decided not to administer CPR.²⁵ It was their understanding at the time that, despite not being qualified to do so, they were to determine whether the deceased was still alive before commencing CPR.²⁶
27. At 1.49 am SJA paramedics arrived at the deceased's unit. At 1.51 am they confirmed that the deceased was pulseless and that her heart rhythm was asystole. They commenced CPR with adrenaline therapy. At 1.58 am the paramedics detected pulseless electrical activity, and at 2.06 am they achieved a return of the deceased's spontaneous circulation. They administered adrenaline again at 2.13 am and 2.23 am, both times improving the deceased's blood pressure dramatically.²⁷
28. The SJA paramedics left the deceased's unit at 2.21 am to convey her to RPH emergency department. They arrived at 2.28 am. On the way, the deceased's peripheral pulse returned.²⁸

ROYAL PERTH HOSPITAL

29. Upon arrival at the emergency department at RPH, the deceased's pupils were fixed and dilated and a CT scan

²⁴ Exhibit 1, Tab 3B

²⁵ Exhibit 1, Tabs 3B and 4

²⁶ ts 10

²⁷ Exhibit 1, Tab 5

²⁸ Exhibit 1, Tab 5

showed loss of grey matter and white matter differentiation, consistent with cerebral oedema and type one respiratory failure. Repeat chest X-rays showed neurogenic pulmonary oedema. The deceased was admitted to the intensive care unit with a diagnosis of hypoxic brain injury and a poor prognosis.²⁹

30. On the afternoon of 21 April 2014 the deceased showed some signs of improvement, but on 22 April 2014 her condition deteriorated rapidly, with an increased temperature and intermittent apnoea. In the early afternoon of 23 April 2014 an EEG showed marked diffuse unreactive suppressed background, consistent with severe encephalopathy with poor prognosis.³⁰
31. On the afternoon of 23 April 2014, brainstem testing results were consistent with brainstem death. Over the next two days medical staff and the deceased's family discussed the deceased's donation of organs, and on 26 April 2014 the deceased donated her heart, lungs and abdominal organs.³¹

CAUSE OF DEATH AND HOW DEATH OCCURRED

32. On 28 April 2014 forensic pathologist Dr A V Spark conducted an external post mortem examination of the deceased's body and, in addition to evidence of medical intervention, found marking around the neck consistent with a ligature mark, in keeping with the electrical cord supplied. There was damage to the cartilage of the neck, with an incision in the membrane between the cartilage plates of the voice box.³²
33. Toxicological analysis showed desmethylvenlafaxine and quinine.³³

²⁹ Exhibit 1, Tab 11

³⁰ Exhibit 1, Tab 11

³¹ Exhibit 1, Tab 11

³² Exhibit 1, Tab 7B

³³ Exhibit 1, Tab 8

34. Neuropathological examination revealed cerebral swelling with features consistent with recent hypoxic ischaemic encephalopathy and global perfusion failure (ventilator brain). There were parasagittal haemorrhages and haemorrhages within the corpus callosum (the haemorrhages).³⁴
35. The haemorrhages indicated that the deceased had traumatic brain injury from an acceleration-deceleration type injury, possibly consistent with an unprotected fall as may be seen from cutting a person down from a ligature.³⁵
36. Dr Spark formed the opinion that the cause of death was consistent with ligature compression of the neck.³⁶
37. Professor Stokes was asked to review the pathology evidence. He advised that the haemorrhages were most likely due to an acceleration/deceleration process occurring at the time the deceased was removed from the ligature, but they were still compatible with life. He said that the brain swelling was almost certainly due to hypoxia associated with the suicide attempt.³⁷
38. Professor Stokes later reviewed the neuropathology report and concluded that the brain haemorrhages were most likely due to the venous congestion and associated hypoxia from the strangulation rather than any trauma. He no longer believed there to be any evidence of direct brain injury.³⁸
39. On the basis of the information available, I am satisfied that that the deceased hanged herself by the neck with a ligature and compressed her neck, which led to the complication of hypoxia and caused her death.
40. I am satisfied that there was no other event that contributed to her death.

³⁴ Exhibit 1, Tab 8

³⁵ Exhibit 1, Tab 8

³⁶ Exhibit 1, Tabs 7A and 9

³⁷ Exhibit 10.A

³⁸ Exhibit 1, Tab 10C

41. I find that death occurred by way of suicide.

RESUSCITATION GUIDELINES

42. To investigate the appropriateness of the police officers' response to finding the deceased, Mr Brink was called to compare what would normally be done by SJA paramedics in similar circumstances. He explained that SJA follows internationally recognised standards applicable to resuscitation and to the decision whether or not to perform compressions on their own or compressions with breathing. Those standards are found, with slight variations, in guidelines (the guidelines) jointly published by the Australian Resuscitation Council and the New Zealand Resuscitation Council (ANZCOR).³⁹
43. The guidelines apply to bystanders, first aid providers, first responders and health professionals.⁴⁰ The guidelines are accepted as best practice across the world, according to Mr Brink.⁴¹
44. With respect to rescuers deciding whether to provide chest compressions, the guidelines provide clear and simple recommendations, as follows.⁴²
- a. All rescuers should perform chest compressions for all persons who are unresponsive and not breathing normally.
 - b. Interruptions to chest compressions should be minimised.
 - c. Those who are trained and willing to give rescue breaths do so for all persons who are unresponsive and not breathing normally.

³⁹ ts 12 per Brink, D

⁴⁰ Exhibit 1, Tabs 12B and D

⁴¹ ts 19 per Brink, D

⁴² Exhibit 1, Tab 12B

45. In relation to CPR, which is defined to mean the technique of chest compressions combined with rescue breathing, ANZCOR recommends as follows.⁴³
- a. Rescuers must start CPR if the person is unresponsive and not breathing normally.
 - b. Bystander CPR should be actively encouraged.
 - c. Compression to ventilation ratio be 30:2 for all ages.
 - d. All rescuers perform chest compressions for all who are not breathing normally. Rescuers who are trained and willing to give rescue breaths are encouraged to do so.
 - e. Chest compressions should be provided at a rate of approximately 100-120 /min.
 - f. Rescuers should aim to minimise interruptions to chest compressions.
46. The guideline for CPR also provides a mnemonic device, DRS ABCD, for remembering the recommended steps of resuscitation:

DANGERS - Check for hazards, risks and safety
RESPONSIVENESS – Check for response
SEND – Send for help
AIRWAY – Open the airway
BREATHING – Check breathing
CPR - Start CPR
DEFIBRILLATION – attach an automated external defibrillator (AED) as soon as practicable and follow the prompts.

47. The guidelines also state that:

⁴³ Exhibit 1, Tab 12B

- a. palpation of a pulse is unreliable and should not be performed to confirm the need for resuscitation;⁴⁴ and
 - b. the risk of disease transmission during CPR performance is very low.⁴⁵
48. ANZCOR also recommends that AEDs be used to increase survival rates of those who have cardiac arrest. The use of AEDs is safe and does not require formal training, though even brief training improves performance.⁴⁶
49. Mr Brink said that the ambulance service in the city of Seattle in the United States has the highest cardiac arrest survival rate in the world of about 62%, compared with about 35% for SJA. He said that in Seattle there is 'co-response' and there are 'AEDs everywhere', even on public service vehicles, including police vehicles.⁴⁷
50. Mr Brink said that SJA paramedics also have an internal guideline for determining that life is extinct, in which case resuscitation is not commenced.⁴⁸ That guideline provides that resuscitation must be commenced unless, relevant to the deceased, the cardiac arrest was not witnessed or no by-stander CPR was performed and the downtime was estimate to be greater than 15 minutes and the following clinical features are present: asystole for at least 30 seconds, fixed and dilated pupils, absent breath and heart sounds on auscultation or no palpable carotid pulses, and absent corneal reflexes.
51. Paramedics use EEG monitors to check patients' heart rhythms to determine if they are asystole.⁴⁹

⁴⁴ Exhibit 1, Tab 12B

⁴⁵ Exhibit 1, Tab 12D

⁴⁶ Exhibit 1, Tab 12C

⁴⁷ ts 20 per Brink, D

⁴⁸ ts 12-13 per Brink, D; Exhibit 1, Tab 12

⁴⁹ ts 14 per Brink, D

WESTERN AUSTRALIA POLICE RESUSCITATION POLICY AND TRAINING

52. During the early stages of investigating the circumstances of the deceased's death, WAPOL investigators determined that operational police officers received training on the mechanics of providing CPR and on the importance of risk identification in making a decision to provide CPR.
53. An investigator told the State Coroner's Office that the decision to commence CPR was situation-based, bearing in mind the risk of the situation. The investigator stated that, 'The decision to commence resuscitation is a difficult one with the risk of cross contamination high and the availability and effectiveness of transportable control measures (face shields, masks) being limited.'⁵⁰
54. The investigator went on to say, 'There is no corporate policy pertaining to this but this danger/risk assessment ethos acts as the basis of all forms of first aid and resuscitation training.'⁵¹
55. Superintendent Flack, who has been the principal of the WAPOL police academy for 18 months and was previously at the academy in a different role,⁵² provided a statement in which he detailed more current information about the training provided to police recruits and to serving police officers. He said that recruits are required to have a senior first aid certificate at the time they commence training. They are then provided with a one day refresher course delivered by Royal Life Saving. Prior to 2016, that course was delivered by SJA. Operational officers undergo an annual first aid refresher course, which appears to be primarily focused on performing CPR and assessing the need to perform it.⁵³

⁵⁰ Exhibit 1, Tab 6A

⁵¹ Exhibit 1, Tab 6A

⁵² ts 24 per Flack, A

⁵³ Exhibit 1, Tab 13C

56. Superintendent Flack said that police officers were expected to apply the DRS ABCD model to determine if and when CPR is required. The primary factors are whether the patient is unresponsive and not breathing, in accordance with the ANZCOR guidelines. There is no reference in the training to circumstances where CPR should not be attempted, nor is there currently any reference to checking the patient's pulse or determining whether the patient is life extinct.⁵⁴
57. However, Superintendent Flack said in oral evidence that, prior to 2014, police officers were trained to check for a pulse. That training was removed because of its unreliability to determine whether to commence CPR. He pointed out that, if a person has gone into cardiac arrest, a pulse would not be expected.⁵⁵
58. When asked if WAPOL should have a policy in relation to the administration of CPR, Superintendent Flack said that it would be virtually impossible to mandate that police officers must do CPR in every instance because there will be occasions when commencing CPR would not be appropriate; for example, where officer safety is an issue. In his view, a better service would be obtained by way of training rather than by attempting to enforce compliance with a policy.⁵⁶

DISCUSSION ON POLICE OFFICERS' FAILURE TO COMMENCE CPR

59. Superintendent Flack felt that, given that the deceased was unresponsive, not breathing and still warm, the attending police officers should have applied CPR.⁵⁷
60. While I accept his view in hindsight, the evidence makes clear that the police officers attending the deceased's home had been informed in a CAD request that they were responding to a report of a sudden death. It is

⁵⁴ Exhibit 1, Tab 13C

⁵⁵ ts 37 per Flack, A

⁵⁶ ts 33 per Flack, A

⁵⁷ ts 36 per Flack, A

likely that, when they found the deceased, they assumed that she had likely been dead for some time.

61. Nonetheless, the senior constable applied what appears to have been his training up to then, and checked the deceased's pulse at her wrist. Even though he did not feel a pulse, he acted quickly to cut her down and to check her carotid pulse, determining more conclusively that she had no pulse. He then used his torch to check the deceased's pupil's reaction to light and found that they did not react, consistent with death.
62. Given those circumstances and the police officers understanding at the time, based on their training to determine whether the deceased was alive before commencing CPR, the police officers' decision not to commence CPR is understandable.

WOULD THE DECEASED HAVE SURVIVED IF THE POLICE OFFICERS HAD ADMINISTERED CPR?

63. About six minutes elapsed from the time the police officers attended the deceased's home until the ambulance paramedics arrived and started CPR. Mr Brink said that it is generally accepted that for every minute that a person who has experienced a cardiac arrest does not receive CPR, the person loses 10% of the chance of survival. Within about 15 minutes of CPR and adrenaline therapy, the paramedics were able to restore the deceased's spontaneous circulation.
64. Mr Brink made clear that it was not possible to determine whether the deceased would have survived had the officers commenced CPR at the outset. That the paramedics were able to restore circulation was a function of the effectiveness of adrenaline therapy. The adrenaline did not itself improve the deceased's survival since it does not reverse any damage to the brain that had occurred before CPR was commenced.

65. Mr Brink said that the deceased's chance of survival depended on when her circulation stopped from the hanging, and the time elapsed between her phone call to '000' and the beginning of hypoxia from asphyxiation was not known. Mr Brink said that due to the dreadful nature of hanging, asphyxiation occurs rapidly.
66. In those circumstances, Mr Brink was unwilling to speculate on what real chance the deceased had of surviving if CPR had commenced six minutes earlier.
67. In these circumstances I am unable to determine whether the deceased would have survived had the police officers administered CPR.

CHANGES TO POLICE TRAINING

68. Superintendent Flack noted that, following the deceased's death, the contents of the refresher course with Royal Life Saving have been changed to include advice that the DRS ABCD model should be applied to all unconscious casualties irrespective of whether they experienced asphyxia from hanging or were unconscious from some other event.⁵⁸
69. It is not clear whether that change to the course had been implemented by the date of the hearing of the inquest, or whether all operational police officers have since undergone the changed course. I note in oral evidence that the constable who attended the deceased's home said that she still receives the same training that she received originally.⁵⁹
70. Superintendent Flack also said that he considered that the deceased's case would be a good case study to use in training to reinforce the dangers of relying on assumptions, but this has yet to take place.⁶⁰

⁵⁸ Exhibit 1, Tab 13C

⁵⁹ ts 10 per Tenardi, D

⁶⁰ ts 32-33 per Flack, A

SHOULD POLICE VEHICLES HAVE AEDS?

71. The ANZCOR guideline for CPR includes the model 'DRS ABCD' of which the D instructs the rescuer to use an AED as soon as practicable. Possibly as a result of that model, police officers are trained in the use of AEDs even though those devices are not carried in police vehicles.
72. Superintendent Flack said that, in his personal view, any equipment in a vehicle would be of use, and he noted that there would be no additional training impost for WA Police. However, he cautioned that, if AEDs were carried in police vehicles, people might call police instead of ambulances as the first port of call, which might pose a danger.⁶¹
73. In my view, the provision of AEDs to police vehicles would clearly be a positive step towards more effective first aid response by police officers in situations where members of the public require CPR.
74. Police officers are trained in administering CPR and, as first responders, are expected to apply their knowledge and their skills in the best way that they can in the first instance and to then continue with that aid until professional assistance arrives.⁶² AEDs would assist them to do so in accordance with world best practice. Mr Brink's information about the substantially higher incident of survival of (what I understand to be) out-of-hospital cardiac arrest in Seattle compared to Western Australia is startling.
75. As the lack of an AED did not appear to have been connected with the circumstances of the deceased's death, I make no formal recommendation under section 25(2) of the *Coroners Act 1996* that police vehicles be equipped with AEDs. However, I encourage the Western Australia Police and the Government to cause that to happen at the earliest opportunity.

⁶¹ ts 29 per Flack, A

⁶² ts 26 per Flack, A

CONCLUSION

76. The deceased died after hanging herself with a intention to end her life in the context of long-term depression.
77. While the police officers who attended her home in response to her '000' call could have administered CPR to her, they acted in accordance with their training in determining not to do so. They bear no responsibility for her death.
78. The deceased's death was the tragic result of her mental illness in circumstances distressingly frequent in our community. To the extent that it is possible, her family may take some solace in the fact that her death has led to beneficial changes to the operational practices of police officers.

B P King
Coroner
15 September 2017