JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	Michael Andrew Gliddon Jenkin, Coroner
HEARD	**:**	29 - 30 NOVEMBER 2022
DELIVERED	**:**	23 DECEMBER 2022
FILE NO/S	**:**	CORC 595 of 2021
DECEASED	**:**	MS L

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr W. Stops appeared to assist the coroner.

Mr G. Stockton and Mr Z. Clifford (State Solicitor's Office) appeared for the Western Australian Police Force.

SUPPRESSION ORDER

On the basis that it would be contrary to the public interest, I make the following order pursuant to section 49(1)(b) of the *Coroners Act 1996* (WA): There be no reporting or publication of the deceased's name. The deceased is to be referred to as "Ms L".

Order made by: MAG Jenkin, Coroner (23.12.22)

Coroners Act 1996
(Section 26(1))

AMENDED RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Ms L*** *with an inquest held at Perth Coroners Court, Central Law Courts, Court 85, 501 Hay Street, Perth, on 29 - 30 November 2022, find that the identity of the deceased person was* ***Ms L*** *and that death occurred on 4 March 2021 at 237 Adelaide Terrace, Perth, from multiple injuries in the following circumstances:*

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INTRODUCTION

1. Ms L was a 27-year old German national living in Perth, who died on 4 March 2021, from multiple injuries. Ms L had been reported missing by her partner at about 9.45 pm on 3 March 2021. Enquiries by the Western Australian Police Force (the Police) led to Ms L being located at an apartment building in Perth (the Building) at about 5.30 pm on 4 March 2021.[1,2,3,4]

2. Police officers spoke with Ms L for about 20 minutes on Level 29 of the Building. After she had taken a call from her mother in Germany, Ms L excused herself, saying she wanted to use the toilet. Instead, Ms L accessed the roof of the Building, where she was found a short time later. Despite the efforts of police, Ms L stepped off the edge of the Building and plummeted to her death.

3. Pursuant to the *Coroners Act 1996* (WA) (the Act), Ms L's death was a "*reportable death*", and members of her family attended the inquest that I conducted into her death on 29 - 30 November 2022. That inquest focused on the circumstances of Ms L's death, and whether her death had been caused, or contributed to, by any member of the Police.[5]

4. The Brief of Evidence tendered at the inquest consisted of one volume, and the following witnesses gave evidence:[6]

a. Acting Sergeant Owen Gregoor (Attending police officer);
b. Constable Aaron Mitchell-Gow (Attending police officer);
c. Probationary Constable Ryan Ishmael (Attending police officer);
d. Constable Benjamin Hastie (Attending police officer);
e. Constable Omar Faydi (Attending police officer);
f. Acting Detective Sergeant Verinia Welch (Internal Affairs Unit);
g. Inspector Louise Ball (Custodial & Mental Health Division); and
h. Sergeant Paul Ritchie (Operational Leadership Development Unit).

[1] Exhibit 1, Vol. 1, Tab 1, P98 - Mortuary Admission Form (04.03.21)
[2] Exhibit 1, Vol. 1, Tab 2, P100 - Report of Death (07.07.21)
[3] Exhibit 1, Vol. 1, Tab 3, PathWest Coronial Identification Report (19.03.21)
[4] Exhibit 1, Vol. 1, Tab 5, Post Mortem Report (10.03.21)
[5] Sections 3 & 22(1)(b), *Coroners Act 1996* (WA)
[6] I have used the ranks of the attending officers as at the time of Ms L's death.

MS L

Background[7,8]

5. Ms L was born in Munich in Germany on 29 July 1993. She had two older sisters, and after finishing school she completed a Bachelor of Tourism Management in 2019. According to her mother, Ms L enjoyed "*travel, adventure, friends, good food and sunsets*".

6. Ms L came to Western Australia in October 2019. Whilst in Perth, she met Mr Cameron Scott, and they began a relationship in November 2019. They separated when Ms L left to travel around Western Australia in August 2020, but when she returned to Perth in December 2020, Ms L and Mr Scott "*started dating again*" and they began living together at a backpacker hostel just before Christmas 2020. Ms L worked in a bar in Perth until 24 February 2021, and Ms L told Mr Scott that she wanted to do some backpacking in the "*Eastern States*".[9]

Medical and mental health history[10,11,12,13,14]

7. Ms L was reportedly diagnosed with depression in 2016 while she was in Germany, and was taking prescribed antidepressants at the time of her death. Other than a presentation to Albany Hospital after fracturing her left foot whilst hiking in November 2019, Ms L does not appear to have been admitted to hospital whilst in Australia.[15]

8. On 9 December 2020, Ms L tested positive for chlamydia, a common sexually transmitted infection, which was successfully treated with antibiotics. On 16 December 2020, Ms L was advised that a strain of the Human Papillomavirus (HPV16) had been detected during her routine cervical screen. HPV16 is a common sexually transmitted infection that can increase a woman's risk of developing cervical cancer.

[7] Exhibit 1, Vol. 1, Tab 20, Background Information obtained from CA (10.03.21)
[8] Exhibit 1, Vol. 1, Tab 8, Memo - FC Const. C Johnson (06.07.21), pp3-4
[9] Exhibit 1, Vol. 1, Tab 17, Statement - Mr C Scott, (04.03.21), paras 4-7
[10] Exhibit 1, Vol. 1, Tab 24, Central City Medical Centre records (09.12.20, 16.12.20, 27.12.20 & 22.01.21)
[11] Exhibit 1, Vol. 1, Tab 24, Report - Dr E Shellabear (14.04.21)
[12] Exhibit 1, Vol. 1, Tab 8, Memo - FC Const. C Johnson (06.07.21), pp3-4
[13] Exhibit 1, Vol. 1, Tab 6, Report - Homicide Squad (06.07.21), pp4-5
[14] Exhibit 1, Vol. 1, Tab 17, Statement - Mr C Scott, (04.03.21), paras 8-33
[15] Exhibit 1, Vol. 1, Tab 24, Albany Hospital Discharge Summary (26.11.19)

9. Ms L was referred to a gynaecologist, (Dr Erica Shellabear), for a colposcopy by Dr Georgia Frew, a GP Ms L had consulted at the Central City Medical Centre. A colposcopy is a procedure that examines the vagina, cervix, and vulva to detect precancerous lesions, and was indicated in Ms L's case because liquid based cytology had reported changes consistent with a possible "*low-grade squamous intraepithelial lesion*". In her referral letter to Dr Shellabear, Dr Frew noted that Ms L was "*quite nervous and shocked with her results*".[16]

10. On 27 December 2020, Ms L saw another GP at the Central City Medical Centre (Dr Mathew John), who noted Ms L was "*in a bad space mentally*" and had been "*in a similar situation some 5 years ago*". Ms L disclosed she was not eating or sleeping, had experienced panic attacks and was "*not thinking well*". Dr John prescribed fluoxetine (an antidepressant), temazepam (a sleeping tablet) and melatonin.[17]

11. In his statement to the Court, Mr Scott outlines Ms L's deteriorating mental health during December 2020. He says that when she had been diagnosed with Chlamydia and HPV16, Ms L told him this was "*the lowest day*" she had ever experienced. Mr Scott described Ms L as being "*emotionally broken*" when he spoke to her on the phone. When they later met, Ms L was crying, and she told Mr Scott she felt stupid for not having had the HPV vaccine when she was younger.[18]

12. Mr Scott said Ms L told him she had taken antidepressant medication for three months after being diagnosed with depression in Germany, five years previously. He said he was aware she had resumed taking antidepressants around 27 December 2020, because she "*was struggling with her depression again*" and was also taking sleeping tablets. Mr Scott was also aware that Ms L was anxious about her HPV diagnosis, and was stressing "*about every little decision*". Mr Scott said that about two weeks before her death, Ms L told him she had doubled the dose of her antidepressants.[19]

[16] Exhibit 1, Vol. 1, Tab 24, Letter - Dr G Frew (16.12.20)
[17] Exhibit 1, Vol. 1, Tab 24, Central City Medical Centre records (27.12.20)
[18] Exhibit 1, Vol. 1, Tab 17, Statement - Mr C Scott, (04.03.21), paras 8-13
[19] Exhibit 1, Vol. 1, Tab 17, Statement - Mr C Scott, (04.03.21), paras 14-19

13. Ms L saw Dr John in the presence of Mr Scott on 22 January 2021. She said she had passed out and "*knocked her head*" and Dr John noted bruising on the left side of her face and head. Ms L said she did "*not feel the fluoxetine was helping*" and complained of pain in her abdomen.

14. Mr Scott said he felt Ms L was hiding how she was really feeling and "*putting on a face to everyone that she was happy, excited about what she was doing next*". Mr Scott also said that from about December 2020, Ms L had stopped eating, washing, and sleeping and was "*on her phone googling how to recover from depression and would just stare at the wall*". Mr Scott said that although he and Ms L had discussed her depression and she told him she did not know where to go to get help, she had never mentioned feeling suicidal or wanting to self-harm.[20]

15. Ms L saw Dr Shellabear for the colposcopy on 28 January 2021. Dr Shellabear noted a history of two episodes of post-coital bleeding in December 2020, and a small amount of breakthrough bleeding since November 2020 whilst Ms L had been taking an oral contraceptive. Dr Shellabear said the colposcopy procedure was uncomplicated, and that two small biopsies were taken for histopathological analysis.

16. Dr Shellabear spoke with Ms L on 3 February 2021, and told her that the biopsy had detected a high-grade squamous intraepithelial lesion. Dr Shellabear recommended that the lesion be removed by a procedure known as a large loop excision of the transformation zone (LLETZ), and sent Ms L a copy of the biopsy results.

17. On 11 February 2021, Ms L attended Dr Shellabear's rooms for the LLETZ, accompanied by Mr Scott. The procedure was "*straightforward*", but Dr Shellabear noted that "[Ms L] *seemed troubled by the diagnosis*" and she reassured her that the LLETZ procedure was "*curative in 95% of cases*". On 25 February 2021, Dr Shellabear spoke with Ms L and "*reassured her that the abnormal skin appeared to have been completely removed and that there was no evidence of cancer*".[21]

[20] Exhibit 1, Vol. 1, Tab 17, Statement - Mr C Scott, (04.03.21), paras 29-38
[21] Exhibit 1, Vol. 1, Tab 24, Report - Dr E Shellabear (14.04.21), p2

EVENTS LEADING UP TO MS L'S DEATH

Ms L books into the Apartment - 2 March 2021[22,23,24,25]

18. Mr Scott says that he spoke with Ms L about her depression on 2 March 2021. He told her she needed to get help and suggested she fly back to Germany for this purpose. Mr Scott says Ms L didn't seem to understand and felt he was "*pushing her away*". He says Ms L didn't want to go home to get help, but didn't know where else to go.

19. In any case, on 2 March 2021, Ms L booked a short-stay apartment on Level 17 of the Building (the Apartment) for one night. According to Mr Scott, Ms L had discussed "*travelling east for backpacking*" and had booked the Apartment as a "*test*" to see how she would manage on her own. Mr Scott says that Ms L was unable to "*do anything on her own or anything for herself*" and after making the booking she became "*unsure*". Mr Scott says Ms L decided to proceed with the booking because she was unable to cancel it.

20. Mr Scott dropped Ms L at the Building at about 12.30 am on 3 March 20201. He waited for her to go inside before driving off and, again, says he got the impression that Ms L felt he was "*pushing her away*". Mr Scott sent Ms L a text message saying his mobile was on, and she could call if she needed him. Ms L sent two messages to Mr Scott at around 1.00 am. The text messages were as follows:

> 1.00 am: I'm so sad this day went completely out of control, I don't want to lose you and it's killing me inside that we are at the point we are at right now.
>
> 1.01 am: You are everything to me and I destroyed everything, I don't know how I will ever be able to make you forgive me, and give me another chance to show you that I will change and work on me more.[26,27,28]

[22] Exhibit 1, Vol. 1, Tab 6, Report - Homicide Squad (06.07.21), pp1-2
[23] Exhibit 1, Vol. 1, Tab 7, Report - Internal Affairs Unit (03.02.22), p2
[24] Exhibit 1, Vol. 1, Tab 17, Statement - Mr C Scott, (04.03.21), paras 33-35 & 39-44
[25] Exhibit 1, Vol. 1, Tab 23, Incident Report (040321 1900 11931), pp1-2
[26] Exhibit 1, Vol. 1, Tab 7, Report - Internal Affairs Unit (03.02.22), p2
[27] See also: Exhibit 1, Vol. 1, Tab 8, Memo - FC Const. C Johnson (06.07.21), p4
[28] Exhibit 1, Vol. 1, Tab 23, Incident Report (030321 1900 17093), p1

The Building[29,30]

21. For contextual purposes, I note that the Building (known as Astra Apartments) is a 30-storey structure located at 237 Adelaide Terrace, in Perth's Central Business District. It comprises one, two, and three bedroom apartments, some of which are rented out on a short-term basis. Access to the Building's lobby is by means of a "*security fob*" which also activates the Building's lifts, the door to the security fob holder's apartment, and certain shared facilities.

22. There are no apartments on Level 29 of the Building, and instead, residents have security fob access to a gym, a pool, and a terrace area with tables and chairs on this level. As can be seen in Diagram 1, the pool and terrace areas are on opposite sides of the Building.

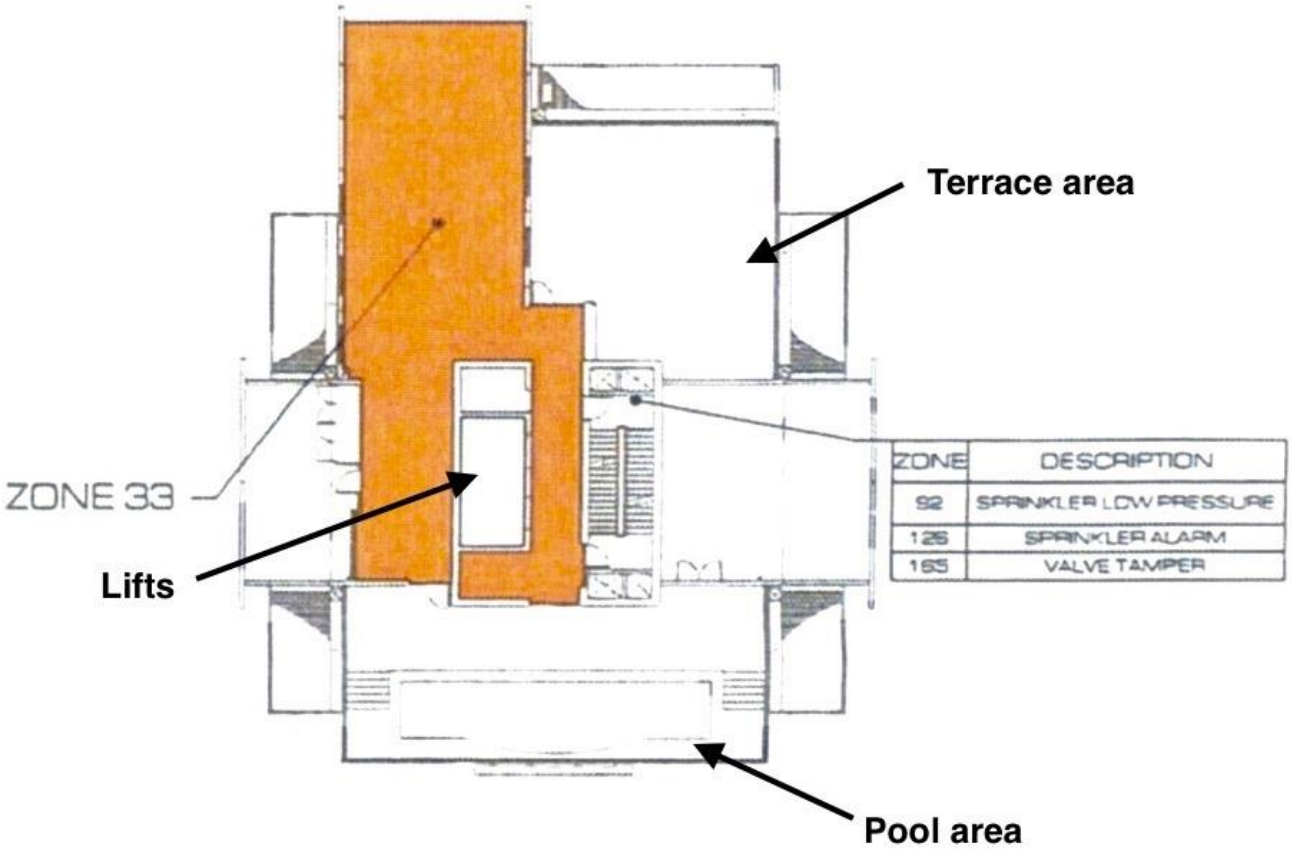

Diagram 1: Fire Block Plan - Level 29[31]

[29] Exhibit 1, Vol. 1, Tab 23, Incident Report (040321 1900 11931), p1
[30] Exhibit 1, Vol. 1, Tab 6, Report - Homicide Squad Report (06.07.21), pp1-2
[31] See: Exhibit 1, Vol. 1, Tab 21, Fire Block Plans - 237 Adelaide Terrace, Perth

23. An alcove off a corridor on Level 29 leads to two multi-user toilets, and the Building's service area, which is accessed through a key-locked door labelled "*Service Area East*". On entering the alcove, the service area door is directly ahead, with the toilets opposite each other on the left and right (see Photos 1 & 2).

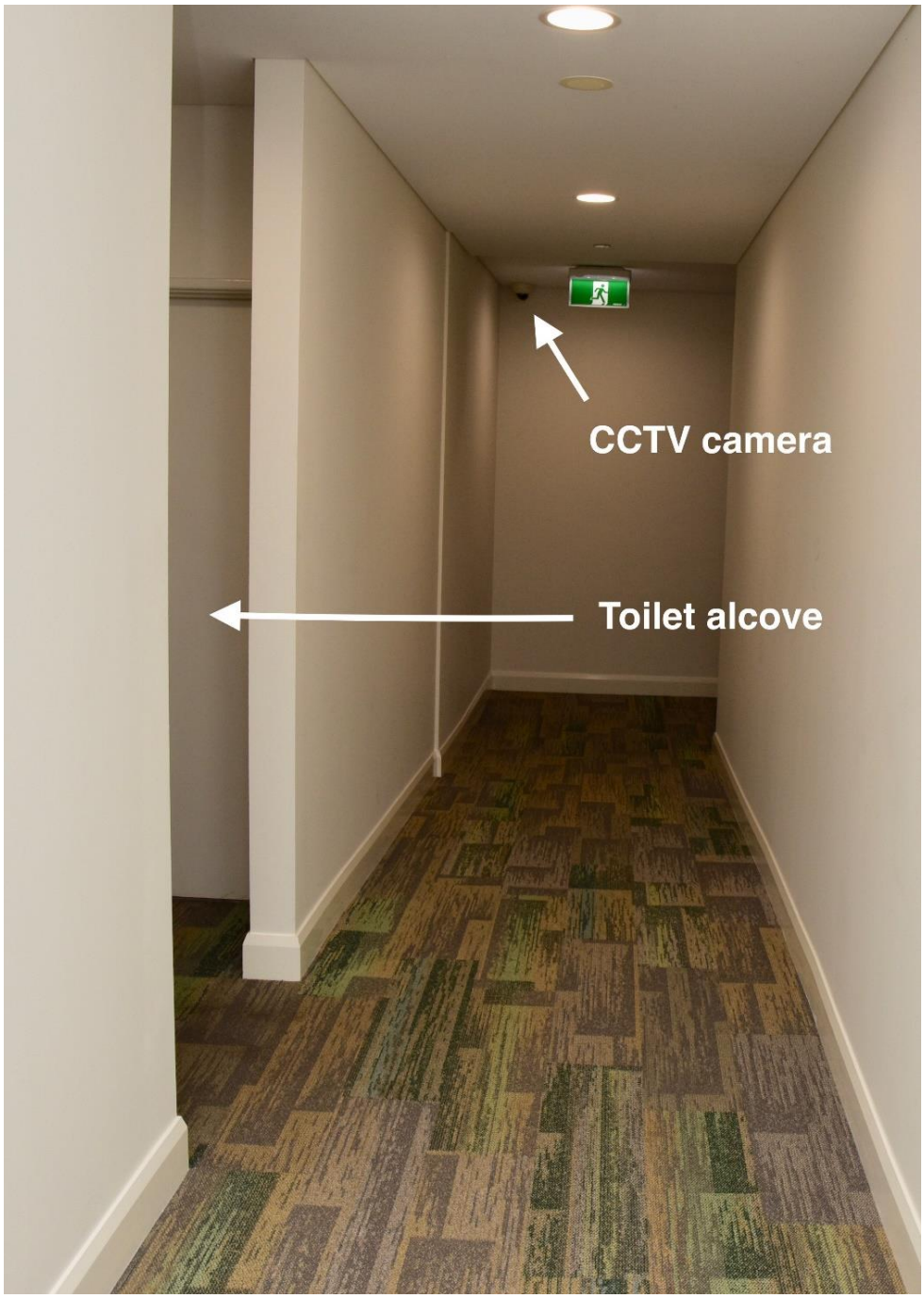

Photo 1: Shows the alcove on Level 29 leading to the toilets and service area[32]

[32] Scene photos taken by WAPOL - BPP-4063 (05.03.21)

Photo 2: Shows the service area and the right-hand toilet door.[33]

24. The service area contains air-conditioner compressors and other engineering services and provides access to the Building's roof by means of a ladder. The access ladder and the service area door (viewed from within the service area) are depicted in Photos 2 and 3.

[33] Scene photo taken by WAPOL - BPP-4065 (05.03.21)

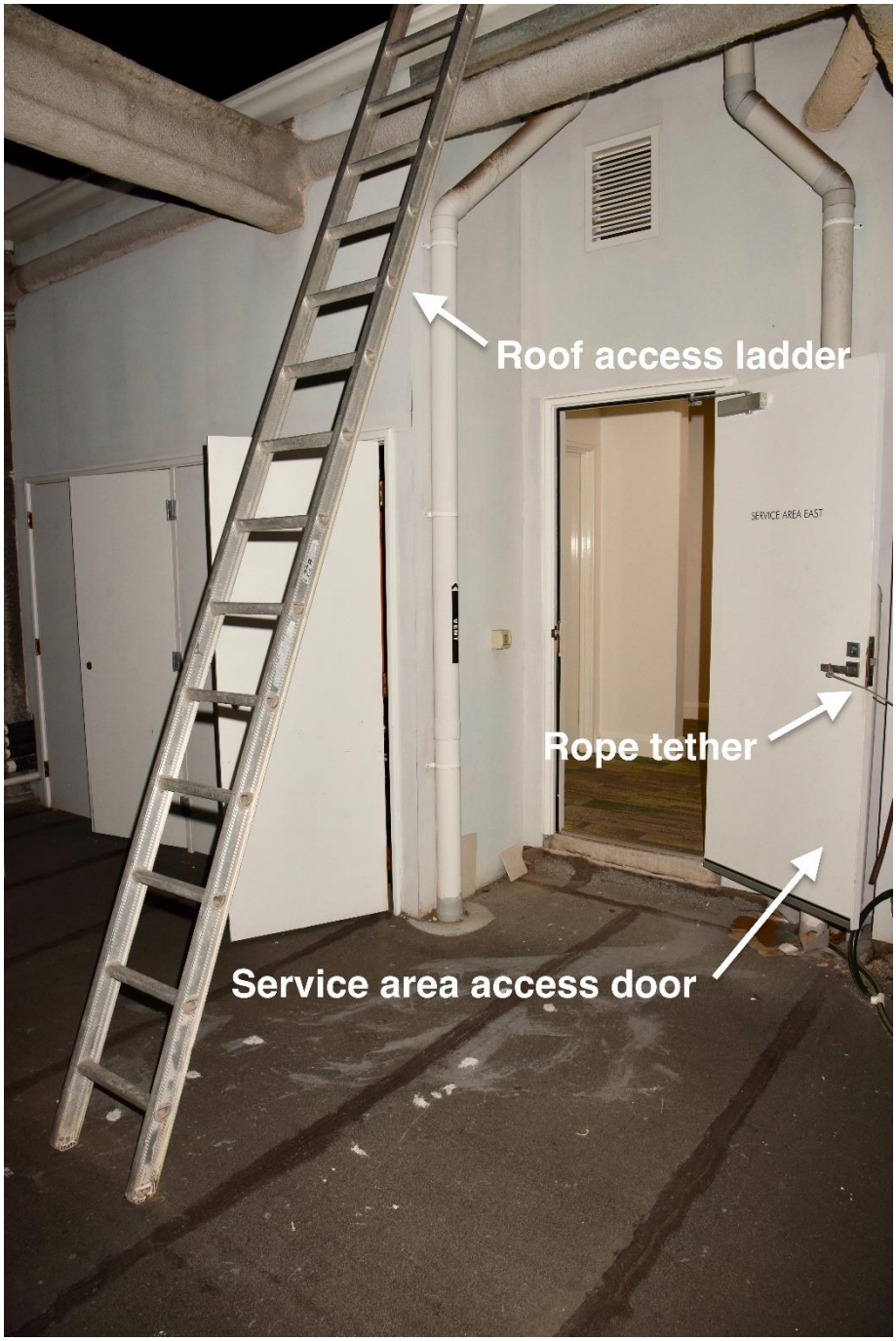

Photo 3: Access door to service area and roof access ladder[34]

25. Closed circuit TV (CCTV) cameras monitor the corridors on Level 29 (see Photo 1). However, because the toilets on Level 29 are accessed via an alcove, the toilet doors, and the door to the service area, are out of view of the CCTV camera. Thus, once a person enters the alcove from the corridor, they cannot be seen on the CCTV footage.

[34] Scene photo taken by WAPOL - BPP-4078 (05.03.21)

Mr Scott's reports to police - 3 March 2021[35,36,37]

26. Mr Scott says Ms L was due to check out of the Apartment at 11.00 am on 3 March 2021. However, she did not respond to his numerous texts and phone calls, and he was therefore unaware of her location. Mr Scott became concerned at not being able to contact Ms L, and he called the Police and Ms L's mother on the afternoon of 3 March 2021.

27. Records show that a computer assisted dispatch task (CAD job) was created after Mr Scott called the Police at 5.42 pm on 3 March 2021. The CAD job shows that Mr Scott told police he had not been able to contact Ms L after dropping her off in the early hours of the morning.

28. A police officer called Mr Scott at 6.01 pm, and it was noted that he had expressed no immediate welfare concerns for Ms L, other than the fact she was a foreign national and he hadn't been able to contact her. Mr Scott was advised that this was not a police matter because "*no real or imminent welfare concerns*" were identified. The CAD job record notes that Mr Scott said he understood what he was being told and that he thanked police for their time.[38]

29. Mr Scott says that Ms L's mother told him that apart from receiving a "*heart*" message from Ms L (sent at about 9.00 am Western Australian time on 3 March 2021), she had not heard from her daughter either. Mr Scott says he drove around Kings Park, Langley Park and Cottesloe Beach looking for Ms L, and that when he could not locate her, he went to the Perth Police station to report her as missing. Records show that Mr Scott went to the station at 9.45 pm on 3 March 2021.

[35] Exhibit 1, Vol. 1, Tab 17, Statement - Mr C Scott, (04.03.21), paras 45-50
[36] Exhibit 1, Vol. 1, Tab 6, Report - Homicide Squad Report (06.07.21), pp1-2
[37] Exhibit 1, Vol. 1, Tab 7, Report - Internal Affairs Unit (03.02.22), pp3-5 & 7-8
[38] Exhibit 1, Vol. 1, Tab 7, Report - Internal Affairs Unit (03.02.22), p1

The search for Ms L[39,40,41,42,43,44,45,46,47,48]

30. Following Mr Scott's missing person report, an electronic document called a "*Running Sheet*" was created in the Police computer system to record the results of police enquiries. The Running Sheet notes that police tried calling Ms L's mobile at 9.46 pm on 3 March 2021, but that the call went to voicemail.

31. At 10.18 pm, police spoke with the Apartment's owner (Ms JH) who confirmed Ms L had not returned her security fob. Ms JH knew this because the person who had booked the Apartment next had contacted her to say the security fob was not in the "*lock box*". Ms JH texted Ms L at 7.20 pm asking about the missing security fob and although the text message was "*opened*", there was no reply. The Apartment was empty when Ms JH checked it at 7.30 pm and 9.40 pm on 3 March 2021.

32. Police called Ms L's mobile at 12.34 am and again at 5.41 am on 4 March 2021, but it appears to have been switched off. There had been no recent activity on Ms L's Facebook account and at 7.11 am, police called the MHERL[49] and confirmed that Ms L had not been in contact with public mental health services.

33. At 7.13 am on 4 March 2021, the Police received a "*concern for welfare*" report from Interpol Canberra, that had been lodged by Interpol Wiesbaden in Germany (the Report). In the Report, Ms L's father advised that his daughter had "*been suffering from depression for many years, and recently broke up with her boyfriend*". Ms L's father also said he believed Ms L had not recovered from the breakup, and "*may harm herself*" and that Ms L had told him several times "*It's too late now, there is no way out*".[50]

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[39] Exhibit 1, Vol. 1, Tab 27.2, Running Sheet - Incident Report 030321 2200 17903 (03-04.03.21)
[40] Exhibit 1, Vol. 1, Tab 7, Report - Internal Affairs Unit (03.02.22), pp2-8
[41] Exhibit 1, Vol. 1, Tab 11, Statement - Const. O Faydi (06.04.21), paras 12-20 and ts 29.11.22 (Faydi), pp60-61
[42] Exhibit 1, Vol. 1, Tab 12, Statement - FC Const. O Gregoor (11.03.21), paras 3-47 and ts 29.11.22 (Gregoor), pp7-13
[43] Exhibit 1, Vol. 1, Tab 13, Statement - Const. B Hastie (11.03.21), paras 4-17and ts 29.11.22 (Hastie), pp56-58
[44] Exhibit 1, Vol. 1, Tab 14, Statement - Prob. Const. R Ishmael (23.03.21), paras 4-31 and ts 29.11.22 (Ishmael), pp45-48
[45] Exhibit 1, Vol. 1, Tab 16, Statement - Const. A Mitchell-Gow (11.03.21), paras 3-60 and ts 29.11.22 (Mitchell-Gow), pp29-34
[46] Exhibit 1, Vol. 1, Tab 6, Report - Homicide Squad Report (06.07.21), p2
[47] Exhibit 1, Vol. 1, Tab 22, Incident Detailed Report (LWP21030300188401)
[48] Exhibit 1, Vol. 1, Tab 22, Incident Brief Report (LWP21030400191446)
[49] MHERL stands for Mental Health Emergency Response Line, a 24 hour/7 days per week service
[50] Exhibit 1, Vol. 1, Tab 19, Report Interpol Canberra - 6565717/2475 (04.03.21)

34. At about 2.15 pm, Acting Sergeant Owen Gregoor (Officer Gregoor), took over the missing person investigation. He reviewed the available material and was aware that a "*welfare job*" had been created and that an email had been received from Interpol. Officer Gregoor noted that the Building's managing agent (Ms DH) had been spoken to about CCTV footage, and he asked Probationary Constable Ryan Ishmael (Officer Ishmael) and Constable Aaron Mitchell-Gow (Officer Mitchell-Gow) to contact hotels in Perth and Scarborough to see if Ms L had checked in there. Scarborough hotels were checked because police were told that Ms L liked the area.

35. Police enquiries continued during the day. Mr Scott said he received a number of phone calls from the Police, and officers attended the backpacker hostel where he was staying. Mr Scott remained in his room at the hostel waiting for further information and spoke with Ms L's mother, who told him:

> [S]he thought she [Ms L] had turned her phone off and [was] not talking to us to show us she could do it on her own.[51]

36. The Running Sheet notes a telephone call to Mr Scott at 1.45 pm, in which he told police Ms L had been depressed since Christmas 2020, and that her cervical surgery in February 2021 "*had caused her to slip into deeper depression*". Mr Scott said he had checked the Kings Park and Langley Park areas and was in contact with Ms L's parents in Germany. Mr Scott also said Ms L had been on medication for two months, but he did not think this "*had improved her depression*".

37. During a telephone call at 2.29 pm, Mr Scott told police that Ms L's current depression was "*the worst she has ever been*". Mr Scott was asked if Ms L had ever attempted suicide or spoken of doing so, and he replied: "*No*". He was also asked if he had any concerns Ms L would self-harm and his reply was: "*I don't think so, I think she may have said to me she thought about it once but* [had] *never spoken about it more or disclosed particular details*".[52]

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[51] Exhibit 1, Vol. 1, Tab 17, Statement - Mr C Scott, (04.03.21), para 50
[52] Exhibit 1, Vol. 1, Tab 16, Statement - Const. A Mitchell-Gow (11.03.21), paras 11-19

38. Mr Scott also confirmed he was in close contact with Ms L's friends and family, but that no one had heard anything from her. Police checks with public hospitals were negative, and checks were also initiated with Transperth, Centrelink, and Medicare.

39. During a handover briefing at 3.00 pm, Officer Gregoor and other officers were told that although police had attended the Building, Ms L had not been located. Police had reviewed CCTV footage which showed Ms L leaving the Apartment at 6.53 am on 3 March 2021 and taking the lifts to Level 29, where she remained until 7.02 am, before returning to the Apartment. At 10.16 am, Ms L left the Apartment again and took the lifts to Level 29 before entering the terrace area. At 10.50 am, she entered the toilet alcove, and was not seen to re-emerge after that time.[53,54,55]

40. After the handover briefing, officers called the Perth City Council camera room and confirmed that street level CCTV had not identified Ms L leaving the Building. The camera room had been sent a passport image of Ms L which police had obtained earlier. At Officer Gregoor's request, "*additional resources*" in the form of Constable Ben Hastie (Officer Hastie) and Officer Omar Faydi (Officer Faydi) were allocated to the investigation. At about 3.30 pm, Officer Mitchell-Gow called Ms L's mobile phone, but the call went through to voicemail. He also contacted nearby city hotels, but Ms L had not booked into any, and St John Ambulance WA confirmed that no one matching Ms L's description had used the services of an ambulance.

41. At about 5.20 pm on 4 March 2021, Officers Gregoor, Ishmael, Mitchell-Gow, Hastie and Faydi (the Officers) went to the Building to conduct a further search for Ms L. Officers Michell-Gow and Ishmael first checked a nearby bar but did not locate Ms L. When they returned, Ms DH (the Building's managing agent) gave Officer Gregoor a set of keys and security fobs to enable the Officers to access all floors.

[53] Exhibit 1, Vol. 1, Tab 6, Report - Homicide Squad Report (06.07.21), p3
[54] Exhibit 1, Vol. 1, Tab 8, Memo - FC Const. C Johnson (06.07.21), p4
[55] Exhibit 1, Vol. 1, Tab 16, Statement - Const. A Mitchell-Gow (11.03.21), paras 28-31

42. Officer Michell-Gow remained with Ms DH to review CCTV footage, whilst the other officers took the lift to Level 29 and went to the toilet alcove area where Ms L was last seen. Officer Gregoor checked the service area door and found it was locked. Although one of the toilet doors was unlocked and the toilet was empty, the door to the other toilet was locked, and the sound of a toilet flushing could be heard coming from within.

43. At about 5.45 pm, Officer Faydi knocked on the locked toilet door, and when there was no response he used a multitool to manually unlock the door. As he did so, Ms L appeared in the doorway, and Officer Gregoor's body worn camera (BWC) captured this interaction. Ms L appeared surprised and somewhat embarrassed by the sight of four police officers outside the toilet door.

Police interactions with Ms L - 4 March 2021[56,57,58,59,60,61]

44. Police spoke with Ms L for a few minutes before she voluntarily accompanied them to the nearby outdoor terrace area. Ms L sat down at a table with Officer Gregoor and BWC footage records their interactions with her. In the BWC footage, Ms L appears tired and somewhat withdrawn as she discusses a range of matters, including an argument with Mr Scott, the reason why she had been in the toilet for so long, and her desire to return home to Germany.

45. On the basis of Ms L's demeanour, Officer Gregoor released Officers Hastie and Faydi, and they left the Building to attend to other duties. Officer Gregoor also said he felt Ms L was embarrassed by the presence of police, and he felt that having five officers on the scene may have been overwhelming for her. In any event, at various times during her interactions with police, Ms L can be seen on the BWC footage rubbing her eyes, as if tired. She also smiles and laughs occasionally and as the interaction progresses, she appears more relaxed.

[56] Exhibit 1, Vol. 1, Tab 7, Report - Internal Affairs Unit (03.02.22), pp3-4 & 8-11
[57] Exhibit 1, Vol. 1, Tab 11, Statement - Const. O Faydi (06.04.21), paras 21-29 and ts 29.11.22 (Faydi), pp61-62
[58] Exhibit 1, Vol. 1, Tab 12, Statement - FC Const. O Gregoor (11.03.21), paras 47-101 and ts 29.11.22 (Gregoor), pp13-22
[59] Exhibit 1, Vol. 1, Tab 13, Statement - Const. B Hastie (11.03.21), paras 18-25 and ts 29.11.22 (Hastie), pp58
[60] Exhibit 1, Vol. 1, Tab 14, Statement - Prob. Const. R Ishmael (23.03.21), paras 32-73 and ts 29.11.22 (Ishmael), pp48-53
[61] Exhibit 1, Vol. 1, Tab 16, Statement - Const. A Mitchell-Gow (11.03.21), paras 61-144 and ts 29.11.22 (Mitchell-Gow), pp35-40

46. When Ms L was asked by Officer Gregoor and later by Officer Mitchell-Gow, she denied there had ever been any domestic violence between her and Mr Scott, and she specifically denied any self-harm or suicidal ideation. The Internal Affairs Report contains the following summary of the Officers' interactions with Ms L, with which I concur:

- Ms L seemed surprised that people had been looking for her;
- Ms L discussed breaking up with her boyfriend;
- Ms L wanted to return to her parents in Germany;
- Ms L was offered medical attention which she declined;
- Ms L asked how she could get back home to Germany;
- Ms L was offered a lift to the backpacker hostel, which she declined;
- Ms L was given some examples of flight costs to Germany;
- Ms L confirmed she had enough money for the airfare;
- Ms L appeared grateful for the assistance of officers;
- Ms L was offered the use of a phone to call her parents;
- Ms L thought Mr Scott would be mad at her;
- Ms L was told Mr Scott and her parents had contacted police;
- Ms L said she was tired and wanted to have a shower;
- Ms L appeared to be calm;
- Ms L appeared grateful for the officers' concern; and
- Ms L appeared to be somewhat embarrassed by the police presence.[62]

47. When Ms L said she wanted to return home to Germany, Officer Gregoor used his mobile to look up available flights. He also made enquiries with his superiors about any COVID-19 restrictions that might apply to international air travel. It appears Ms L sent a text message to her mother, because her mobile began silently ringing and Ms L told the Officers that it was her mother calling her.

48. Ms L answered the call, and she and her mother spoke in German for about 10 minutes. During the call, Ms L paced back and forth speaking quietly, and was seen to "*sporadically wipe tears from her eyes*".[63]

[62] Exhibit 1, Vol. 1, Tab 7, Report - Internal Affairs Unit (03.02.22), pp8-9 and ts 30.11.22 (Welch), pp70, 75-76
[63] Exhibit 1, Vol. 1, Tab 16, Statement - Const. A Mitchell-Gow (11.03.21), paras 66-68

49. During this call, officers switched off their BWC because Ms L was not being detained, and they considered her conversation was private. After Ms L's call with her mother, Officer Mitchell-Gow, who had joined the other officers on Level 29, spoke with Ms L and asked her what was going on and why she had not been communicating with anyone. Ms L said: "*I don't know, I just didn't want to*". Ms L also said she and Mr Scott had an argument and when asked if she was homesick, she said "*Yeah but it's kind of hard with Cameron*".[64]

50. Officer Mitchell-Gow continued speaking with Ms L, and asked her about her immediate plans. She said she was embarrassed to return to the backpacker hostel, having not been there for a few days. When asked what she wanted to do, Ms L said: "*I just want to talk to* [Mr Scott]". Officer Mitchell-Gow said that when he asked Ms L if there was any domestic violence between her and Mr Scott, she had smiled and said "*No, no*" in a way that suggested she almost found the idea "*comical*".[65]

51. By this stage, Officer Gregoor had confirmed that Mr Scott was on his way to the Building to collect Ms L, and there was a further discussion about Ms L's medication and ticket prices for flights to Germany. Officer Mitchell-Gow said he was satisfied that Ms L "*presented no intention of self-harm or suicide*" on the basis of her increasingly relaxed attitude, the fact she was smiling and laughing and the fact she was discussing the need to obtain additional medication. Ms L was also making future plans, namely being collected by Mr Scott and exploring return flights to Germany.[66]

52. A short time later, Ms L stood up and told police she was "*having her period*", and after producing a feminine hygiene product from her bag, she asked if she could visit the toilet. The request seemed reasonable, and in light of her demeanour and her interactions with police over the previous 20 minutes, the officers had no reason to suspect Ms L was significantly distressed, much less suicidal. On that basis, the officers agreed to her request.

[64] Exhibit 1, Vol. 1, Tab 16, Statement - Const. A Mitchell-Gow (11.03.21), paras 76-90
[65] Exhibit 1, Vol. 1, Tab 16, Statement - Const. A Mitchell-Gow (11.03.21), paras 99-113
[66] Exhibit 1, Vol. 1, Tab 16, Statement - Const. A Mitchell-Gow (11.03.21), paras 115-121

53. BWC footage shows Ms L leave her bag on the table and walk through the terrace area door in the direction of the toilets. CCTV footage shows Ms L walking down the corridor towards the toilets, with what appears to be a sanitary pad in her hand, before she enters the alcove leading to the toilets and disappears from view. As I have noted, CCTV footage does not show Ms L again, meaning she did not emerge from the alcove.

54. The officers had quite reasonably assumed that Ms L would only be gone for a short time, but when she had not returned after four or five minutes, they became concerned and went looking for her. The search assumed more urgency when officers checked the toilets and found Ms L was not in either one. According to his police statement, which he signed on 11 March 2021, Officer Mitchell-Gow said he checked the service area door and found it was locked. At the inquest, Officer Mitchell-Gow said he didn't believe he checked the service area door and thought Officer Ishmael had done so instead.[67]

55. At the inquest Officer Ishmael said "*Not to my knowledge*" when he was asked whether he had checked the service area door. I note that Officer Mitchell-Gow's statement was signed just one week after Ms L's death, and it seems reasonable to assume that these terrible events would have been fresh in his memory at that time. For that reason, I prefer to rely on Officer Mitchell-Gow's statement, and I am satisfied he checked the service area door and found it was locked.[68]

56. After not being able to find Ms L in the gym, pool or terrace areas, the officers reasonably assumed she had left the Building and made their way to the ground floor to look for her. Officers Ishmael and Mitchell-Gow ran out onto the street but did not see Ms L, but a short time later a radio call from the Police Operations Centre (POC) advised that someone was on the roof of a building on St Georges Terrace. This was quickly updated to say a person had been spotted on the roof of the Building, and the officers immediately returned to Level 29.

[67] Exhibit 1, Vol. 1, Tab 16, Statement - Const. A Mitchell-Gow (11.03.21), para 133 and ts 29.11.22 (Mitchell-Gow), p40
[68] ts 29.11.22 (Ishmael), p51

57. It appears that the information about a person being on the roof of the Building had come from a person looking out of their window from an adjacent hotel, and also from a passer-by, both of whom called emergency services.[69,70,71]

58. When he got back to Level 29, Officer Gregoor used the keys he had been given earlier by Ms DH to unlock the service area door. He then climbed onto the Building's roof using the access ladder shown in Photos 2 and 3. As he did so, he was confronted by the appalling sight of Ms L standing on the south-eastern ledge of the Building. She had her back to Officer Gregoor and was facing towards the Swan River, and was obviously in extremely serious and immediate danger.

59. Meanwhile, at considerable risk to themselves, Officers Ishmael and Mitchell-Gow had managed to access the Building's roof by standing on a balustrade in the pool area and scaling an adjacent parapet wall. Officers Ishmael and Mitchell-Gow were further away from Ms L, and as they appeared on the roof, Officer Gregoor motioned to them to stay back.

Attempts to bring Ms L to safety[72,73,74,75,76]

60. BWC footage from the attending police officers captures the attempts by Officer Gregoor to get a visibly distraught Ms L to step back from the Building's ledge. She is seen continuously looking back to Officer Gregoor and then over the edge. When Officer Gregoor took a step towards Ms L she seemed to become more agitated and he reassured her he was not trying to get closer. Officer Gregoor asked Ms L "*What can we do to help you right now?*" and referred to her earlier conversation with her mother. Ms L is heard to say: "*I tried*", before Officer Gregoor tells her "*It's starting to rain and it's going to get slippery*", in a further attempt to have her step off the ledge.

[69] Exhibit 1, Vol. 1, Tab 10, Statement - Ms D (09.03.21), paras 6-15
[70] Exhibit 1, Vol. 1, Tab 15, Statement - Mr K (04.03.21), paras 3-17
[71] Exhibit 1, Vol. 1, Tab 7, Report - Internal Affairs Unit (03.02.22), p5
[72] Exhibit 1, Vol. 1, Tab 7, Report - Internal Affairs Unit (03.02.22), pp3-4 & 9-11 and ts 30.11.22 (Welch), pp72-74
[73] Exhibit 1, Vol. 1, Tab 12, Statement - FC Const. O Gregoor (11.03.21), paras 102 -110 and ts 29.11.22 (Gregoor), pp22-26
[74] Exhibit 1, Vol. 1, Tab 14, Statement - Prob. Const. R Ishmael (23.03.21), paras 73-77 and ts 29.11.22 (Ishmael), pp53-54
[75] Exhibit 1, Vol. 1, Tab 16, Statement - Const. A Mitchell-Gow (11.03.21), paras 144-159 and ts 29.11.22 (Mitchell-Gow), pp40-42
[76] Exhibit 1, Vol. 1, Tab 17, Statement - Mr C Scott, (04.03.21), paras 51-57

61. Officer Gregoor used his police radio to request attending units switch off their sirens, because he was concerned that the noise was further distressing Ms L. The desperation and urgency in Officer Gregoor's voice is plain, and when Ms L says: "*Please tell* [my mother] *that I love her*" and that she is sorry, Officer Gregoor responds "*You can tell her yourself*", and offers to call Ms L's mother on his mobile phone.

62. Tragically, despite Officer Gregoor's repeated pleas, Ms L stepped off the edge of the Building and plummeted 30 storeys to the carpark below. She died instantly from the injuries she sustained.

63. Meanwhile, Mr Scott says that at about 5.45 pm, he saw Ms L was active on the messenger service *WhatsApp*, but that there was no reply when he tried calling her. Mr Scott says he spoke to Ms L's mother at about 6.10 pm, who told him that Ms L was waiting with five police officers and "*that she was fine*". Ms L's mother asked Mr Scott to go to the Building to collect Ms L, and he did so.

64. When Mr Scott arrived at the Building he was initially unable to get inside. However, someone eventually let him in and he took the lift to Level 29. He did this because Ms L's mother had mentioned that Ms L was "*upstairs*", and he had taken this to be a reference to the outdoor area.

65. When Mr Scott reached Level 29, he called out to Ms L, but there was no reply. As he could not see the police or Ms L, Mr Scott used the fire stairs to make his way back to the ground floor of the Building. Mr Scott described the horrifying events which followed in these terms:

> Some random male walked past and told me that a girl was on the roof. That's when I heard what was [Ms L] falling to the ground. I then went with the police in the lift to the carpark and remained with police where I wrote this statement. [Ms L] had never said anything to me about jumping from a roof and never told me she was suicidal.[77]

[77] Exhibit 1, Vol. 1, Tab 17, Statement - Mr C Scott, (04.03.21), paras 55-57

How did Ms L access the Building's roof?[78]

66. Despite extensive enquiries, police have not been able to determine how Ms L was able to access the Building's roof. After carefully considering the available evidence, it appears to me that the only way Ms L could have done so was via the service area door. However, how she was able to do so remains a mystery.

67. During the initial police search before Ms L was located in one of the Level 29 toilets, Officer Gregoor had checked the service area door and found that it was locked. Later, when Ms L did not return from the toilet, police began to search for her and it was during this search that Officer Mitchell-Gow had checked the service area door and found it was still locked.[79,80]

68. It is therefore unclear how Ms L could have accessed the service area through a locked door. At the inquest, mention was made of some keys that were found on the roof, and I became concerned this meant Ms L had somehow obtained keys to the service area door. However, further enquiries have confirmed that none of the keys to the service area access door were unaccounted for, making it impossible for Ms L to have gained entry to the service area access door using a key.[81]

69. The other possibility I considered was whether Ms L might have been able to access the roof in the same manner that Officers Ishmael and Mitchell-Gow did, namely by clambering up a parapet wall in the pool area on Level 29. However, in order to access the roof in this manner, Ms L would have to have entered the pool area, meaning she would have had to have used the corridor.

70. Although CCTV footage shows Ms L using the corridor to access the alcove leading to the toilets, subsequent CCTV footage does not show her re-emerging. This effectively excludes the possibility that Ms L access the Building's roof from the pool area.

[78] ts 29.11.22 (Gregoor), pp26-27
[79] Exhibit 1, Vol. 1, Tab 16, Statement - Const. A Mitchell-Gow (11.03.21), paras 132-133
[80] ts 29.11.22 (Gregoor), pp13 & 20
[81] Email from Mr T Sharp to Sen. Const. C Robertson (08.12.22)

71. The security fobs issued to residents do not provide access to the Building's service area, although several contractors have been issued with keys to the service area door to enable them to respond to emergency call-outs.[82] Whilst it is theoretically possible that a contractor inadvertently left the service area door open on 4 March 2021 (or that the door had failed to close properly after being opened), there is no evidence to suggest that this was the case.

72. The Building's current managing agent has suggested Ms L may have accessed the service area after police used a rope tether to secure the door open (see Photos 3 and 4). However, this suggestion is directly contradicted by the evidence of Officers Gregoor, Mitchell-Gow, and Ishmael that the tethering of the service area door occurred only after Ms L had died.

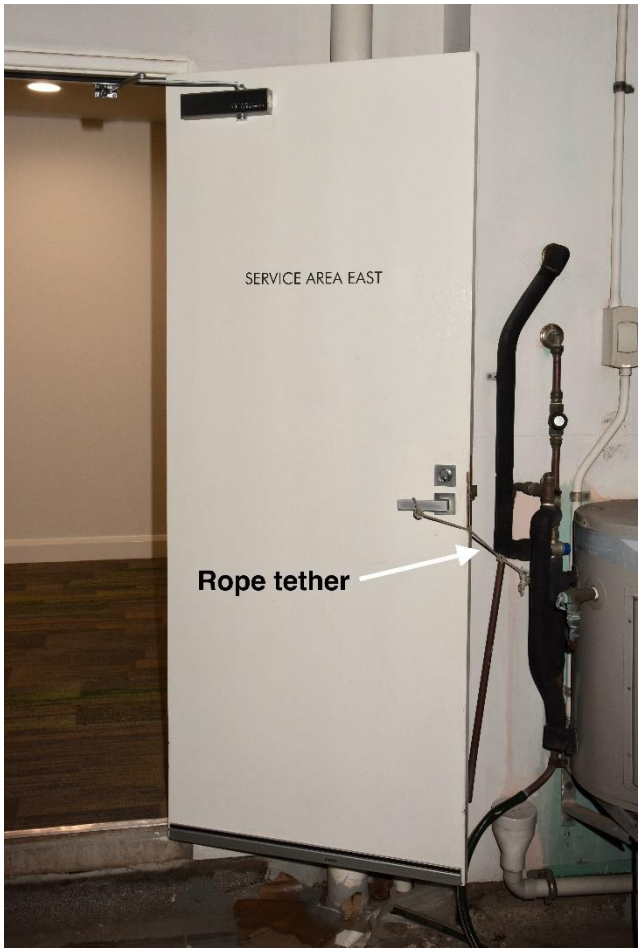

Photo 4: Shows the service area door held open by a small piece of rope.[83]

[82] Emails from Mr T Sharp to Sen. Const. C Robertson (01.12.22 & 02.12.22)
[83] Scene photos taken by WAPOL - BPP-4077 (05.03.21)

73. I deeply regret that I have been unable to determine how Ms L accessed the Building's roof. All that can be said with any certainty is that she somehow did so.

MS L'S STATE OF MIND

Observations

74. It seems clear that from December 2020 onwards, Ms L had been experiencing an exacerbation of her depressive symptoms, which appears to have coincided with her diagnoses of chlamydia and HPV16. Given what Dr Frew and Mr Scott said about Ms L's reaction to this unwelcome news, it seems reasonable to conclude that these diagnoses weighed heavily on her mind, notwithstanding the fact that both chlamydia and the HPV16 lesion had been successfully treated.

75. With the exception of Ms L's father's comment to Interpol that he thought Ms L "*may harm herself*", no one else close to Ms L appears to have thought she was at any significant risk. Mr Scott said that Ms L had never mentioned feeling suicidal to him, and Ms L's mother had told Mr Scott that her daughter was "*fine*" after speaking with her by phone.[84,85]

76. Attending police had spoken with Ms L for about 20 minutes before she excused herself to use the toilet, and had noted she seemed increasingly more relaxed and calm as their interaction with her went on. The officers noted nothing about Ms L's demeanour that suggested she was at risk of self-harm or suicide, and were comforted by the fact that she had spoken of being collected by Mr Scott and had expressed interest in flying back to Germany.

77. In previous inquests I have presided over, I have heard evidence from psychiatrists and psychologists about the well-known fact that a person's risk of suicide is extremely unpredictable. That is because suicide is a rare event, and it is impossible to predict rare events with any certainty.[86]

[84] Exhibit 1, Vol. 1, Tab 19, Report Interpol Canberra - 6565717/2475 (04.03.21)
[85] Exhibit 1, Vol. 1, Tab 17, Statement - Mr C Scott, (04.03.21), paras 37-38 & 52
[86] See for example: [2022] WACOR 48 (published 28.11.22), paras 15-23

78. It is also the case that suicidality can fluctuate, often on a very short time frame. Thus an assessment done at one point in time may be invalid hours, or even minutes, later. On the available evidence, it is impossible to know when Ms L decided to take her life, or the extent to which her suicidality may have fluctuated in the period before her death.[87]

Ms L's journal[88]

79. After her death, police seized Ms L's journal, and the handwritten entries were translated into English. The entries show Ms L was feeling depressed and she lists reasons to live and not live. In one of the entries, which appears to be a letter addressed to her family, Ms L clearly expresses suicidal ideation. She refers to the struggles she is having with her mental health and thanks her family for their unwavering support.[89]

Ms L's mobile phone[90]

80. Police downloaded Ms L's phone and confirmed her last call was made in police presence on 4 March 2021, to a contact saved as "*Mama*", which is clearly Ms L's mother. The next most recent call Ms L answered was on 1 March 2021, from a contact saved as "*Papa*", presumably her father. Text messages and missed calls on Ms L's mobile phone were consistent with the evidence of Mr Scott and police attempts to contact her.

81. Between 1 March 2021 and 4 March 2021, there are numerous missed calls from family members trying to contact Ms L, and the calls and messages on her phone are "*consistent with the statement obtained* (from Mr Scott) *and the information provided by* (Ms L's) *family in Germany*".

[87] [2022] WACOR 48 (published 28.11.22), paras 15-23
[88] Exhibit 1, Vol. 1, Tab 6, Report - Homicide Squad (06.07.21), p4
[89] Exhibit 1, Vol. 1, Tab 25, Extract from Ms L's journal, p27
[90] Exhibit 1, Vol. 1, Tab 6, Report - Homicide Squad (06.07.21), p4

CAUSE AND MANNER OF DEATH

Post mortem examination[91,92]

82. Dr Reimar Junckerstorff, a forensic pathologist, conducted an external post mortem examination of Ms L's body on 10 March 2021 and reviewed CT scans. Dr Junckerstorff's examination found that Ms L had sustained multiple lacerations, bruises and abrasions, as well as fractures of her skull, facial bones, spine, ribs, sternum, pelvis, left and right radius, left and right ulna, right tibia, right fibula and fractures of both heels.

83. Toxicological analysis did not detect alcohol or other common drugs in Ms L's system; however, it did detect levels of the antidepressant medication fluoxetine and its metabolite norfluoxetine, within the range reported in six fatalities involving this medication. However, Dr Junckerstorff noted that the blood sample tested was taken from Ms L's chest cavity and that "*the raised level* (of fluoxetine and norfluoxetine) *may be due to post mortem redistribution*", a reference to the changes that can occur in drug concentrations after a person's death.

Cause and manner of death[93]

84. At the conclusion of the post mortem examination, Dr Junckerstorff expressed the opinion that the cause of Ms L's death was multiple injuries.

85. I respectfully accept and adopt Dr Junckerstorff's conclusion as to the cause of Ms L's death, and in all of the circumstances, I find that death occurred by way of suicide.

[91] Exhibit 1, Vol. 1, Tab 5, Post Mortem Report (10.03.21)
[92] Exhibit 1, Vol. 1, Tab 4, Toxicology Report (12.03.21)
[93] Exhibit 1, Vol. 1, Tab 5, Post Mortem Report (10.03.21)

DEALING WITH VULNERABLE PEOPLE

Police communication training[94]

86. Sergeant Paul Ritchie (Officer Ritchie) explained that since 2014, police recruits have undergone training in aspects of mental health and their duty of care responsibilities with respect to vulnerable people. Police recruits also receive an introduction to de-escalation, engagement and active listening techniques, presented by the Police Negotiators Unit.

87. In 2020, an eight-hour Effective Communication training package was piloted for in-service officers. The training was initially prioritised for officers in the Perth District and proved to be highly successful. From 1 January 2021, the Effective Communication package (referred to as CS5) has been deemed a "*critical skill*", meaning all officers must complete CS5 (which includes scenario based training and roleplays) every two years.

88. Officer Ritchie also advised that since February 2020, police recruits have undertaken a 20-hour Effective Communication training module designed to better equip them to deal with "*people presenting with mental health issues, alcohol and substance abuse, and other conditions that cause increased vulnerability*".[95] Apart from CS5, the Police deliver other communication and mental health awareness training, including modules aimed at officers attending development and promotion courses.

89. A CS5 refresher package was introduced on 19 October 2022, and CS5 itself has recently undergone an extensive evaluation with input from specialist units within the Police, as well as the Department of Health, Edith Cowan University Sellenger Centre, the Verbal Judo Institute and the Samaritans.

90. Officer Mitchell-Gow completed the Effective Communication module on 3 March 2021. He said the active listening aspects of CS5 had been useful during the time he interacted with Ms L.[96,97]

[94] Exhibit 1, Vol. 1, Tab 26, Memo - Sgt. P Ritchie (20.10.22) and ts 30.11.22 (Ritchie), pp83-89
[95] Exhibit 1, Vol. 1, Tab 26, Memo - Sgt. P Ritchie (20.10.22), p2
[96] Exhibit 1, Vol. 1, Tab 7, Report - Internal Affairs Unit (03.02.22), p8

Mental health co-response team[98]

91. In 2017, a collaboration between the Police, the Mental Health Commission and the Department of Health saw the introduction of the Mental Health Co-response (MHCR) model. At the time of Ms L's death, the MHCR model included a co-ordination unit, a mental health practitioner based at the POC and another at the Perth Watch House, as well as four mobile MHCR teams. The teams consist of two police officers and a mental health practitioner, and operate six days per week between 1.00 pm and 11.00 pm.

92. The aim of the MHCR teams is to provide support to general service officers encountering vulnerable people with mental health, polysubstance and/or other issues. The focus is on de-escalating situations and ensuring that affected persons receive treatment and care.

93. It seems obvious that the MHCR teams provide the Police with an enhanced capability to respond to vulnerable people. However, as I said in another inquest, I remain concerned that the MHCR teams are only available six days per week between 1.00 pm and 11.00 pm, and that outside of those hours, only phone support from the Mental Health Emergency Response Line is available.[99]

94. In passing, I note that Inspector Louise Ball (Officer Ball), the officer responsible for the management and oversight of the MHCR, recently sent an email to the Court. Officer Ball advised that as of July 2022, the MHCR teams had become secondary responders rather than primary responders, because of unspecified "*changes in safety legislation*" and "*a mitigating strategy to facilitate the safe deployment of the clinician to police managed tasks*".

95. Officer Ball also advised that: "*At present the MHC (Mental Health Commission) in collaboration with the HSPs (Health Service Providers) and WA Police (are) considering options to re-vitalise / re-position the MHCR program*."[100]

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[97] ts 29.11.22 (Mitchell-Gow), p43
[98] Exhibit 1, Vol. 1, Tab 27, Memo - Insp. L Ball (26.10.22) and ts 30.11.22 (Ball), pp77-82
[99] [2021] WACOR 24 (published 30.07.21), paras 223-228
[100] Email to the Court from Insp. L Ball (21.11.22)

96. I am deeply troubled by these developments, and I remain firmly of the view that, rather than diminish the important service provided by the MHCR teams, the Mental Health Commission, the Police and the Department of Health should consider expanding the hours and days of operation of these teams.

97. In any event, Officer Ball confirmed an MHCR team was not called in the present case, and that this had been appropriate because Ms L's presentation whilst interacting with police did not meet the criteria for the team's attendance. Police had been attempting to locate a missing person, and as Officer Ball pointed out:

> Even when police located [Ms L], she did not initially present to police as someone experiencing a mental health crisis and requiring the assistance of an [Authorised Mental Health Practitioner].[101]

98. Officer Ball also observed that:

> Through police inquiries into trying to locate [Ms L], (including advice from her partner [Mr] Scott), and in their communications with [Ms L], responding officers were aware that [Ms L] had struggled with depression, however, they did not establish that there were any imminent threats to her safety or health, or that there was an imminent threat to the safety of others.[102]

99. For the same reasons, there was no justification for police to have apprehended Ms L under the *Mental Health Act 2014* (WA).[103] After watching the BWC footage, Officer Ball expressed the opinion that attending officers had complied with the requirements of the Police policy relating to mental health.[104] Further, Officer Ball said that in relation to the decision to permit Ms L to go to the toilet:

> [T]here were no triggers that would suggest that [Ms L] should not be left unattended, or that the matter was unresolved. Evidence shows [Ms L] is still engaging [with] police, whilst they are awaiting the arrival of [Mr Scott].[105]

[101] Exhibit 1, Vol. 1, Tab 27, Memo - Insp. L Ball (26.10.22), p3
[102] Exhibit 1, Vol. 1, Tab 27, Memo - Insp. L Ball (26.10.22), p4
[103] Section 156, *Mental Health Act 2014* (WA) and ts 29.11.22 (Gregoor), p28
[104] Exhibit 1, Vol. 1, Tab 27.1, MH-01.01: Mental Health (27.11.18)
[105] Exhibit 1, Vol. 1, Tab 27, Memo - Insp. L Ball (26.10.22), p4 and ts 30.11.22 (Ball), pp81-83

COMMENTS ON THE ACTIONS OF POLICE

Standard of proof and hindsight bias

100. In relation to the standard of proof I should adopt when considering the actions of the officers interacting with Ms L, I have applied the Briginshaw principle[106]. The Briginshaw principle requires a consideration of the nature and gravity of the conduct when deciding whether a finding that is adverse in nature has been proven on the balance of probabilities.

101. I must also be mindful not to insert hindsight bias into my assessment of the actions of police in their dealings with Ms L. Hindsight bias is the tendency, after an event, to assume that the event was more predictable or foreseeable than it actually was at the time.[107]

102. The need to be mindful of hindsight bias is particularly relevant in this case because, although it later emerged that Ms L had expressed suicidal ideation in her journal, at the relevant time the only indication of potential self-harm had been a comment from Ms L's father in his report to Interpol.

Overview of police interactions with Ms L

103. When police encountered Ms L in one of the toilets on Level 29 of the Building, she appeared shocked and somewhat embarrassed. It appears she had not properly appreciated the level of concern her family and Mr Scott would exhibit when she made herself uncontactable.

104. The police request that Ms L accompany them to the terrace area on Level 29 was logical and reasonable. The terrace area offered chairs and tables and was relatively private. Although the terrace area was "*open air*" any risk was mitigated by the way officers positioned themselves around Ms L as they spoke with her. The decision was also understandable given Ms L's apparent embarrassment when she was found in the toilet on Level 29.

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[106] ***Briginshaw v Briginshaw*** (1938) 60 CLR 336, at 361-362 per Dixon J
[107] Dillon H and Hadley M, *The Australasian Coroner's Manual (2015)*, p10

105. In any case, in my view, the interaction between Ms L and police on the terrace area was professional, respectful, and appropriate. Ms L was specifically asked whether she had any self-harm or suicidal ideation, and her denials seemed plausible at that time. Police made various offers of assistance to Ms L, all of which were politely rebuffed.

106. Ms L's apparent desire to be collected by Mr Scott and thereafter to return home to Germany suggested that she was future focused. Her demeanour, and her responses to the questions she was asked, appear to have dispelled any concerns police may have had about the fact she had apparently been in the toilet on Level 29 for an extended period.

107. At no stage did any of the attending officers who spoke with Ms L in the Building's terrace area have any concerns that she was significantly distressed, or that she was at risk of self-harm or suicide. In their view, Ms L appeared calm and, as their interaction with her continued, she seemed more engaged. The evidence of the attending officers is corroborated by, and entirely consistent with, the BWC footage which I have viewed.[108,109,110,111,112,113]

108. Ms L's request to go to the toilet appeared reasonable, especially as she had told police she "*was on her period*" and produced a sanitary pad from her bag. The fact that she left her bag and mobile phone behind in the terrace area was no doubt a reassuring sign, as it suggested to the officers that she would be returning. Officers became concerned about Ms L not having returned from the toilet within a reasonable time, and their attempts to locate her were efficient and appropriate.

109. When officers were informed that Ms L was on the Building's roof, they rushed to the area, and two officers (Officers Ishmael and Mitchell-Gow) accessed the roof at some risk to themselves.

[108] Exhibit 1, Vol. 1, Tab 11, Statement - Const. O Faydi (06.04.21), para 27 and ts 29.11.22 (Faydi), pp61-62
[109] Exhibit 1, Vol. 1, Tab 12, Statement - FC Const. O Gregoor (11.03.21), paras 48 & 62 and ts 29.11.22 (Gregoor), pp15 & 19
[110] Exhibit 1, Vol. 1, Tab 13, Statement - Const. B Hastie (11.03.21), para 23 and ts 29.11.22 (Hastie), p59
[111] Exhibit 1, Vol. 1, Tab 14, Statement - Prob. Const. R Ishmael (23.03.21), paras 34-38 & 56 and ts 29.11.22 (Ishmael), p49
[112] Exhibit 1, Vol. 1, Tab 16, Statement - Const. A Mitchell-Gow (11.03.21), paras 119-121 & 127
[113] ts 29.11.22 (Mitchell-Gow), pp36-37

110. In order to determine whether attending officers had complied with the Police policy relating to mental health, Officer Ball assessed statements of the attending officers and Mr Scott, the BWC footage, and Incident reports and CAD jobs relevant to the missing person search for Ms L, and the subsequent interaction between her and attending police. Officer Ball's conclusion was that:

> Having reviewed police policy MH-01.01 *Mental Health – Police Initiated Contact in the Community*, as well as the aforementioned evidence at hand, I am of the view that police have complied with policy.[114]

111. I further note that following an investigation, the Internal Affairs Unit concluded that "*No adverse findings have been raised in relation to the response to the welfare check, missing person report or attending officers' response or actions*".[115]

112. Having carefully considered all of the available evidence, I respectfully agree with the conclusions reached by Officer Ball and by the Internal Affairs Unit.

Did the actions of police cause or contribute to Ms L's death?

113. As I have noted, the inquest into Ms L's death was mandatory because of section 22(1)(b) of the Act which provides:

> (1) A coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and…
>
> (b) it appears that the death was caused, or contributed to, by any action of a member of the Police Force.

114. Section 22(1)(b) of the Act is enlivened when the issue of causation or contribution in relation to a death arises as a question of fact, irrespective of whether there is fault or error on the part of any member of the Police. In the coronial context, issues of causation and contribution are determined in a common-sense manner.

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[114] Exhibit 1, Vol. 1, Tab 27, Memo - Insp. L Ball (26.10.22), p6 and ts 30.11.22 (Ball), pp81-83
[115] Exhibit 1, Vol. 1, Tab 7, Report - Internal Affairs Unit (03.02.22), p11 and ts 30.11.22 (Welch), pp68-71 & 74-75

115. For that reason, I have taken the view that a factor must have made a material contribution to the death in order for it to be said to have contributed to that death.[116]

116. On the basis of all of the available evidence, I am satisfied that the actions of officers who interacted with Ms L were reasonable and appropriate, and complied with relevant Police policies. Further, after carefully considering the meaning of the words used in section 22(1)(b) of the Act, and mindful of the Briginshaw principle, I have been unable to conclude that the actions of any member of the Police caused or contributed to Ms L's death.

Comments on Officer Gregoor's actions

117. Having watched the BWC footage depicting Ms L's final moments, I am satisfied that the desperate attempts made by Officer Gregoor to save her were entirely reasonable and appropriate. After initially attempting to get Ms L to come back from the edge of the roof, Officer Gregoor tried to connect with her by referring to matters they had earlier discussed. Tragically those efforts were unsuccessful.

118. I cannot imagine the anguish Officer Gregoor must have experienced, having been so close to Ms L when she took her life. No doubt he continues to be deeply affected by the experience. It may very well be that since Ms L's death, Officer Gregoor has endlessly ruminated on the question of what more he could have done to save her life. That is an understandable, but ultimately futile, endeavour. In my judgement, on any reasonable view, there was nothing more Officer Gregoor could have done.

119. Officer Gregoor should be commended for his actions in the appalling circumstances he found himself in. The fact that ultimately, and tragically, his desperate efforts to save Ms L were unsuccessful is a heavy burden for him to bear. I can only hope that he may take some comfort from the certain knowledge that he did everything humanly possible to help Ms L in her darkest hour.

[116] Freckleton I, Causation in Coronial Law (1997) Volume 4 *Journal of Law and Medicine,* p289

CONCLUSION

120. The death of a loved one is always a sad occasion, but Ms L was only 27 years old. The death of such a young woman so far from home, and in such truly awful circumstances, is almost an unfathomable tragedy.

121. Ms L had her entire life in front of her. There were so many things she was yet to experience, so many things she was yet to achieve and, as her mother had mentioned, so many sunsets for her yet to enjoy. I simply cannot imagine the grief and sadness that Ms L's death has caused her family and loved ones.

122. It is a common misconception that at some point after a loved one's death there is "*closure*". Those who have experienced profound loss know this is not the case. The aching void left by the loved one's death does not get filled, nor do the feelings of grief and sadness disappear.

123. However, with the passage of time, perhaps it is the case that the sense of pain and loss becomes a little easier to bear. As well, memories of happier times tend to emerge and these memories can help to deaden the ache. It is my sincere hope that Ms L's family may have this experience.

124. In conclusion, I wish to publicly acknowledge the bravery and resilience displayed by Ms L's two sisters, who travelled to Perth to represent the family at the inquest into their beloved sister's death. They did honour to her memory by their presence. Finally, on behalf of the Court, I wish to extend to Ms L's family and loved ones my very sincere and deepest condolences.

MAG Jenkin
Coroner
23 December 2022