JURISDICTION	:	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	:	CORONERS ACT 1996
CORONER	:	SARAH HELEN LINTON, ACTING STATE CORONER
HEARD	:	11-12 JUNE 2025
DELIVERED	:	29 JUNE 2026
FILE NO/S	:	CORC 2461 of 2022
DECEASED	:	LAVARS, ROBERT

Catchwords:

Nil

Legislation:

Nil

Counsel Appearing:

Mr D McDonald assisted the Coroner.
Ms K Niclair (SSO) appeared for the Department of Justice and the WA Police Force.
Ms J Negus appeared for Mr Bradley Knowles.

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 ***Robert LAVARS (aka McDONALD)*** *with an inquest held at the* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth*** *on 11 to 12 June 2025, find that the identity of the deceased person was* ***Robert LAVARS*** *and that death occurred on 6 September 2022 at Rockingham General Hospital, Eleanora Drive, Cooloongup, from phosphine toxicity in a man with atherosclerotic heart disease in the following circumstances:*

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SUPPRESSION ORDER

On the basis it would be contrary to the public interest, I make an Order under s 49(1)(b) of the *Coroners Act 1996* (WA) that there be no reporting or publication of the details of any evidence surrounding operational aspects of WA Police urgent duty/emergency driving policies and procedures, including any cap on the speed at which police officers are authorised to drive.

INTRODUCTION

1. Robert Lavars died suddenly on 6 September 2022 after deliberately ingesting the highly toxic pesticide aluminium phosphide in the presence of police officers.

2. A coroner must hold an inquest if it appears that a reportable death was caused, or contributed to, by any action of a member of the Police Force.[1] Given Mr Lavars ingested the phosphine tablets in the presence of police officers, after being arrested, it was determined his death fell within this category of mandatory inquest under the *Coroners Act 1996* (WA) and an inquest was required to be held.

3. I held an inquest on 11 to 12 June 2025. The primary focus of the evidence was the police conduct on the night of Mr Lavars' death; in particular, whether they could (or should) have prevented Mr Lavars taking the tablets with better supervision and whether they should have sought medical attention for Mr Lavars more promptly once they became aware he had ingested an unknown substance, particularly so when he became unwell soon after.

4. As well as the tendering of documentary evidence obtained as part of the coronial investigation, a number of witnesses were called to give evidence about the events leading up to Mr Lavars' death, as follows:

   - Mr Bradley Knowles – a security officer who attended on behalf of DOJ initially,
   - Senior Constable Mitchell Lewis – attending police officer,
   - First Class Constable Thomas Hood – attending police officer,
   - Police Constable Blake Kennedy – attending police officer,
   - Police Constable Erika Mischewski – attending police officer,
   - Sergeant Charles Hutton – Officer in Charge of Rockingham Station,
   - Detective Senior Sergeant Craig Annesley – Internal Affairs Unit (IAU), and
   - Professor David Joyce – expert pharmacologist/toxicologist.

5. Most of the witnesses were called to give evidence about their involvement in the events on the night Mr Lavars died. In addition, Detective Senior Sergeant Annesley spoke to the outcome of the WA Police IAU investigation into the critical incident and Professor Joyce provided expert evidence in relation to the effect of the aluminium phosphide and the likelihood Mr Lavars' death might have been prevented if the police officers had responded differently on the night when he became ill.

6. In reaching my conclusions about the appropriateness of the police conduct, I have been conscious of the need to consider what was known to the security officer and the police officers who attended Mr Lavars' home that night, rather than looking back in hindsight, with the benefit of all the information that is now before me.

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[1] Section 22(1)(c) *Coroners Act 1996* (WA)

BRIEF BACKGROUND

7. Mr Lavars was born and raised in Perth. He met his wife, Zenaida, in the Philippines in 1985 and they married in Australia in 1986. They lived first in Sydney, and then moved to Perth in 1990. Mr Lavars and his wife had three children: two sons, Adrian and Steven, and a daughter, Katherine.[2]

8. Mr Lavars reported he had an unhappy childhood. His family had moved house regularly due to financial issues, which had impacted on his schooling and ability to make friends. His parents separated and his father had married three times, which contributed to his disrupted childhood. Mr Lavars also told his wife that he regularly experienced violence in the home. As an adult, he had become estranged from his parents and siblings and in 2005 he changed his name from his birth name, McDonald, to Lavars, telling his wife he wanted to cut ties with his family name and make a fresh start.[3]

9. At the time of his death Mr Lavars lived with his wife and his son Adrian at a property in Shoalwater. Mr Lavars had a special interest in birds and had built an aviary at back of his property, where he kept a number of different native birds and two ducks. He also had three cockatoos that lived in the house and formed a close attachment to Mr Lavars, often sitting on his shoulder as he moved about his home. He was also a keen supporter of the Essendon AFL team and he named one parrot in honour of the team.[4]

10. Mr Lavars had previously been employed in construction and landscaping/gardening work but he was unemployed at the time of his death due to health reasons and the restrictions of his home detention bail.[5]

11. Mr Lavars had a significant forensic history, including convictions for assault, possession and manufacturing prohibited weapons, burglary, cultivation of cannabis and receiving stolen property. There was some information before me that suggested Mr Lavars had difficulty accepting responsibility for his past offending and externalised blame to others. It was said he lacked problem solving skills and did not cope well when in an agitated state.[6]

12. It is apparent from his offending behaviour and other materials before me that Mr Lavars had long held intense feelings of hostility and persecutory beliefs towards police and other government agencies. He blamed police for many of his troubles and portrayed himself as the 'victim' of unfair police attention. Mr Lavars' most recent offending was consistent with his offending pattern of targeting government agencies, and is set out in more detail below. His attitude towards the police is relevant when considering his actions on the fateful night of his arrest on 6 September 2022 and whether it was prompted by the police in any way.[7]

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[2] Exhibit 1, Tab 2, Tab 11 and Tab 20.
[3] Exhibit 1, Tab 2, Tab 11, Tab 20, Tab 21 and Tab 29.
[4] Exhibit 1, Tab 11.
[5] Exhibit 1, Tab 20, Tab 21 and Tab 26.
[6] Exhibit 1, Tab 20, Tab 21 and Tab 26.
[7] Exhibit 1, Tab 20, Tab 21 and Tab 26.

MEDICAL AND MENTAL HEALTH HISTORY

13. Mr Lavars had a significant medical history, which included both physical and psychological issues. Mr Lavars' had a rare haematological condition called thrombotic thrombocytopenic purpura (TTP). In TTP, many small blood clots (thrombi) form throughout the body, which results in a low platelet count/low red blood cells due to their breakdown and dysfunction in multiple organs. He had suffered cerebrovascular accidents (stroke) on Christmas Day 2010 and again on Christmas Day 2020, which required significant medical treatment and rehabilitation therapy. Mr Lavars suffered some residual effects, in particular the second stroke noticeably affected his speech and some of his movement. Ongoing concerns were also raised following the 2020 stroke that Mr Lavars had potentially suffered from some ongoing neurological impairment, which may have led to disordered thinking and contributed to his later offending.[8]

14. He had also been diagnosed with significant renal disease, ischaemic heart disease, hypertension and hypercholesterolaemia and a patent foramen ovale (hole in heart). Heart surgery had been planned to have the hole in his heart closed but it appears it did not occur before his death.[9]

15. Mr Lavars was a long-term patient at a GP medical practice in Shoalwater. The doctors at the practice managed his health care in consultation with a number of specialists. Mr Lavars had follow-up with haematology, cardiology, rehabilitation and respiratory medicine clinics but he had not attended any recent scheduled appointments in the lead-up to his death. Mr Lavars was prescribed a number of regular medications for his health conditions, but records suggest that he was not taking his medications as prescribed in the lead up to his death.[10]

16. As noted above, records indicate Mr Lavars had long held persecutory beliefs in relation to the police and other government agencies. This was consistently recorded in the notes during mental health practitioner contacts, noting Mr Lavars had made numerous threats to various public agencies over a number of years. Mr Lavars had sporadic contact with Rockingham/Kwinana Community Mental Health Services, with the earliest contact recorded in 2000 when Mr Lavars had experienced suicidal ideation in the context of the stress of an impending court case. He had further brief contacts in 2001, 2002, 2012, 2013, 2019 and 2022. Mr Lavars had longstanding (pre stroke) anger management issues. He had symptoms associated with major depressive disorder and traits of paranoid personality disorder. He sometimes voiced suicidal thoughts and on at least one occasion had mentioned he had access to weapons and chemical means to end his life. He was generally discharged from mental health services after a short period of contact as Mr Lavars did not attend appointments and declined follow-up.[11]

[8] Exhibit 1, Tab 2, Tab 11, Tab 29 and Tab 30.
[9] Exhibit 1, Tab 29 and Tab 30.
[10] Exhibit 1, Tab 11 and Tab 29.
[11] Exhibit 1, Tab 21, Tab 29 and Tab 30.5.

17. Of particular note in the context of this inquest, in 2012 Mr Lavars mentioned to a health professional that if he did die by way of suicide, there would be an inquest and words to the effect that 'all would be exposed.'[12]

18. Mrs Lavars recalled that the impact of the second stroke on her husband's speech and mobility was very difficult for him. He was no longer able to work in the construction industry, although he could still do some gardening and landscaping. He became very depressed but he did not seek treatment for his depression. She also became aware he stopped taking his medications for his other health conditions. He would complain of not being able to think or breathe properly and he struggled to verbally express himself. It is clear both his physical and mental health were in decline in 2021 and heading into 2022.[13]

HOME DETENTION

19. On 14 December 2021, Detectives from State Security Investigation Group executed a search warrant at Mr Lavars' home in Shoalwater. The search related to allegations that, between 18 August 2021 and 13 December 2021, Mr Lavars sent twenty-eight envelopes and packages via Australia Post to various agencies and individuals, including the Police Minister, Police Headquarters, Rockingham Police Station, the Fines Enforcement Agency and a debt collection agency. The parcels were alleged to have contained human faecal matter, dead rats and raw pig trotters. Mr Lavars was said to have made full admissions to sending the parcels during the execution of the search warrant. He reportedly admitted to sending the packages and told the detectives he did so as he felt victimised due to perceived ongoing issues he had with WA Police, the debt collection agency and the other individuals and entities.[14]

20. Mr Lavars was charged with 28 counts of endangering the life, health or safety of a person pursuant to s 304(1)(b) of the *Criminal Code* and he was also charged with a number of drugs offences under the *Misuse of Drugs Act 1981* (WA) relating to cannabis found at the premises during the search. A freezing notice was put on his home in relation to the drug charges.[15]

21. Mr Lavars was taken to Rockingham General Hospital ED in police custody after the search was conducted at his home as he stated to the attending police officers that he would decapitate himself in front of Centrelink. A mental health assessment was requested at the hospital given the threat. Mr Lavars told the attending doctor who reviewed him in the ED that he had not taken his regular medications for a few months and declined to take any in the ED. He denied feeling suicidal and said he would not harm himself or others. The impression was of a social problem (the arrest) rather than a psychiatric illness, and Mr Lavars was discharged back into the care of police.[16]

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[12] Exhibit 1, Tab 3 and Tab 4.
[13] Exhibit 1, Tab 11.
[14] Exhibit 1, Tab 4 and Tab 31.
[15] Exhibit 1, Tab 31.
[16] Exhibit 1, Tab 30.4.

22. Mr Lavars was transferred to Hakea Prison and I understand he then went on a hunger strike as well as refusing to take any of his medications as a form of protest about what he felt was his lack of rights and in the hope it might prompt some conversations with the authorities about his circumstances. According to Mr Lavars, he lost around 20 kg while on the hunger strike.[17]

23. On 11 February 2022, Mr Lavars was assessed by a registered mental health nurse to determine if he was mentally fit to attend court. It was concluded that his behaviour was not psychotically driven, although it was felt that his strokes may have impacted his capacity to make good decisions and also made impulsive decisions more likely, which Mr Lavars appeared to accept. He mentioned he was on a hunger strike and also refusing all his medications, but the person reviewing him thought Mr Lavars looked to be normal weight. His cognition was felt to be intact and there was no basis for Mr Lavars to be made an involuntary patient under the *Mental Health Act 2014* (WA). He was deemed fit to attend court and face his charges, although it was suggested a psychological report might be of benefit to the court to explain his behaviours and likely long term prognosis.[18]

24. On 1 March 2022, Mr Lavars' GP, Dr Bradley Price, wrote a letter addressed to Adult Justice Services setting out some of Mr Lavars' medical history, including his TTP diagnosis, which had caused him to have multiple strokes and almost killed him. Dr Price expressed the view that Mr Lavars' mental state had been affected by the strokes and made him less culpable for his actions. Dr Price also advised that if Mr Lavars went on a hunger strike again he could develop an acute exacerbation of his illness, which might be life threatening.[19]

25. Mr Lavars was granted bail on 4 March 2022, but subject to the condition of home detention with electronic monitoring equipment, as well as a condition that he was not to communicate with WA Police, the Department of Justice – Fines Enforcement Section and some other entities and individuals, other than in defined circumstances. He was released from prison on the same day and returned home. Mr Lavars' bail conditions extended to his next scheduled court appearance on 27 September 2022.[20]

26. Mr Lavars was seen by Dr Price on four consecutive days from 11 to 14 March 2022 following his release from custody. Dr Price conducted a mental health assessment on 13 March 2022 and diagnosed Mr Lavars with depression. He referred him to see a local psychologist and to the Peel and Kwinana Adult Mental Health Services (Peel AMHS). At the time, Dr Price noted that Mr Lavars was on home detention bail with an ankle bracelet. Mr Lavars had been told by the Court he required psychiatric review and Dr Price considered Mr Lavars was quite depressed, noting he admitted to experiencing suicidal thoughts. Dr Price saw Mr Lavars four days later on 18 March 2022 and made some changes to Mr Lavars' medication, as well as ordering bloods to monitor his TTP.[21]

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[17] Exhibit 1, Tab 10.
[18] Exhibit 1, Tab 30.5.
[19] Exhibit 1, Tab 29.
[20] Exhibit 1, Tab 4, p.3 and Tab 32.
[21] Exhibit 1, Tab 29.

27. The GP referral to Peel AMHS led to Mr Lavars being reviewed by Dr Omar Hamad, a Senior Medical Officer with the Rockingham Kwinana Community Mental Health Service, on 28 March 2022. Dr Hamad noted that Mr Lavars was on home detention at the time of review and he was accompanied by his wife to the assessment. The interview lasted about 80 minutes. According to Dr Hamad, most of the interview involved Mr Lavars setting out his longstanding grievances against the police. Mr Lavars appeared to feel no remorse or contrition for any of his behaviours that had led to his offending and his narrative was essentially of him being "a victim of injustice and having no rights."[22] Dr Hamad noted this was consistent with Mr Lavars' history recounted to clinicians over the previous 10 years. Mr Lavars had threatened self-harm through hunger strikes and medication refusal and said he did not care if he lived or died. He also reported he had been consuming large volumes of spirits every day since being released from prison, even though he was aware of the risk of medical complications from alcohol use, including further strokes.[23]

28. Dr Ahmad observed Mr Lavars showed some difficulty in speech, as a consequence of his previous stroke in December 2020. Dr Hamad assessed Mr Lavars as a "cognitively rigid person"[24] who exhibited a disregard for laws and social conventions. He was angry about the response of police to his demands. He exhibited no insight into his own personality and no willingness to consider an alternative perspective to his own. At the time of this psychiatric assessment, Mr Lavars expressed no acute suicidal intent, but Dr Hamad assessed Mr Lavars as being at chronic risk of self-harm due to his antisocial personality disorder and his excessive alcohol consumption. Dr Hamad provided some supportive psychotherapy, validating Mr Lavars' suffering, but also explained to him the risks of his continuing with his current stance. Dr Hamad was satisfied Mr Lavars understood the implications and possible consequences, including possible paralysis and death, but it was his impression that Mr Lavars would choose to maintain his stance no matter how harmful it may be to him, "out of anger, resentment and a sense of being wronged."[25] Dr Hamad explained apologetically to Mrs Lavars that there was little that could be done by the Mental Health Service in those circumstances and he was discharged from the service on 4 April 2022.

29. On 17 May 2022, Mr Lavars' GP, Dr Price, made a note that he had spoken to Mr Lavars' lawyer and Mr Lavars had reportedly stated 'he will kill himself'. He also said he had throat cancer and his wife was going to take him to hospital.[26]

30. On 21 May 2022, Dr Price had a telehealth consultation with Mr Lavars, who was still in home detention and could not leave the house. There was a note that he needed a statutory declaration signed.[27]

31. In June 2022, Mr Lavars failed to attend Fiona Stanley Hospital and Fremantle Hospital for his scheduled heart surgery and an eye clinic review. It is unclear from

[22] Exhibit 3, p. 1.
[23] Exhibit 3.
[24] Exhibit 3, p. 1.
[25] Exhibit 3, p. 2.
[26] Exhibit 1, Tab 29, p. 3.
[27] Exhibit 1, Tab 29, p. 3.

the records whether this was due to his home detention conditions or if it was a choice made by Mr Lavars not to engage with further treatment.

32. The last notation in Mr Lavars' medical notes at his regular GP practice was made on 29 July 2022. A registered nurse recorded that a call had been received from a psychologist. The caller advised that Mr Lavars was 'pissed off with the world' and felt he was being ignored. It was noted a close friend of Mr Lavars had observed he was a very different person prior to his strokes. His mental state had been deteriorating significantly since his stroke in December 2020 and the psychologist thought Mr Lavars had likely suffered an organic personality disorder, with symptoms of paranoia, rigid thinking and an inability to let go of things that were troubling him.[28]

33. Mrs Lavars recalled that at this time she would have to leave her husband at home by himself all day while she went to work. He would sometimes do some gardening, but his stroke had significantly impacted on his health and he would often complain of not being able to think clearly or breathe very well. He also struggled to verbally express what he wanted to say and was losing his hearing. All of this would have been understandably frustrating and upsetting for Mr Lavars, exacerbating his already poor mental state.[29]

34. Adding to his frustration, Mr Lavars' wife recalled that his initial ankle monitor constantly lost signal to the rear of the house, which meant whenever he went out into the aviary he would receive a call from the security monitoring service checking on him. The ankle bracelet was eventually changed to a GPS based anklet to avoid that problem. Unfortunately, the new model brought with it a different problem; namely, it would beep repeatedly for a period, then stop for a while, before recommencing beeping again. Mrs Lavars recalled the beeping made Mr Lavars very anxious as he wasn't sure when it was going to beep. The beeping would also wake him up, causing him to experience disrupted sleep. She recalled Mr Lavars had asked the security company for help to stop the beeping, but they told him it was working normally.[30]

35. The week before Mr Lavars' death, he received a call from the security company at 1.00 am asking him where he was as they had received an alert from the monitoring device. Mr Lavars told the security officer he was at home. He was asked to go to the front door so they could check he was at home, but when Mr Lavars went to the front door there was no one there. The officer then established he had called the wrong phone number. Mr Lavars was understandably annoyed and reportedly swore at the officer before hanging up.[31]

36. I accept the issues with the ankle bracelet were causing Mr Lavars additional stress and this puts some context around the events leading to his death. He was tired, frustrated that his complaints about the device's functioning were not being listened

[28] Exhibit 1, Tab 29, pp.2 – 3.
[29] Exhibit 1, Tab 11.
[30] Exhibit 1, Tab 11.
[31] Exhibit 1, Tab 11.

to and due to his health and bail conditions he was unable to get out of the house and spent a lot of time on his own ruminating about his grievances.

37. An undated and unsigned document found on Mr Lavars' computer after his death sets out his thoughts on many of his frustrations relating to police and other government departments. It's clear his health, financial and legal issues were overwhelming him and he was in a poor mental state leading up to the final events.[32]

EVENTS LEADING UP TO 6 SEPTEMBER 2022

38. Mr Lavars had been on home detention bail for approximately six months when, in early September 2022, things escalated. Mr Lavars began to make threats to harm himself when interacting with Department of Justice (DOJ) Monitoring Team staff. He made reference to seeing a lawyer to prepare a will and then harming himself in the context of frustration about his alarm activating and beeping and vibrating.[33]

39. In the early hours of 3 September 2022, WA Police were notified that Mr Lavars had spoken to a member of the DOJ Electronic Monitoring team at approximately 2.30 am. During the conversation Mr Lavars had threatened suicide. It was noted his speech was slurred, which was thought possibly due to alcohol intoxication although it was also noted he had previously had a stroke. Mr Lavars also stated he was not taking his prescribed medications. Two police cars were dispatched to Mr Lavars' address, arriving at around 5.30 am. He was reportedly unhappy to see the police officers. They asked if he was okay and in response Mr Lavars asked them to leave. The police officers asked to speak to another family member, so Mr Lavars got his wife to come and talk to them. She explained that her husband had been having problems sleeping, which was causing him to be irritable. Mrs Lavars told the police officers she would keep an eye on him and did not raise any concerns about his mental health or indicate a need for ambulance or police attendance. The police officers had no ongoing concerns for Mr Lavars' welfare after speaking to his wife, so they left. It was understood that Mr Lavars would be meeting his DOJ case manager on 6 September 2022 to discuss compliance issues, re-iterate his bail conditions and canvas mental health supports.[34]

40. At 3.55 pm on 5 September 2022, a staff member from Rockingham Community Corrections rang WA Police to report some concerns in relation to Mr Lavars. The caller stated that he had spoken to Mr Lavars over the phone and, in the context that Mr Lavars was on home detention and was experiencing sleep deprivation, mental health issues and physical health issues, Mr Lavars had said he had "made his will"[35] and was sick of being on detention. Police officers went to the house, arriving at around 5.30 pm. They knocked on the door and when Mr Lavars opened it and saw the police, he swore and slammed the door. It was noted he was at home with his wife and two other people and was apparently in good spirits and cleaning the house.

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[32] Exhibit 1, Tab 10.
[33] Exhibit 1, Tab 2 and Tab 4, p. 12.
[34] Exhibit 1, Tab 2, Tab 4 and Tab 22.3 – 22.4.
[35] Exhibit 1, Tab 22.2, p.1 – 2.

Police held no welfare concerns for Mr Lavars at that time and noted that any further police action at that time was likely to aggravate him, so the officers left.[36]

41. At 11.40 pm on 5 September 2022, DOJ's Electronic Monitoring Unit received a tamper alert for Mr Lavars' ankle bracelet. They contacted Mr Lavars, who confirmed he had removed the device. Sureguard Security, who were contracted to assist with monitoring by Wilson Security on behalf of DOJ, were requested to send someone to the house.[37]

42. Wilson Security subcontracted some of these duties to Sureguard Security at that time. A security officer from Sureguard Security, Mr Bradley Knowles, received a call from the Wilson Security Operations Centre at 11.50 pm and was instructed to attend Mr Lavars' home in Shoalwater to respond to an alarm relating to his security equipment. Mr Knowles arrived at the house just after midnight. He was initially unable to raise anyone, so he notified the Operations Centre, who called Mr Lavars and told him to answer the door. When Mr Lavars answered the door, Mr Knowles introduced himself. Mr Lavars did not have his ankle monitor attached and he told Mr Knowles he had cut it off. He invited Mr Knowles inside and showed him where he had left it in the kitchen. Mr Lavars stated he had cut it off and disconnected it as it kept going off and waking him up in the night. He then handed it to Mr Knowles. Mr Knowles noted that Mr Lavars started to become agitated at this time, raising his voice and clenching his fists. Around the same time, Mr Knowles received a phone call from Wilson Security Control Operator Josh Green, who advised that Mr Lavars had some alerts associated with his name, including that he may be aggressive. Mr Knowles became concerned for his safety, so he kept the phone call open and placed the phone in his pocket, so Mr Green could listen to the conversation and send help if the situation escalated.[38]

43. Mr Knowles told Mr Lavars that he might need to come back during the night to conduct more checks, given he had removed the monitor. Mr Lavars said he didn't want Mr Knowles or other security staff coming to the door as they would disturb his son, so he took Mr Knowles outside and showed him his bedroom window. He asked Mr Knowles to knock on the window, to avoid waking up the rest of the family. Mr Knowles said he would try to come back later in the morning, so as not to disturb him too much.[39]

44. Mr Lavars then asked Mr Knowles if he was aware Mr Lavars had "written out his will"[40] and was "prepared to commit suicide."[41] Mr Knowles later noted he had said he would "commit suicide as he has had a stroke, has cancer and is done with living."[42] Mr Lavars also stated that "DOJ are going to be sorry if I commit suicide."[43] Mrs Lavars was not within hearing at the time these statements were made, as the two men were standing outside the house on the front lawn. Mr Lavars

[36] Exhibit 1, Tab 4 and Tab 22.2.
[37] Exhibit 1, Tab 4.
[38] T 8 – 9; Exhibit 1, Tab 12 and Tab 28.
[39] T 10; Exhibit 1, Tab 12 and Tab 28.
[40] Exhibit 1, Tab 12 [45].
[41] T 10.
[42] Exhibit 1, Tab 28.
[43] Exhibit 1, Tab 12 [48].

did not mention any plans for a particular way he intended to take his own life, but Mr Knowles took the threats seriously. He gave evidence that he tried to show empathy and keep Mr Lavars calm. He suggested to Mr Lavars that he shouldn't do anything for his wife's sake and then encouraged him to go inside.[44]

45. Relevant to later conversations with the police officers, Mr Lavars did not say to Mr Knowles that he required anyone to witness his will at that time. He simply mentioned that he had written his will in the context of being prepared to end his own life, without providing any detail about a particular method or plan.[45]

46. Mr Knowles took Mr Lavars' ankle monitor with him and returned to his car. He spoke to Mr Green, the control operator from Wilson Operations Centre, who had overheard the exchange. Mr Green indicated he would pass on the information about Mr Lavars' threat to harm himself to DOJ. Not long after, Mr Knowles received another telephone call and was told he was cleared to leave and the police would be notified and would attend Mr Lavars' address. Mr Knowles left the premises at 12.28 pm.[46]

47. Mrs Lavars later told police she had been awake during Mr Knowles' visit and she recalled that her husband's plan was to speak to someone from DOJ in the morning about the anklet. It seems she did not overhear any of his threats to harm himself.[47]

POLICE ATTENDANCE – 6 SEPTEMBER 2022

48. A DOJ electronic monitoring officer, Mr Frank Moloney, who was based at the Police State Operations Command Centre (SOCC), advised Senior Constable Mitchell Lewis at SOCC of Mr Lavars' threats at 12.54 am on 6 September 2022. Senior Constable Lewis recalls Mr Moloney advised a tamper alarm had been activated on Mr Lavars' monitoring bracelet and communication with Mr Lavars had confirmed he had removed the bracelet. Security staff had attended Mr Lavars' home and he had reportedly stated, "I will be using my will tonight,"[48] which was taken to mean that he was intending to self-harm. At that time, Mr Moloney had formed the impression Mr Lavars had then got in a vehicle and left the house, given the ankle monitor was seen to be moving, although soon after he established the security officer Mr Knowles had taken the device, which explained why it was moving.[49]

49. Senior Constable Lewis initiated a task on the police computer-aided dispatch (CAD) system. The WA Police Incident Report recorded the initial information that Mr Lavars was on home detention on thirty-six charges including endangering life and sell/supply and he was subject to home detention with electronic monitoring. After a tamper alert was received, DOJ security had attended the Shoalwater house and spoken to Mr Lavars, who confirmed he had removed the device. It was also

[44] T 10 – 11; Exhibit 1, Tab 12 and Tab 28.
[45] T 11.
[46] Exhibit 1, Tab 12 and Tab 28.
[47] Exhibit 1, Tab 11.
[48] Exhibit 1, Tab 17 [7].
[49] T 16 – 17. 24; Exhibit 1, Tab 17.

recorded that Mr Lavars had "advised his intent to self-harm"[50] before DOJ staff had left. A warrant was to be issued for Mr Lavars in relation to removing the monitoring device and police were requested to attempt to locate Mr Lavars and check on his welfare.[51]

50. Senior Constable Lewis was asked why he didn't put down the exact words, 'I will use my will tonight' in the task. He explained at the inquest that he was concerned the phrase was ambiguous (not knowing if he was referring to a physical will or more his will to do an act), so he wrote that Mr Lavars' had threatened to self-harm. In hindsight, the specific information about the will was relevant and Senior Constable Lewis gave evidence he would probably enter the exact words if a similar matter arose now, but at the time Senior Constable Lewis believed what he wrote in the task was clearer and more direct and focussed on Mr Lavars' threat to suicide.[52]

51. Senior Constable Lewis added a warning to the CAD task in highlighted text for officer safety, noting "SOCC all care LAVARS on bail for sending envelopes containing faeces to police & banks"[53] and added the Wilson Security Operations Centre number provided by Mr Moloney. Senior Constable Lewis was not aware of any previous threats to self-harm, so he did not add any information to that effect. His primary concern was to alert the attending officers to the potential risk to them, given Mr Lavars' hostile attitude towards police.[54] The CAD task was then dispatched by someone from the police communications area.

52. It was noted in the Incident Report that if attending police officers held any concerns in regard to the person's mental health, the Mental Health Emergency Response Line (MHERL) should be contacted for advice, either pre-attendance and or while in attendance at the scene. Senior Constable Lewis explained he did not contact MHERL on this occasion, which on reflection he thought was probably because there was some confusion initially as Mr Lavars' tracker was moving and then he was arrested soon after, rather than the focus remaining on a welfare check. It was also suggested that the DOJ Security officer should stay at the premises until police arrived if Mr Lavars was suicidal, but I understand Mr Knowles had already left by this time, so that was not an option.[55]

53. Also, on the WAPOL Incident Management System holdings were specific warnings in relation to Mr Lavars. There was a warning indicating he was not to be issued a firearm, dating back to 1996, and he was also rated as 'Very High' on the system for the following alerts:[56]

- Talk of Self-Harm,
- May Inflict Self Injury, and
- Caution – Suffers from Depression.

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[50] Exhibit 1, Tab 22, p.1.
[51] T 19; Exhibit 1, Tab 4 and Tab 22, p.1.
[52] T 21 – 23.
[53] Exhibit 1, Tab 17 [13].
[54] T 20 – 21.
[55] T 24 – 25; Exhibit 1, Tab 22, pp.1 – 2.
[56] Exhibit 1, Tab 4, p. 15.

54. There were notes on another police information system that Mr Lavars had, in the past, allegedly threatened to burn down the Rockingham Council with all of the staff inside, to 'deal with' his neighbours he believed had complained about him to the council and threats towards police.[57]

55. The Police Operations Centre dispatched the job to Rockingham Police vehicle callsign OR105. The police officers in the car were Police Constable Thomas Hood, Probationary Constable Erika Mischewski and Probationary Police Constable Blake Kennedy.[58] They had just been cleared after completing another welfare check that had taken them to Rockingham Hospital and were the only unit that was clear at the time, so they accepted the job.

56. All three officers were relatively junior police officers at the time. Constable Hood was the most experienced of the three, having been an officer for two and a half years. He had only come off probation about six months prior to this incident. Probationary Constable Kennedy had graduated from the academy four months prior and Probationary Constable Mischewski had been in the police service for just over one year.[59] I note Constable Hood had also previously worked in Corrections and served for many years in the Navy, so he had significant equivalent experience, even if he was relatively junior in terms of policing experience. That was evident in how he took charge and conducted himself on the night.[60]

57. In addition, evidence was led from a number of witnesses that a significant amount of the police attendances for the officers stationed at Rockingham Police Station at that time were for welfare checks, with estimates from 30% to 50% of the jobs each day being welfare checks. Many of them were for mental health reasons. Therefore, even Probationary Constable Kennedy, had completed many welfare checks at that time, although always in company with someone higher in rank than him, even if only with a constable such as Constable Hood.[61]

58. The attending officers were aware that Mr Lavars had made threats of self-harm and they were attending his home to conduct a welfare check, given the threats. They were not told specifically what comments were made, so they were unaware of the mention of a will as part of the threat. They also did not have an opportunity to view the CAD tasks for the jobs a few days' earlier. Constable Hood gave evidence he believed this information would have changed his approach on the night, providing a stronger sense Mr Lavars was making a genuine threat to harm himself. As it was, he simply took Mr Lavars at face value, and responded to how Mr Lavars presented to them on the night.[62]

59. The police car took approximately six to seven minutes to drive under Priority 2 conditions from the hospital to Mr Lavars' home, arriving at 1.01 am.

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[57] Exhibit 1, Tab 4.
[58] I note they have since changed rank, but I refer to them throughout as the ranks they were at the time of these events.
[59] Exhibit 1, Tab 4, Tab 15 and Tab 16.
[60] T 26 – 27, 58; Exhibit 4.
[61] T 53, 58 – 59.
[62] T 27 – 31, 33, 59.

Constable Hood then took the lead. Constable Hood activated his body worn camera (BWC), approached the front door and knocked, so all of the interactions with Mr Lavars were captured on BWC footage.[63]

60. Mr Lavars answered the door. When Constable Hood attempted to tell him why they were there, Mr Lavars replied, "Fuck Off" and tried to slam the door. Constable Hood managed to block it with his foot and hand and reopen the door. It was apparent Mr Lavars was agitated at the presence of the police at his home. Constable Hood told Mr Lavars they were there because DOJ had informed police that he had made threats to harm himself and did his best to calm the situation. He asked Mr Lavars if he was going to harm himself and Mr Lavars responded, "Not tonight."[64]

61. Constable Hood informed Mr Lavars that because he had removed his electronic monitoring device, a warrant would be issued and he was under arrest. Constable Hood asked Mr Lavars how he was feeling and queried whether he wanted to go to hospital for a health assessment. Mr Lavars declined and Constable Hood then told Mr Lavars he was under arrest and cautioned him. He informed Mr Lavars they would wait until the warrant paperwork came through, which Mr Lavars acknowledged.[65]

62. At about this point, Mr Lavars' wife joined them. Constable Hood referred again to Mr Lavars' threats to self-harm and Mrs Lavars confirmed they had been having trouble with the monitoring equipment. Mr Lavars stated the beeping was keeping up him, his wife and his son. Constable Hood acknowledged that they appeared frustrated and upset about the beeping. Constable Hood asked Mr Lavars if the DOJ had made any suggestions about the equipment, to which he replied, "No."[66] Mr Lavars said he intended to call up DOJ in the morning. Constable Hood responded that he would call DOJ now and try to figure out the situation. Constable Hood then left the house. I have watched the BWC footage and I accept Constable Hood was doing his best to be empathetic and to de-escalate the situation. As he left the house, he deactivated his BWC so he could make some calls.[67]

63. Constable Hood called VKI and asked for a contact for DOJ. He was given a number and tried to call it, but was unable to make contact with DOJ. He then rang VKI again and asked them to check if there would be a warrant for Mr Lavars to be actioned. They confirmed that this would occur.[68]

64. Probationary Constable Kennedy and Probationary Constable Mischewski remained with Mr Lavars while Constable Hood made the calls, and he began talking to them. Mr Lavars started to complain about the way he had been treated by police previously and seemed slightly agitated at the presence of the police at his home. Mr Lavars then raised an issue of some paperwork with them. They found it difficult

[63] T 28; Exhibit 1, Tab 14.
[64] Exhibit 1, Tab 14 [12] and Tab 16 [38].
[65] Exhibit 1, Tab 14.
[66] Exhibit 1, Tab 14 [25].
[67] T 31 – 32; Exhibit 1, Tab 14.
[68] Exhibit 1, Tab 14.

to understand what he was asking. While they were still discussing it and trying to clarify his request, Constable Hood reactivated his BWC and rejoined them.

65. Constable Hood advised Mr Lavars that he had confirmed that DOJ intended to pursue the matter and Mr Lavars would have to accompany police back to Rockingham Police Station. Constable Hood was apologetic but explained the police officers did not have any choice at that time as they were simply acting on behalf of DOJ. Constable Hood formed the impression Mr Lavars was accepting of the situation and the fact he would be going back into custody. Mr Lavars gestured to himself and his attire. Mr Lavars was in his pyjamas and dressing gown, so Constable Hood told Mr Lavars he would give him an opportunity to get changed before they left, acknowledging that it would not be fair to take him into custody in his nightclothes. Constable Hood's tone was apologetic and conciliatory, acknowledging the difficulty of the situation.[69]

66. Constable Hood gave evidence he had formed an opinion at that time that Mr Lavars was not a risk to himself or others at that point of time. He understood that Mr Lavars had been upset and frustrated due to the beeping of the monitoring device and so he did not think his risk of self-harm was still present. For that reason, he did not consider it necessary to call MHERL or the WAPOL mental health co-response team at that time.[70]

67. Probationary Constable Kennedy agreed in evidence that each officer conducted their own risk assessment, but they "were all on the same page that there was no risk at that time"[71] that Mr Lavars might harm himself. This was because Mr Lavars had explained his threats of self-harm had been connected with his frustration in relation to the ankle bracelet and its constant beeping. Probationary Constable Mischewski also felt Mr Lavars seemed calm and compliant by that time, and after saying that he would not hurt himself that night, she felt there was no immediate risk.[72]

68. The three officers followed Mr Lavars into the house, where they were joined by Mr Lavars. Mr and Mrs Lavars had apparently given instructions for wills to be drawn up some time before, but they had only received them back the day before. They explained they had planned to go in to the local courthouse and have them witnessed on 6 September 2022. Mrs Lavars recalled that because her husband wasn't sure when he would be released from custody, she asked the attending police officers if they would mind witnessing some paperwork for them, which was their two wills, before they left.[73]

69. Constable Hood recalled Mr Lavars mentioned the paperwork first when they were outside the house, and at that time he had dismissed it. However, inside the house it was Mrs Lavars who approached with the paperwork, and mentioned they had been planning to get it completed that day, which caused him to change his mind. Mrs Lavars produced a yellow envelope containing the paperwork. Both Mr and

[69] T 32; Exhibit 1, Tab 14 and Tab 16.
[70] T 33.
[71] T 60.
[72] T 75.
[73] Exhibit 1, Tab 11.

Mrs Lavars appeared calm and seemed happy that police would consider assisting them with witnessing the documents. Constable Hood was keen to ensure Mr Lavars voluntarily complied with going into custody, and it seemed that helping with the paperwork would assist. Constable Hood asked Mrs Lavars if she just needed a witness, which she confirmed. As a result, the officers began to assist with witnessing the wills of Mr Lavars and Mrs Lavars.[74]

70. After Mr Lavars had signed his will, he began to walk towards his bedroom. Constable Hood asked Probationary Constable Kennedy to follow Mr Lavars, reminding him that Mr Lavars was under arrest at this time. Probationary Constable Kennedy then followed Mr Lavars to the bedroom so he could get changed. The other police officers remained with Mrs Lavars, continuing to assist with signing the paperwork.[75]

71. All three police officers agreed that if they had known Mr Lavars' specific threat about using his will, it might have elevated the significance of the signing of the will in their minds. However, at the time it seemed reasonable that Mr and Mrs Lavars wanted it done before he went into custody.

72. I note from the BWC footage that Mr Lavars does appear calm and cooperative at that stage. The scene is a little chaotic given some of Mr Lavars' parrots are present in the house and squawking at times, but otherwise everything seemed reasonably calm.

73. Once Mr Lavars went out of the room, Constable Hood took the opportunity to ask Mrs Lavars if she believed Mr Lavars' comments about self-harm were because he was frustrated at the situation. She agreed. Constable Hood then continued to talk to Mrs Lavars while waiting for Mr Lavars to return.[76]

74. As Probationary Constable Kennedy and Mr Lavars walked towards the bedrooms, Mr Lavars asked to go to the toilet. He then walked into the bathroom and shut the door. Probationary Constable Kennedy did not open the door, but instead leaned against it to listen. He thought he could hear Mr Lavars using the toilet, although it was somewhat difficult to hear over a bird squawking in the kitchen. Mr Lavars then flushed the toilet and came out of the bathroom. He walked into the bedroom and got changed. Probationary Constable Kennedy stood in the doorway and kept watch while Mr Lavars dressed. Probationary Constable Kennedy reminded Mr Lavars to get socks and shoes, which he did, before they headed back towards the communal area. On reviewing the BWC footage, Probationary Constable Kennedy notes it appears Mr Lavars was holding something in his right hand by this time, which appeared to be a chewing gum wrapper.[77]

[74] T 34 – 35; Exhibit 1, Tab 14 and Tab 16.
[75] T 75; Exhibit 1, Tab 14 and Tab 16.
[76] Exhibit 1, Tab 14.
[77] Exhibit 1, Tab 15.

INGESTION OF THE PILLS

75. Mr Lavars re-entered the main lounge/common room with Probationary Constable Kennedy following. Mr Lavars had changed into some casual clothes. Mr Lavars then signed some more paperwork.

76. After signing the paperwork, Mr Lavars then walked into the kitchen and out of view. BWC footage shows Mr Lavars was not in the line of sight of any of the attending officers for a period of about 25 seconds. Probationary Constable Kennedy accepted at the inquest he should have followed Mr Lavars, and not let him move out of sight. However, at the time he believed Mr Lavars was not showing any indication he might harm himself.[78]

77. Constable Hood called out to Mr Lavars to ask him whether he needed to bring any medication with him, and shortly after there is a loud crash that seemed to come from the pantry where Mr Lavars had walked. Probationary Constable Kennedy then walked into the kitchen and Mr Lavars came back into view. He could see Mr Lavars standing in the laundry, with his back to the kitchen. It appeared he was holding something in his left hand, which Probationary Constable Kennedy assumed was medication. Mr Lavars then walked to the fridge and took out some orange juice, before pouring himself a glass. Mr Lavars began drinking the juice and Probationary Constable Kennedy asked him if he was on any medication. Mr Lavars responded that he had not taken any medication for six months as the police had it. Probationary Constable Kennedy then asked him what he was holding in his left hand? Mr Lavars began to talk. Probationary Constable Kennedy found his answer hard to understand, but eventually established that Mr Lavars was saying "lolly."[79]

78. Constable Hood's focus had primarily been on Mrs Lavars and helping to complete the paperwork, although he did briefly look over at Mr Lavars when he was pouring a glass of orange juice, as can be seen on his BWC footage. The other officer was also assisting to sign Mrs Lavars' paperwork. Constable Hood then walked over and joined Probationary Constable Kennedy and Mr Lavars in the kitchen. As he approached, Constable Hood saw Mr Lavars take a sip of orange juice and Constable Hood then told Mr Lavars he couldn't take anything. Mr Lavars responded that it was a "vitamin lolly"[80] or "lollies."[81] Mr Lavars showed Probationary Constable Kennedy two brown circular items in his left hand, then showed him the gum wrapper in his other hand. Constable Hood looked away briefly, and as he looked back at Mr Lavars, he saw Mr Lavars put the items held in his left hand into his mouth and took a drink of orange juice, followed by a visible swallowing motion.[82]

79. Probationary Constable Kennedy gave evidence there was a split second when he could have grabbed the items from Mr Lavars' hand, but it didn't occur to him in the

[78] T 62; Exhibit 1, Tab 2.
[79] T 63; Exhibit 1, Tab 15 [103].
[80] Exhibit 1, Tab 16 [58].
[81] Exhibit 1, Tab 14 [52].
[82] T 37 - 38; Exhibit 1, Tab 14 and Tab 15.

moment.[83] Constable Hood agreed in his evidence at the inquest that the officers should have taken more steps to prevent Mr Lavars consuming anything, including orange juice, as per general policy. A glass of water from a tap would be allowed, but anything else presented a risk. However, Mr Lavars' demeanour at the time had reassured them that he was unlikely to harm himself and so they had made a judgment call on the night. When they saw him swallow what appeared to be tablets, the level of concern increased, but everything seemed to suggest whatever he had taken was not harmful.[84]

80. Constable Hood immediately asked Mr Lavars in a firm tone what he had just taken. In response Mr Lavars just continued to swallow down the pills. Constable Hood asked Mr Lavars if they needed to take him to hospital. Mr Lavars shook his head in response and seemed very calm in his demeanour as he finished the glass of orange juice and put it in the sink.[85]

81. Constable Hood went to where Mrs Lavars was still signing paperwork and she appeared calm and did not give any indication that something was amiss. In her statement, Mrs Lavars recalled hearing a police officer ask her husband what he had taken. She had seen him drinking orange juice and assumed, like the officers, he must have taken some medication. She did not know what it was as she had understood he had not been taking any of his prescription medications for at least a year, but Mrs Lavars did not suspect her husband had deliberately taken a poisonous substance.[86]

82. Constable Hood returned to the kitchen and he and Probationary Constable Kennedy checked the kitchen bench and the laundry for any medication packets that might give some indication as to what Mr Lavars had taken. They did not find anything that matched the tablets they had seen in Mr Lavars' left hand. They observed Mr Lavars and his wife both remained calm and Mr Lavars continued to sign more of the paperwork. He then went and sat on the couch so he could put on his shoes, preparing to leave. This reassured the officers as Mr Lavars seemed calm and collected and showed no sign of becoming unwell.[87]

83. Constable Hood can be seen checking his phone. Constable Hood then left the house and called Acting Sergeant Dominic Walsh (A/Sgt Walsh) to discuss where they should take Mr Lavars. Due to staffing levels, it was arranged that they should return to the police station so another vehicle could be organised for the conveyance.[88]

84. Acting Sergeant Walsh was working in a supervisory capacity as the acting Sergeant at Rockingham Police Station that evening and he became aware the Rockingham police vehicle had been dispatched to Mr Lavars' house in Shoalwater under priority conditions to complete a welfare check, in response to the information provided by DOJ. While reviewing the CAD Job, A/Sgt Walsh also became aware the DOJ were

[83] T 64.
[84] T 49 – 50.
[85] T 37 – 38; Exhibit 1, Tab 14 and Tab 15.
[86] Exhibit 1, Tab 11.
[87] T 37 – 38; Exhibit 1, Tab 14.
[88] Exhibit 1, Tab 14.

in the process of issuing an arrest warrant for Mr Lavars. He then received a call from Constable Hood advising him that he had arrested Mr Lavars. Due to staffing levels, Constable Hood and A/Sgt Walsh agreed it would be more beneficial for the car to return to the Rockingham Police Station.

85. Constable Hood returned inside and informed Mr Lavars it was time to go. He hugged his wife and they had a brief conversation before Mr Lavars left the house with police. As the police were taking Mr Lavars away, his wife heard them ask him one more time what he had taken but she didn't hear his response. She was aware he was stressed about being taken into custody and she knew he had been experiencing recent heart issues and problems breathing. He had also threatened to kill himself on more than one occasion, which had led to the recent regular police attendances. She did not recall him mentioning a particular method that he would use. Before Mr Lavars left, he had turned to his wife and asked her to look after the birds. She didn't pay much attention at the time as she thought it was an ordinary request and didn't interpret it indicating he wouldn't be coming back.[89]

86. As they went to the police car, Constable Hood asked Mr Lavars again about the pills he had taken inside the house. Constable Hood told Mr Lavars he was concerned about Mr Lavars ingesting an unknown item in conjunction with the fact he had asked them to witness his power of attorney forms (referencing the will). Mr Lavars declined to provide any further information, so Constable Hood advised him they would take him to hospital for assessment. Mr Lavars was prompted by this statement to volunteer that the pill was, "It was basically something to relieve the pain."[90] Constable Hood responded that they would still need to take him to hospital if that was the case. In response, Mr Lavars clarified that they were tablets for reflux. Constable Hood clarified that they were indigestion tablets, and Mr Lavars agreed. Mr Lavars then got into the rear pod of the police vehicle.[91]

87. Given Mr Lavars' response, and noting both Mr Lavars and his wife remained composed and Mr Lavars did not appear unwell, Constable Hood felt reassured and believed Mr Lavars had not taken something harmful. However, it quickly became apparent this was not the case.[92]

RETURN TO THE POLICE STATION

88. As they began the drive back to Rockingham Police Station, the police officers discussed how many tablets Mr Lavars had taken, and agreed it was possibly three or four of them. About halfway through the journey, Mr Lavars began to appear drowsy. When they were a couple of minutes from the station, Mr Lavars was then seen on the camera to vomit. They had a brief conversation about whether to divert and go to the hospital, but they were not far from the station by this time and Mr Lavars was under arrest, so they made a joint decision to continue to the police station where there was first aid equipment and it was a controlled environment. At

[89] Exhibit 1, Tab 11 and Tab 16.
[90] Exhibit 1, Tab 14 [67].
[91] Exhibit 1, Tab 14.
[92] Exhibit 1, Tab 14.

that stage, they weren't clear if his change in condition was due to what he had ingested or something else. The police car arrived back at the station at about 1.40 am, after an approximately eight minute drive.[93]

89. Acting Sergeant Walsh was acting as the Sergeant on duty at that time, but Sergeant Charles Hutton (Sgt Hutton) was also present as he had been requested to stay on past his shift and assist A/Sgt Walsh due to staff shortages. In terms of overall supervision, Sgt Hutton was therefore the 'ranking' supervisor at the station at that time, but he was primarily there to provide support and advice to A/Sgt Walsh as the Officer in Charge of the station at the time, and would only assume control if a large or significant incident occurred. It was intended that Sgt Hutton would reassess the level of demand at around 3.00 am, and if the rostered staff who were present could manage, then he would go home.[94]

90. Acting Sergeant Walsh recalled that shortly after the police vehicle arrived back at the station, Constable Hood came into the sergeant's office and advised him and Sgt Hutton that Mr Lavars had ingested approximately three pills of an unknown substance. Mr Lavars had said they were indigestion pills but he had now vomited. Sergeant Hutton recalled his immediate assumption was that the pills had caused his illness, despite Mr Lavars' claim they were only for indigestion.[95]

91. Sergeant Hutton and Constable Hood went to the sally port area, where Mr Lavars could be seen sitting in the pod of the police vehicle. Mr Lavars was sitting upright but he appeared drowsy and unwell. He was grey in colour and sweating and he was refusing to answer questions about what he had taken. There was visible vomit next to him. Acting Sergeant Walsh rang St John Ambulance (SJA) on their emergency number and asked them to attend the police station Priority 1 to provide emergency care to Mr Lavars. Constable Hood also radioed VKI to inform them of the situation and Probationary Constable Kennedy rang Mr Lavars' wife to try to get more information about what Mr Lavars had ingested and to advise her that her husband was unwell. She could not assist with identifying the substance.[96]

92. Sergeant Hutton spoke to Mr Lavars while they were waiting for the ambulance to arrive. He asked Mr Lavars what pills he had taken and tried to build a rapport with him, explaining the police were extremely concerned for him and an ambulance was on its way. At one stage Sgt Hutton placed his hand on Mr Lavars to prevent him falling out of the vehicle, and as he did so Mr Lavars lashed out at his arm. Mr Lavars did not engage with Sgt Hutton's questions, other than to swear at him when asked about what he had taken, and Mr Lavars was then seen to vomit again.[97]

93. St John Ambulance had received the call at 1.47 am and they arrived at the scene at 1.56 am. Acting Sergeant Walsh had waited at the back entrance to the station to allow the SJA crew quick access. On their arrival, Mr Lavars was still sitting in a police vehicle pod. He was breathing fast, had a slow pulse and low blood pressure.

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[93] T 40, 64 – 65; Exhibit 1, Tab 13 and Tab 15.
[94] T 83; Exhibit 1, Tab 18.
[95] T 89 – 90; Exhibit 1, Tabs 13 to 16.
[96] T 89; Exhibit 1, Tabs 13 to 16.
[97] T 90 – 91; Exhibit 1, Tab 18.

He was also noted to be sweating and his head and chest were cyanotic. It was apparent he had vomited and soiled himself and his abdomen was distended. The first set of observations taken at 2.10 am were very abnormal and indicated Mr Lavars was in peri-arrest. The SJA assessment was that it was possible Mr Lavars had ingested rat poison (organophosphate poison) or else it was a possible polypharmacy overdose. The paramedics initiated emergency treatment and transferred Mr Lavars as a Priority 1 to hospital with a police escort. Due to the hospital transfer, the warrant from DOJ was never executed on Mr Lavars.[98]

94. Mr Lavars arrived at Rockingham General Hospital at 2.32 am. The suspicion about possible organophosphate toxicity had been relayed to the ED staff and all staff treating Mr Lavars donned personal protective equipment. Mr Lavars was haemodynamically unstable on arrival and he was intubated soon after his arrival. Post intubation Mr Lavars went into ventricular fibrillation arrest and at 2.35 am, CPR was commenced. Ambulance staff assisted with compressions. Three shocks were administered, along with doses of adrenaline, and advice was sought from a toxicology service that large amounts of atropine may be required, so that was sought. As it was suspected that Mr Lavars' cardiac arrest was toxicological, CPR was continued for over an hour, before it was decided, in consultation with Mr Lavars' wife and son, that all resuscitation efforts should be ceased. Resuscitation was ceased and Mr Lavars' death was confirmed at 3.53 am.[99]

CAUSE AND MANNER OF DEATH

95. A post mortem examination was performed by Forensic Pathologists Dr Daniel Moss and Dr Leana Downs on 8 September 2022. The initial examination found no significant injury. The heart was enlarged (cardiomegaly) and the arteries were hardened and narrowed (coronary artery atherosclerosis) The previously identified patent foramen ovale, being the cardiac issue, that Mr Lavars had been scheduled to have surgery to repair, was also present. Large fragments of plant material were found in the gastric content, which prompted further investigation into the type of plant material, although this was later felt not to be relevant to the cause of death.[100]

96. Microscopic examination of the major body tissues confirmed the above findings and also found widespread granulomatous inflammation in the lungs and changes of high blood pressure in the kidneys.[101]

97. Specialist neuropathology examination of the brain reported an old stroke in the left frontal lobe.[102]

98. Toxicology analysis detected the presence of several medications in keeping with resuscitation attempts. Carbon monoxide was detected at less than 5% saturation. Significantly, phosphine was detected in the gastric content with three different

[98] Exhibit 1, Tab 14, Tab 15 and Tab 25.
[99] Exhibit 1, Tabs 23 to 25.
[100] Exhibit 1, Tab 7.
[101] Exhibit 1, Tab 7.
[102] Exhibit 1, Tab 7 and Tab 9.

techniques; however, the laboratory does not have a validated method for the detection of phosphine in blood, so it could not be tested for in the blood samples.[103]

99. An initial search of Mr Lavars' home did not identify any clear source of poison that he might have consumed. However, after the initial toxicology analysis was performed, police offenders re-attended Mr Lavars' home on 21 November 2021 and located a cannister of Fate Fumigation Tablets in a filing cabinet adjacent to the laundry area. Each tablet weighs 3 grams and yields 1 ram of phosphine from 1.7 grams of aluminium phosphide. The tablets were similar in appearance to the tablets observed in Mr Lavars' hand prior to him ingesting them. Enquiries established Mr Lavars had purchased the tablets from a stockfeeds store in September 2019, two years prior to his death, presumably for use around his property.[104]

100. Aluminium phosphide is a highly toxic pesticide with a high mortality rate if ingested. Aluminium phosphide reacts rapidly with water to release the highly volatile gas phosphine. In this case, when Mr Lavars swallowed the tablets, they would have come into contact with the juice he swallowed as well as with fluid in his gastrointestinal system, initiating the chemical reaction. Aluminium phosphide toxicity is associated with cardiovascular collapse with hypotensive shock and cardiac arrhythmias. The forensic pathologists observed the presence of background atherosclerotic cardiovascular disease, which would have made Mr Lavars more susceptible to the cardiovascular toxic effects of aluminium phosphide.[105]

101. Dr Moss and Dr Downs formed the opinion the cause of death was consistent with phosphine toxicity in a man with atherosclerotic heart disease.[106]

102. Considered within the context of all of the information before me, I find the cause of death was phosphine toxicity in a man with atherosclerotic heart disease.

EXPERT EVIDENCE OF PROFESSOR JOYCE

103. Professor David Joyce is a Physician and Clinical Pharmacologist and Toxicologist. Professor Joyce regularly provides expert opinions to this Court within his area of expertise. In this case, Professor Joyce provided a report examining the relationship between toxin exposure and death, notably the phosphine, and whether different handling of the circumstances could have avoided a lethal outcome from the poisoning.[107]

104. Professor Joyce noted the WA Police located Apparent Fate Fumigation Tablets, containing aluminium phosphide, in Mr Lavars' home in a location where he could have readily accessed them on the night. The evidence pointed to these tablets being the source of the phosphine.[108]

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[103] Exhibit 1, Tab 7 and Tab 8.
[104] Exhibit 1, Tab 4, Tab 7 and Tab 19.
[105] Exhibit 1, Tab 7.
[106] Exhibit 1, Tab 7.
[107] Exhibit 1, Tab 19.1.
[108] T 118; Exhibit 1, Tab 19.1.

105. Professor Joyce explained in his report that phosphine poisoning can occur through inhalation of phosphine gas or through generation of phosphine in the gut from ingested aluminium phosphide. Professor Joyce observed that "the stomach content is a particularly conducive environment for the transformation of aluminium phosphide into phosphine."[109]

106. The early signs of severe aluminium phosphide poisoning include abdominal pain and vomiting, circulatory failure with low blood pressure and pulmonary oedema and a range of cardiac arrhythmias that may be inconsistent with life. The clinical observation made by police and ambulance officers of Mr Lavars would, therefore, be explained by the evolving stages of phosphine poisoning from the ingested aluminium phosphide into his stomach. The 'cyanosed' colouration described by the ambulance officers is likely to have actually represented methaemoglobinaemia, a recognised consequence of aluminium phosphide poisoning. This was evident in the laboratory tests done at Rockingham Hospital.[110]

107. In Professor Joyce's expert opinion, the clinical course, the rapidly worsening methaemoglobinaemia, the post-mortem examination findings and the detection of phosphine in stomach contents are sufficient for a confident diagnosis of aluminium phosphide poisoning, consistent with the findings of Dr Moss and Dr Downs. Professor Joyce also agreed that it is reasonable to propose that Mr Lavars was compromised in his ability to survive phosphine poisoning because of his pre-existing cardiac disease.[111]

108. In any event, the apparent dose of aluminium phosphide Mr Lavars consumed exceeded the amounts that are generally regarded as lethal in individuals who have no underlying cardiac disease. Survival would not have been expected after ingestion of two or more tablets, and the evidence points to Mr Lavars having consumed at least two, and likely more, tablets. The fast onset with which Mr Lavars progressed from ingestion at 1.22 am to objective evidence of poisoning only 12 to 14 minutes later, and thence to life-threatening toxicity by the time of the first ambulance observations at 2.10 am, also points to a dose that was likely unsurvivable. In addition, Mr Lavars had pre-existing cardiac disease and so he would have been more sensitive to any poison that targets the heart.[112]

109. Professor Joyce gave consideration to whether earlier presentation to hospital might have allowed treatment that would have prevented progression to this stage. He noted treatment recommendations emphasise support for whatever cardiac function remains, although these measures cannot be sufficient where ongoing phosphine generation in the gut continues to reinforce the poisoning, so removing aluminium phosphide from the gut (such as stomach pumping) or administering chemicals that may limit the phosphine reaction would have been necessary.[113] However, such measures may potentially carry their own risks and are not considered very likely to

[109] T 119.
[110] T 119; Exhibit 1, Tab 19.1.
[111] Exhibit 1, Tab 19.1.
[112] T 119 – 120; Exhibit 1, Tab 19.1.
[113] T 121.

improve survival. Professor Joyce noted the "literature does not seem to include instances of survival in patients who have taken doses high enough to bring them to lethal cardiovascular collapse in hardly more than an hour."[114] Most of the literature would support possible benefit from various treatment options in the case of a marginal dose, but even then it would be fairly hopeful. As most documented "attempts to remove aluminium phosphide from the gut have met with wither no success or almost no success."[115]

110. Professor Joyce noted some plant material was recovered from the gastric contents. He had not been informed of the botanical identification of the plant material when preparing his report, and noted it could potentially have been a toxic plant; however, there wasn't anything in the clinical course or outcome that revealed a role for poisons other than the aluminium phosphide.[116]

111. Professor Joyce observed that Mr Lavars ingested a dose of aluminium phosphide that a healthy person would not be expected to survive and given Mr Lavars had a cardiac condition, that further compromised his chances of surviving a poison that targets the heart. Although there is a theoretical possibility that he might have survived if gut decontamination had been instituted within minutes of ingestion, followed by intensive cardiopulmonary support, even then the chance of benefit was low and the literature does not provide examples to support this.[117]

112. In conclusion, Professor Joyce expressed the opinion it is "very unlikely that Mr Lavars was going to survive the dose of aluminium phosphide that he took, even if he had arrived at hospital within minutes of the ingestion."[118] For a start, it would have required anyone treating him to immediately know the identity of the poison, which was unknown at that early stage. By the time he had been seen by ambulance officers, there were some signs to suspect organophosphate poisoning, but aluminium phosphide poisoning is rare in Australia and would not have been considered likely at that stage.[119]

113. Professor Joyce's opinion was sought on whether there was any likelihood of Mr Lavars harming others after ingesting the phosphine, noting he was in the company of his wife, police officers and ambulance officers for some period before SJA officers donned personal protective equipment (PPE), once they had briefly assessed him and recognised the risk that he had ingested a potentially toxic substance. At the hospital, health staff also donned (PPE) to minimise any risk of exposure, so it was primarily the police officers who were most exposed to potential harm. Professor Joyce observed that the likelihood others might be harmed "depended mostly on the amount of phosphine that was released into the air, the volume of air that received the released phosphine (that is, whether it was outdoors or in a small enclosure) and the time that police and medical staff spent breathing

[114] Exhibit 1, Tab 19.1 [17].
[115] T 122.
[116] T 124; Exhibit 1, Tab 19.1.
[117] Exhibit 1, Tab 19.1.
[118] Exhibit 1, Tab 19.1 [22].
[119] T 123 - 126.

that air."[120] There is also some small chance of transfer across the skin. In those circumstances, Professor Joyce identified a risk to others that would have prompted a need for personal protective equipment if it had been known that Mr Lavars had ingested aluminium phosphide, but it is impossible to quantify the level of that risk.[121] There is no evidence to suggest that in the end anyone other than Mr Lavars suffered any ill effects from exposure to phosphine.

HOMICIDE SQUAD AND IAU INVESTIGATIONS

114. Given the circumstances leading up to Mr Lavars' death occurred while he was in police custody, a joint response was coordinated between Major Crime Division (Homicide Squad) and Internal Affairs Unit (IAU) for the investigation into his death, as per WA Police policy. The investigation including taking officer and witness accounts, forensic examination, investigative scene examination, review of CCTV and BWC, input from the post-mortem examination, and wider consideration of any intelligence holdings, mental health history and criminal history.[122]

115. It was noted that the interactions between police and Mr Lavars at his home were captured on BWC and upon his arrival at Rockingham Police Station, the interactions were visually captured from within the sally port on CCTV footage (although there is no audio for the CCTV). All of the BWC recordings were viewed by Homicide Squad investigators soon after the incident and the initial accounts provided by the involved officers were corroborated by the BWC footage. The initial assessment by the Homicide investigators found there was no apparent criminality or suggestion of unlawful conduct by the officers. It was noted that the actions of the attending police at and immediately following their attendance was in accord with s 30 and s 31 of the *Criminal Code*, in that they were acting lawfully to enforce the pending warrant and hold Mr Lavars in custody during this period.[123]

116. As for the decision of the police to allow Mr Lavars a certain amount of freedom in the home, it was noted that it was possibly due to the inexperience of the three officers present, as well as the generally compliant manner of Mr Lavars once his initial aggression had dissipated. The deliberate deceit of Mr Lavars as to what he had taken was also noted, and in that sense it was considered there was no evidence to support a charge under s 262 or s 304 of the *Criminal Code*.[124]

117. On 6 September 2022, after Mr Lavars' death at the hospital, Forensic Field Operations officers attended Mr Lavars' home in Shoalwater and a forensic examination was also conducted on Mr Lavars' body at the hospital. Several items were seized from the home for analysis, with a focus on plant material and tablets given that plant material was seen in Mr Lavars' vomit and he was believed to have ingested tablets that had led to poisoning. During the initial forensic examination, no plants or drugs were identified that were felt could account for the death.[125]

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[120] Exhibit 1, Tab 19.3.
[121] Exhibit 1, Tab 19.3.
[122] Exhibit 1, Tab 2 and Tab 3.
[123] Exhibit 1, Tab 2, Tab 3 and Tab 4.
[124] Exhibit 1, Tab 2 and Tab 3.
[125] Exhibit 1, Tab 2 and Tab 3.

118. Following the interim toxicology report being issued on 18 October 2022, forensic officers and Homicide Squad investigators returned to Mr Lavars' home in Shoalwater and undertook an examination of the plant material at the property. Some plants commonly known as *Black Nightshade* were located and samples were seized, but these samples were subsequently ruled out as being a match to the leafy materials in Mr Lavars' stomach.[126] The leaf material was ultimately not identified.[127]

119. As for the tablets, as noted above, two cannisters were located in the top drawer of the cabinet adjacent to the laundry area, which contained 'Apparent Fate Fumigation Tablets'. The tablets are an insecticide containing aluminium phosphide. Enquiries established Mr Lavars had purchased the tablets at a stockfeed store on 11 September 2019. It is believed these were the source of the aluminium phosphine that caused his death.[128]

120. The IAU investigation was led by Detective Senior Sergeant Craig Annesley. The materials gathered by the Homicide Squad investigators were considered as part of the IAU investigation, along with managerial interviews conducted with some of the police officers involved. All of the officers provided frank and honest accounts of their thoughts and actions on the night, which were broadly supported by the objective evidence available from the BWC footage and the CCTV footage. The focus of the IAU investigation was whether the actions of any of the officers involved in Mr Lavars on the evening in question failed to comply with Western Australia Police Force policy and the Code of Conduct.[129]

121. Constable Hood confirmed during the investigation he understood the primary purpose of the police attendance at Mr Lavars' house that night was to conduct a welfare check, and then to effect the arrest warrant. His initial impression had been that Mr Lavars was hostile towards the police, but it then became apparent he was agitated and irritable due to the beeping of the monitoring device and his manner towards police seemed to improve. Constable Hood also noted Mr Lavars' wife appeared to be a calming influence on him.[130]

122. Constable Hood agreed that he had thought the request to sign the wills was a little odd, but it hadn't significantly raised his level of concern as Mrs Lavars was involved and she did not appear to be concerned about it. Constable Hood had seen no need to use handcuffs on Mr Lavars, as it would have been an excessive use of force in the circumstances given he was compliant. The signing of the documents and allowing Mr Lavars an opportunity to change was all intended to ensure his voluntary compliance with his arrest.[131]

123. After it became apparent Mr Lavars had ingested something, Constable Hood looked for any medications in the area as he was aware people often self-harm in that

[126] Exhibit 1, Tab 2 and Tab 3.
[127] Exhibit 1, Tab 2, pp.16 – 17 and Tab 4.
[128] Exhibit 1, Tab 2, pp.16 – 17 and Tab 4.
[129] Exhibit 1, Tab 2.
[130] Exhibit 1, Tab 4.
[131] Exhibit 1, Tab 4.

manner, but he found none. He also saw nothing else obvious that Mr Lavars might have taken to harm himself, which is consistent with the insecticide tablets being out of sight in the cabinet. Constable Hood agreed that in hindsight it would have been opportune to inform A/Sgt Walsh that Mr Lavars had ingested an unknown substance when he spoke to him before returning to the station, but there was nothing that seemed to suggest Mr Lavars had suffered any harm at that time. It was only during the car journey that Mr Lavars' condition rapidly declined. Constable Hood then spoke to Sgt Hutton, who told the officers to continue on to the station. Even so, Constable Hood stated that if he had thought Mr Lavars was in a life-threatening state, he would have taken him to the hospital despite this instruction.[132]

124. Constable Hood told the IAU investigators that since these events he has learned to keep a closer eye on any person in police presence, especially if it's a welfare check, and is more likely to limit their freedom of movement and search them if there are any doubts about their personal safety. He accepted that in hindsight, it seems Mr Lavars did have a plan to harm himself, but he hadn't shared it with his wife, which is why Mrs Lavars did not appear overtly concerned on the night.[133]

125. Probationary Constable Mischewski looked to Constable Hood as the senior officer in the vehicle that night, but she also felt reassured at the time by Mr and Mrs Lavars' calm and compliant behaviour. She didn't recall holding any active concern that Mr Lavars might self-harm when they first arrived, and she saw no change in his demeanour when he was informed he would be arrested that might have changed the level of risk. She also saw no change in his physical appearance after taking the tablets, so although they were all a little concerned that it may not have been simply vitamins or lollies he had taken, there was nothing to suggest he had suffered any ill effect. When he became unwell on the way to the station, it did not cross her mind to go straight to the hospital as they weren't far from the station and they could call an ambulance from there, if required.[134]

126. Probationary Constable Kennedy, as the most junior of the group, looked to Constable Hood and Probationary Constable Mischewski for guidance on the night if he was unsure about anything, and in particular Constable Hood. His perception, like the other officers, was that Mr Lavars quickly calmed down after the police arrival and there was nothing to suggest the need to get mental health advice or assistance. He followed Mr Lavars to the toilet that night and then to the bedroom and watched him get changed, but made sure that he pointed his BWC in a direction that avoided this being recorded for Mr Lavars' privacy. When Mr Lavars moved out of view in the kitchen, he hadn't realised it was for the length of 25 seconds, and recalled he soon moved so Mr Lavars was back in view. He saw Mr Lavars take the tablets, but it happened so quickly he wasn't able to prevent it. He helped question Mr Lavars about what he'd taken and wanted to believe it was lollies, as suggested by Mr Lavars, although he remained concerned from that time that they might be wrong. His concern that it might be something else played on his mind from that time, but he didn't raise it with the other officers.

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[132] Exhibit 1, Tab 4.
[133] Exhibit 1, Tab 4.
[134] Exhibit 1, Tab 4.

127. When Mr Lavars became unwell, Probationary Constable Kennedy recalled they all discussed whether they should take Mr Lavars straight to the hospital, but decided to go to the station as there were senior officers there to assist. When they opened the pod, it quickly became clear how unwell Mr Lavars had become, which led to the ambulance being called.[135]

128. All three police officers agreed that Mr Lavars had been agitated when they first arrived and his speech was somewhat disjointed, but they understood that his speech issues were due to his stroke. When asked if he intended to harm himself, he responded "Not tonight,"[136] which they took as reassuring. All three officers were aware they could seek information and guidance from the Mental Health Emergency Response Line (MHERL), but they did not believe the situation required it as they did not perceive he was a threat to himself or others at the time they were engaged with him. There was also limited time to do so, given the journey was very short. The IAU investigators concluded the three officers did not fail to conduct an appropriate mental health assessment of Mr Lavars. Rather, they did assess his mental health and genuinely believed he was not a threat to himself at the time until after he took the tablets.[137]

129. At the conclusion of the IAU investigation, it was determined that the three relatively junior police officers who attended Mr Lavars' house breached WA Police procedure and policy by failing to search Mr Lavars for security risk items and did not demonstrate an appropriate level of vigilance to prevent Mr Lavars from suffering illness, injury or death while a person in custody. The officers were issued with managerial notices as a result. These are designed to be educational and change officers' behaviour, and Det S/Sgt Annesley explained they are "not considered to be a sanction,"[138] unlike other options in the hierarchy of outcomes available. It was noted that the lack of vigilance and situational awareness had led to a risk to the other people present at the home and the officers themselves, not just to Mr Lavars, which is a reason to reinforce the need to follow police policy to search a person in custody and maintain control of that individual, while also continually conducting a risk assessment. Other than the managerial notices delivered to the three attending officers by the superintendent of their local district as part of the education process, no further action was taken.[139]

130. Following his evidence at the inquest, Det Sen Sgt Annesley interrogated the WA Police Force complaints management system to check whether there was any evidence to suggest any patterns of a lapse of vigilance by police in the course of welfare checks. The search did not identify any patterns that might suggest a systemic issue that would require consideration by this Court.[140]

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[135] Exhibit 1, Tab 4.
[136] Exhibit 1, Tab 4, p. 37.
[137] Exhibit 1, Tab 4.
[138] T 93.
[139] T 99 – 101, 105 - 110; Exhibit 1, Tab 4.
[140] Exhibit 1, Tab 2.

FAMILY RESPONSE

131. Mr Lavars' son, Steven McDonald, spoke at the inquest on behalf of his mother and other family members. Mr McDonald generously extended his empathy and sorrow to the security contractor and three police officers who were assigned to this case, and did not seek to cast blame on any individual for his father's tragic death. Instead, Mr McDonald focussed upon what he described as a "cultural inadequacy within the Western Australian Police Force."[141]

132. Mr McDonald stated that he had informed WA Police in the past of his father's expressed intention to take his own life rather than go into custody. In that context, Mr McDonald expressed concern that the relatively junior attending officers described limited mental health training and also a lack of available information to them of Mr Lavars' complex history at the time of their attendance. The conclusion of the IAU investigation that there was a lack of effective control of Mr Lavars after his arrest, which allowed him to access and ingest the poison that led to his death, along with a failure to request an ambulance immediately after that had occurred, was an understandable source of concern for Mr McDonald and his family and he expressed the hope that the lessons learned will be taken on board by the agency as a whole, rather than simply the few junior officers who were directly involved.[142]

COMMENTS ON SUPERVISION, TREATMENT AND CARE

133. It was generally accepted that there was a lapse in supervision and vigilance at key moments on the night, which created an opportunity for Mr Lavars to obtain the aluminium phosphide tablets and consume them in the presence of the police officers, which rapidly led to his death. If Mr Lavars had been prevented from accessing the tablets, then it follows he would not have died in that manner on the night, so this was an important omission.

134. All of the officers involved have accepted they could have been more vigilant and supervised Mr Lavars more closely, and they have learned an important lesson from these sad events, which informs how they conduct themselves as police officers today. They accepted their managerial notices following the conclusion of the IAU investigation, and I make no further comment about their conduct in that regard.

135. However, the officers' conduct needs to be viewed in the context they were unaware of the exact words Mr Lavars had made to the security officer that evening in relation to using his will, and also some significant information about Mr Lavars' offending history and mental health history. Although they all made a mental health assessment of Mr Lavars, based upon their understanding he had made a threat to self-harm that night, without the additional information they were reassured by his presentation and statement he didn't intend to harm himself that night. It was accepted in submissions filed on behalf of the WA Police Force that with the benefit of hindsight, "it is

[141] T 127.
[142] T 126 – 129.

accepted that the attending officers needed more information to assist in responding to Mr Lavars."[143]

136. They were also relatively junior officers who did not have the benefit of the guidance of a more senior officer in person at the scene due to the staffing challenges at Rockingham Police Station at the time, although they were able to telephone a more senior officer for advice or direction.

137. Constable Hood's evidence was that at the time of this incident, Rockingham Police Station was very understaffed, which is why he was not partnered with a more senior officer on the night. The evidence indicates that at the relevant time, Constable Hood's team (Team 2) was rostered to have 10 staff members that shift, but six were absent, leaving only four in the team. He and the two probationary constables were placed together, and the senior constable from the team, who was the other team member there, was supervising the station. There was only one other police car responding to jobs for the subdistrict that night, also staffed with probationary constables, and it was tied up with another welfare check task at the hospital.[144]

138. As a Constable, it seems that WA Police policy allowed Constable Hood to supervise the probationary constables,[145] although there is a question of which jobs you might then send those officers to attend on their own. Sergeant Hutton expressed his personal view that he would prefer to send out at least a First Class Constable with probationers, but due to staffing levels at the relevant time, it was very difficult to allocate that level of experience. In any event, Sgt Hutton was very familiar with Constable Hood and Probationary Constable Mischewski and held them both in high regard. He was very aware in particular of Constable Hood's performance and had confidence in his abilities to deal with more complicated jobs and difficult jobs. Therefore, while assisting the shift supervisor, Sgt Hutton had felt some confidence that Constable Hood could help the less experienced officers manage the job. He was also aware that Constable Hood was in contact with A/Sgt Walsh, which reassured him that the job was under control.[146] In hindsight, the case was probably more complex than anyone understood at the time, and it seems to be generally agreed that a little more experience might have helped.

139. Detective Senior Sergeant Annesley acknowledged there are challenges around resources, with those challenges experienced by police across the country. To try to counter some of those issues, along with active recruitment of new officers, the agency has introduced a tenure policy to try to balance the level of experience in the first responders who attend these kind of incidents, to ensure there is more seniority and experience on the front line.[147] I am informed of other steps the WA Police are taking to further focus their resourcing towards the local level and what might be described as core policing duties, as well as ensuring there is enhanced supervision and remote support through the use of technology. As it is a complex issue, I do not

[143] Submissions filed 28 July 2025 [14].
[144] T 43 – 44.
[145] Submissions filed 26 July 2025 [38] – [40].
[146] T 86 – 87.
[147] T 103 – 104.

propose to comment further on the steps being taken by the Commissioner to that end, but I understand there are many planks to the plan to address resourcing.[148]

140. Another issue was whether the officers ought to have called an ambulance immediately once they became aware Mr Lavars had consumed an unknown substance. The officers agreed in evidence this would, in hindsight, have been the preferable course. This was also the advice that Sgt Hutton would have given them, if they had called him at the station at the time.[149]

141. Whilst this would have been the safer course, based on the evidence before me, it does not seem that Mr Lavars would have been able to be saved, given the amount of poison he consumed and how quickly he succumbed to its effects.

142. I have adopted the helpful chronology provided by Professor Joyce in his report to demonstrate the short timeframe within which the attending police officers became aware Mr Lavars had taken some tablets and Mr Lavars becoming very unwell, and then eventually being certified life extinct. I have also noted above Professor Joyce's expert evidence, which suggested that without knowing what he had consumed, even immediate medical treatment would have been unlikely to change the outcome.

Time	Event
01:01	Police arrival at 95 Safety Bay Road Shoalwater and subsequent admission to the home.
01:01 – 01:18	Interactions between home occupants and police officers, including witnessing signatures to wills and Mr Lavars' preparations to accompany police officers into arrest.
01:18	Period of 25 seconds when Mr Lavars was apparently not under direct observation while in the house laundry.
01:19	Mr Lavars leaves the laundry, giving the appearance of having something in his left hand.
01:21	Mr Lavars and police officers converse about what he is holding in his hand
01:22	Ingestion and swallowing of two tablets, described in the statement of Probationary Constable, par 106 - 111. Probationary Constable Kenned allows the possibility that hand movement he had observed earlier might have represented ingestion of additional tablets.
01:22 - 01:30	Mr Lavars represents the ingested tablets as lollies, "Eclipse" sweets and indigestion remedies.
01:30	Conversation about the indigestion as Mr Lavars enters the pod on the police vehicle. He does not reveal evidence of ill health to police officers.

[148] Submissions filed 28 July 2025, [71] – [87].
[149] T 70, 80 – 82.

Time	Event
01:30 – 01:38	8-minute journey between Mr Lavar's home and Rockingham Police Station. CCTV within the pod shows objective evidence of ill health, during the journey. The time of onset of drowsiness is estimated as, "about half way" by Probationary Constable Kennedy(Paragraph 151 of statement), followed by vomiting "about 1 to 2 minutes away from the station" (Paragraph 153 - 155). Other accounts (Probationary Constable Mischewski, Paragraph 80) vary a little in the timing, but not in any way that is consequential.
01:38 – 01:43	At police station, in pod of police vehicle. Further vomiting occurred. Police witnesses describe him as "breathing" and "appeared to be sweating profusely" (Probationary Constable, Paragraphs 167 - 168), "very pale and appeared drowsy" (Probationary Constable Mischewski, Paragraph 88) on opening the pod door.
2:10	Ambulance attended (01:56) and accessed patient (02:07). First observation incorporated into the St John Ambulance report included bradycardia (54 beats per minute), hypotension (systolic 50mm Hg, diastolic not recorded), tachypnoea (34 breaths per minute) and hypoxaemia (haemoglobin oxygen saturation 62% on room air). "Rales" and "course creps [crepitations]" are described, meaning abnormal cracking noises in lungs heard through a stethoscope. Skin is described as cool, moist, pale and cyanotic (blue appearance). Urinary and faecal incontinence are described. He was, nonetheless, still able to leave the pod with assistance, according to police officer statements.
2:20	Declining conscious state (Glasgow Coma Scale [GCS]), elevated heart rate and elevated blood pressure observed.
2:30	Further decline in GCS. Bradycardia, hypoxaemia on supplemental oxygen.
2:37	Cardiorespiratory arrest during transfer of care to Rockingham General Hospital.
2:58 – 3:28	Laboratory records indicate a severe metabolic lactic acidosis and methaemoglobinaemia of 5.2%, then 6.5% (normal <1.5%).
3:53	Cardiopulmonary resuscitation efforts were ultimately unsuccessful

143. The general position is that the police officers, in taking Mr Lavars into custody, needed to prioritise the safety of Mr Lavars, the other people in the house and the police officers themselves. It seems that Mr Lavars' calm demeanour reassured them that the risk he presented to himself and others in that state was low, and their focus was on keeping Mr Lavars calm and cooperative as the safest option for everyone involved. However, we know now that the most important thing on the night was to prevent Mr Lavars accessing anything that might allow him to harm himself in police custody, a threat he had been known to make in the past.

144. Constable Hood commented in evidence, "hindsight is a wonderful thing."[150] With the benefit of hindsight, if the attending officers had been aware of Mr Lavars' specific threat to use his will that night and his history in the previous days, Constable Hood believes they would have watched Mr Lavars more closely and made sure he was never unsupervised at any time as they would have appreciated there was a heightened risk of self-harm.[151]

145. However, based upon what is now known, Constable Hood also believes Mr Lavars had formed a deliberate plan to deceive the police officers and take his life in custody. His manner on the night was designed to not arouse the police officers' suspicion or alarm and even with that extra knowledge, his presentation on the night may have still reassured them. Constable Hood gave evidence this incident has changed the way he now operates if conducting a welfare check. He now assumes the worst could happen at every welfare check, regardless of the person's demeanour. This change in his practice has developed through experience, and the officers agreed in evidence that if a more senior officer had been present at the time, their added experience may have assisted in that regard, as there was a missed opportunity to prevent Mr Lavars from taking the tablets, if he had been more closely supervised.[152]

146. Once Mr Lavars had obtained the tablets, Constable Hood expressed the belief it would have been very difficult to stop him ingesting them, as it happened very quickly and, even if they reacted with sufficient rapidity, they would have had to physically restrain him. Given Mr Lavars was an older gentleman with obvious health issues in his own home at the time, any physical action against him would have run the risk of an allegation of excessive force given they did not at that time have any suspicion he was taking a harmful substance. Probationary Constable Kennedy wondered if he might react more quickly now, with the benefit of the additional experience he has obtained as an officer, although the more important change would be to supervise him more closely and prevent him obtaining the tablets and orange juice in the first place.[153]

147. In the end, there were a number of safety steps missed on the night, including allowing Mr Lavars to be out of view more than once in his home after his arrest, not searching his clothing and not removing certain items, such as his shoelaces, before placing him in the van. It appears these steps were not observed due to the belief Mr Lavars was compliant, was not presenting as suicidal and he was an older man being taken out of his home late on a cold night, so his comfort was prioritised. With the benefit of hindsight, the involved officers accepted that they would now provide closer supervision, and been more cautious of the potential dangers, but even the more experienced officers who gave evidence acknowledged that it was not an easy task as there was a balance between obtaining compliance and removing him from his home with the least amount of restraint and also making sure everyone was kept safe.[154]

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[150] T 31.
[151] T 31.
[152] T 38, 47 – 50, 66 – 67, 80.
[153] T 51, 67 - 69.
[154] T 50 – 52, 89.

Mental Health Training

148. Constable Hood was asked about the mental health training provided to recruits at the Academy and ongoing to police officers. He could not recall the specifics of the training provided to him at the Academy, but did refer to annual online training related to mental health response. Probationary Constable Kennedy agreed the mental health training is limited.[155]

149. Both officers felt that what was learned on the job through experience was probably more useful, noting the mental health issues attending police face are often more complex than the kinds of issues covered by the training. Constable Hood gave evidence he does not believe police officers are equipped, through this training, to always accurately identify people who are suicidal. Whilst they are trained to look for any physical signs that someone has self-harmed, and to consider any known previous history, he noted that each suicidal person may present differently, which is "what makes the job so hard."[156]

150. While he was stationed in Rockingham, Constable Hood completed many welfare checks relating to people considered at risk of self-harming, often seeing the same person multiple times in one week, and he observed a full spectrum of behaviour in that time. All of these attendances build up an officer's level of experience, which helps them to assess risk and anticipate likely responses to police attendance. However, he and his colleagues were at an early stage in their careers on this night. In addition, I think it is reasonable to categorise Mr Lavars as an unusual case, given his very complicated history with the WA Police and other authorities, and the possible contribution of his medical issues to his mental state. Without knowing all of that history, it put the others at a considerable disadvantage on the night.[157]

151. Constable Hood observed that since this sad event, there have been system improvements implemented which allow officers on the road better access to information on their phones.[158] Probationary Constable Kennedy, who is now based in Mandurah and still working frontline, agreed that there is a lot more information available to police officers out on the road, and he feels that information is a lot more accessible than it was at the relevant time. Further, I am informed the WA Police Force is working on an update to their CAD system to allow automated queries to be performed, which will allow CAD users to enter data quickly and the system will run default vehicle and person queries, which will hopefully assist with providing more information to attending officers in a faster time frame.[159]

152. Police officers are first responders and are not trained mental health professionals. As first responders, they are required to make an assessment of whether they might need to use their powers under s 156 of the *Mental Health Act 2014* (WA) to apprehend a person with a mental illness. Suicide is extremely difficult to predict and, noting police officers are not mental health practitioners, the emphasis is on the officers

[155] T 72 – 73.
[156] T 54.
[157] T 52 – 55.
[158] T 56.
[159] T 72, Submissions filed 28 July 2025, Attachment D.

making a reasonable assessment of any mental health issues that are apparent. In this case, the officers made an assessment and decided there was no risk at the time to Mr Lavars or any other person, which the internal investigation concluded was reasonable at the time. Whether or not they may have missed more subtle signs of suicidal intent was not part of the analysis of their conduct by internal affairs investigators.[160]

153. It seems on the evidence that their first assessment of low risk may have been correct. It was only that they were then required to take Mr Lavars in to custody in relation to the breach of his bail condition, which likely elevated his risk again, given his prior threats to harm himself if he was taken into custody.

154. In submissions filed following the inquest, I am advised that the WA Police Force has been working with the State Government and various agencies (such as SJA and the Mental Health Commission) to ensure that members of the community experiencing mental distress are provided the best care. "Recently, that partnership has increasingly focussed on the right care being given by the right person."[161] That is, in effect, a focus on a health-led response for mental health-related call outs where possible if violence is absent. I am informed in practice this involves directing those attendances away from police as first responders to authorised mental health practitioners or SJA paramedics. Since the inquest, the WA Police Force continue to work with other relevant agencies to develop and implement that Mental Health Co-Response model to best assist those persons experiencing a mental health crisis.[162]

155. The shift to mental health practitioners attending in some cases, would not have applied in Mr Lavars' case, given they were required to attend in relation to his removal of his electronic monitoring device in any event, but it is relevant information to allay some of the understandable concerns expressed by Mr Lavars' family about how mental health crises are dealt with in the future by police officers. In addition, I am informed that currently recruits receive 22 hours of training in relation to mental health, including live scenario training to develop effective communication techniques, along with information about the Mental Health Co-Response model and additional refresher training as part of the Critical Skills training. In addition, I am informed that there is further compulsory training on mental health for officers to progress to the rank of First Class constable and Senior Constable and additional training for Sergeants.[163]

156. Another initiative that has been proposed is for changes to be made to the *Mental Health Act 2014* to allow the use of live streaming of BWC to allow an authorised mental health practitioner to advise police officers while they are responding to violent mental health incident.[164]

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[160] T 96 – 97.
[161] Submissions filed 28 July 2025, [48].
[162] Submissions filed 28 July 2025, [44] – [70].
[163] Submissions filed 28 July 2025, [60] – [70].
[164] Submissions filed 28 July 2025, [79] – [87].

157. All of these are positive changes, although I note that in the particular circumstances of Mr Lavars' case, they would have been unlikely to have altered the outcome, given police attendance was required and he was not considered overtly suicidal at the time he was in police presence. Once again, vigilance in monitoring Mr Lavars would have been the most effective tool in this case to prevent him harming himself.

158. It was noted in the submissions that since the Inquest hearing into Mr Lavars' death, State Coroner Fogliani's Finding into the death of Joyce Gladis Clarke has been published. In the Finding, the State Coroner made a recommendation directed towards the sharing of mental health information between service providers and WA Police, subject to privacy considerations. The aim of the recommendation is to place WA Police in a position where they may be properly alerted to relevant mental health information about a person in order for the police to identify safety risks in relation to that person towards self or others. It was noted in submission that this kind of information sharing may have been beneficial in this case. Having checked our records, I am not aware of any progression by the State Government on this recommendation to date.[165]

CONCLUSION

159. The police officers involved have reflected at length on the events of this awful night. It was a traumatic experience for very young police officers. With the benefit of hindsight, and knowing much more now about Mr Lavars' history and mental state, the most important change would have been to ensure Mr Lavars was more closely supervised. This might have prevented him from accessing the tablets. A more experienced officer, who is aware of how this kind of thing can occur, might have done so, although it is only speculative. It is also important to note that Mr Lavars appears to have been committed to taking his life once in custody, so if he had not succeeded in this manner, it is possible he would have found another one. Again, that is speculative.[166]

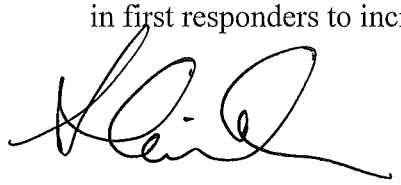
160. Once Mr Lavars had ingested the tablets, I am satisfied that even if the police officers had requested an ambulance attend or taken Mr Lavars directly to hospital, his death was unlikely to have been prevented. He had deliberately ingested a large quantity of poison, which on his background of cardiovascular disease, was going to be fatal.

161. This is a very sad case involving a man with serious health issues who had developed a level of significant hostility towards police and other authority figures due to perceived ill treatment. Unfortunately, we know from other tragic incidents in this country that this type of attitude towards the authorities has sometimes led to the deaths of police officers and other innocent bystanders. There was, in this case, a risk to others from the nature of the poison Mr Lavars took, although there is no evidence anyone else was harmed in the end. It does, however, emphasise the need for this kind of information about pre-existing mental health issues and hostile attitudes towards authorities to be readily available to police officers attending an incident.

[165] Submissions filed 28 July 2025, [88] – [90].
[166] T 38, 46 – 47.

More information and better preparedness might have prevented Mr Lavars harming himself, at least in this way, on this night, and reduced the risk to others.

162. Mr Lavars' family hope for lessons to be learned from his death and changes made. I am satisfied that the individual officers involved, along with WA Police Force as an agency, have reflected upon this incident and there are changes being implemented towards how the first response to mental health incidents is managed and the information that is available to attending officers in cases involving significant prior history of this kind. Significant efforts are also being made to recruit more police officers and to increase the level of seniority available at local police stations, such as Rockingham Police Station, to ensure that there is an appropriate level of experience in first responders to incidents like the one involving Mr Lavars.



S H Linton
A/State Coroner
29 June 2026