National Justice Project

Coroner delivers critical findings over death of Ms Wynne

Introduction

A WA Coroner has released his findings into the death of Ms Cherdeena Wynne, a 26-year-old Noongar Yamatji mother of three who stopped breathing whilst she was being detained by WA Police the side of the Albany Highway at Bentley.

Her family have been left doubly traumatised as Ms Wynne's late father, Warren Cooper, died whilst in the care and custody of WA Police 20 years before Ms Wynne's death.

The family say that, although the findings of the Coroner are critical of the police, there is no accountability or justice for them in the recommendations and the family is concerned that without the systemic changes they sought more preventable deaths will occur. The family does not want other Indigenous families to suffer the loss of their loved ones in custody.

Remember that Ms Wynne was not being detained or arrested for any criminal conduct. She was stopped by police who were assisting an ambulance team to get her into a mental health facility.

Ms Wynne was clearly very unwell and the police were supposed to be there for her welfare. Sadly, her treatment in those minutes before she died leaves a completely different impression. CCTV footage shows her being manhandled and forced to the ground with a policeman's knee in her back holding her face down and another policeman holding down her legs. The video evidence gives the impression of a dangerous criminal being caught and arrested by police, not a vulnerable young woman in need of assistance.

Ms Wynne's family is demanding cultural change in WA policing. They want an apology and real accountability for the way that Ms Wynne was treated by police.

They are demanding that police should not be first responders to those experiencing a mental health crisis.

They want independent investigations of WA Police conduct. They don't want police investigating police, and they criticise the inadequate and poor quality of the police investigation in this case. They were also concerned that one Police Internal Affairs Unit (IAU) officer completed the investigation and another then finalised the report, signed it and appeared in the Coroner's Court to answer questions without the presence of the officer who completed the investigation.

They also asked for improved cultural safety for Indigenous families in the WA Coroners Court.

It was not just the moments before Ms Wynne died that has caused the family's anger and frustration with the police. Earlier that morning, the police raided her mother's apartment, grabbed Ms Wynne, handcuffed her and searched the premises. As Ms Wynne was already unwell with mental health issues and traumatised by the removal of her twenty-month-old baby girl a few days earlier, that harsh treatment caused her to become very distressed, and ultimately led to her to escape from an ambulance which was taking her to get her help shortly thereafter.

The family know that Ms Wynne's death represents a pattern of deaths in custody throughout Western Australia and Australia. Deaths that are preventable. The family knows that little has changed to prevent such deaths in the 30 years since the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**) made over 330 recommendations, which have been largely ignored by Governments throughout Australia.

"*Look at what happened to JC in Geraldton – Police were called out to a welfare check and JC was shot dead by those who were sent to help her. Police should not be intervening in health crises. They are trained to use force and they don't follow their training to keep people safe,*" Ms Wynne's grandmother, Aunty Jennifer Clayton said.

"The Commissioner of Police wants to be the Governor of this State but he has to acknowledge that what happened to Ms Wynne and JC, Ms Dhu and Baby Charlie Mullaley highlights a serious cultural problem inside the WA police," Aunty Jennifer Clayton said.

Background

Ms Wynne was hospitalised at Joondalup Health Campus on 24 March 2019, where she had attended to get medical help for her baby girl. She was detained and deemed 'at risk' requiring a psychiatric assessment for her mental health, and placed on a one-to-one watch alert which was later removed. On 26 March 2019, she escaped from the hospital and police were alerted to look out for her and to complete a welfare check.

On 4 April 2019, Ms Wynne encountered police as she was walking to her mother's home in the early morning. The police attempted to stop her, but due to her panic and fear of police she ran from them to her mother's house. The officers claimed they were suspicious about Ms Wynne, even though she had committed no crime, no crime had been reported in the area and she was not wanted for any offence.

When she had returned to her mother's home, she encountered more police who were conducting a search on her mother's apartment looking for a different woman. They handcuffed her and, escorted her outside where they completed an identity check but failed to complete a welfare check, before releasing her. Not one of the nine police officers who attended the apartment asked Ms Wynne if she was okay or if they could get her some help. Her mother says that she was left in an anxious and distressed condition and, no doubt, had her already delicate mental health condition triggered even further by their behaviour.

When the police finally left the premises, Ms Wynne's mother said her daughter ran from her mother's apartment in tears, shaken and terribly upset. She was found a short time later having a mental health crisis and was attended to by police and ambulance staff. Ms Wynne was placed in an ambulance but she escaped from it just before it departed. She was then reported to be running through traffic and police were able to catch up with her on Albany Highway. At that point Ms Wynne was treated like a criminal, taken down from a standing position on the verge, placed face down and handcuffed with two male officers on top of her, preventing her from standing up or rolling over. There were four officers in total crowding around her.

One officer weighing 88kgs restrained Ms Wynne's legs with his body and the second officer weighing 115kgs put his knee across the top of her back, near her shoulders, restraining her face down. This position was known to police as the prone position, which can be fatal.

No words of comfort or explanation were given to Ms Wynne during this time by police. Not one officer calmed her and told her that they were getting medical help and that she was not being locked up. Not one checked to see how she was and if she was still breathing. The police officers said she had not uttered a word. A scared and frightened young woman spent her last moments in this dreadful state, panicking that she was being arrested.

An ambulance arrived and one of the ambulance officers asked her to get up. She didn't move. Her upper body was lifted by the police. Her eyes were rolled back, her lips were blue and saliva was around her mouth. By then Ms Wynne had already lost consciousness and CPR was commenced. She was taken to hospital but died as a result of her injuries on 9 April 2019. The last moments of her life were spent, in acute mental health distress, with four uniformed police officers restraining her and holding her down, treating her without care and without dignity, no compassion or empathy shown for another human being. The footage of the last minutes of her life is harrowing and upsetting to watch. She was 26 years old and had three young children who will now be – like she was - forced to grow up without one of their parents who died in police custody.

Findings/Criticisms

The family accepts the Coroner's finding that the restraint of Ms Wynne in the prone position was a contributing factor in her death [87].

The family had asked that the Coroner find that that positional asphyxia also contributed to or caused her death. Sadly, the Coroner said there was not enough evidence to include that in his findings but he did not rule it out. Regardless, it must be the case that, whatever the cause was, the prone position is a dangerous position to hold anyone in except for the briefest time. The Coroner confirmed as much.

The family agrees with the Coroner's criticisms of the treatment of Ms Wynne by the WA Health Service and the WA Police Force.

The Coroner stated his concerns about the removal of the one-to-one supervision of Ms Wynne at the hospital, [94]-[99] and the lack of mental health beds available [347] which contributed to her escaping mental health care.

The Coroner found that the police officers who handcuffed Ms Wynne at her mother's house restrained her longer than was necessary [156]-[157], [350] and failed to complete an adequate mental health welfare check [167] & [176], a check which could have got her the help she needed if it had been performed properly [180]-[181].

The Coroner found that a police officer who arrested Ms Wynne by the side of the Albany Highway drove at an unsafe speed [202] which would have frightened Ms Wynne further and put her life in danger [204]-[205].

The Coroner observed that Ms Wynne was not offering significant resistance, that the police were in control of her [213] and that she could have been moved to a safer place away from the highway with a minimum of force [221].

The Coroner expressed his concern that, even if it was appropriate for the police to handcuff Ms Wynne, she was not handcuffed in a position other than the prone position [232-233] which we know is extremely dangerous and has led to deaths in other cases.

The Coroner also observed that there was no evidence that officers had complied with their Manual to give clear and audible commands when arresting Ms Wynne [226]. The Manual specifies that "*When using any technique to gain control over the subject Tactical Communication is critical. Officers must instruct the subject and give them a chance to react to the commands and the techniques being used*" [226].

The Coroner also found that the use of the prone position to handcuff Ms Wynne was close to the threshold of becoming unreasonable [238], which would have made it unlawful, but he ultimately declined to make that finding.

The Coroner also found that once police officers place a person in the prone position they need to be very careful not to put the person's life at risk [239]. He questioned whether the leg hold on Ms Wynne was appropriate for as long as it was held and observed that there were other alternatives [250]. In any event, the Coroner found that Ms Wynne should have immediately been brought up from the prone position once the police had removed her cannula from her hand [253], [259] - [264]. And more importantly, that if proper monitoring had been undertaken of Ms Wynne's breathing by officers then her cardiac arrest may have been detected earlier [265].

In a damning assessment of the police witnesses, the Coroner pointed out that the four police officers who all claimed that there was **no delay** in moving Ms Wynne from the prone position were contradicted by the CCTV footage [269]. The Coroner warned the police that their credibility would be assessed accordingly where inconsistencies were exposed by CCTV footage [270].

The Coroner was highly critical of the police failure to monitor Ms Wynne's breathing in the prone position [273]-[284] and sadly observed that any movement that Ms Wynne may have made before she became unconscious was most likely due to her inability to breathe, rather than an attempt to resist or escape [285]. The family had pointed out that training for police required them to discount that a person might be thought to be struggling while restrained, but that their movements might be of panic because of the difficulties in breathing in that position.

The Coroner was also critical of the inadequate Police Internal Affairs Unit (IAU) investigation which failed to scrutinise the CCTV footage carefully [289] and which did not investigate the critical aspects of the restraint of Ms Wynne immediately before she stopped breathing [288]. The Coroner said, "*How it could be said that the restraint and handcuffing of Ms Wynne "was done in line with policy and procedures" when no officer had effectively monitored her breathing is, quite frankly incomprehensible*." [290]. He further criticised the IAU for failing to undertake interviews with the police officers involved, and for failing to further investigate their actions [314]-[316].

The Coroner reserved his most critical findings to last when he found that -

1. Officer Williams erred in maintaining his leg hold on Ms Wynne's back for longer than was necessary and that this delayed her being lifted from the prone position [297]; and

2. That four police officers erred in failing to ensure that Ms Wynne's breathing was properly monitored when she was in the prone position [326].

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Family Response

The family are grateful to the National Justice Project and their barristers for representing them at the inquest and providing them with barristers Claire O'Connor SC, Steven Castan and Sophie Jeliba to ask questions of witnesses and make written submissions for them.

Inquest Process

The family say, that the hardest part of the hearing was that they were not able to view the CCTV footage of the last moments of Ms Wynne's life until the hearing began and then had to do so in a court room. Each of the family attending were seated in court chairs normally used by lawyers and watched the footage hugging and comforting each other as best they could of their daughter, cousin, granddaughter and mum of three little children being forcibly held on the grass verge of a highway take her last breaths with police on top of her.

"We could clearly see our loved one was disorientated while running along the road in need of help, why couldn't anyone else?" said Ms Wynne's grandmother Jennifer Clayton.

The Coroner's Court of WA did not make the CCTV footage of Ms Wynne's death accessible to Ms Wynne's family before the Inquest commenced, which meant that a traumatised family was unable to see what had happened to their loved one for two years after her death.

Coroners in WA don't seem to understand the therapeutic role that viewing the circumstances of a death promptly can play to allay a relative's fears and to dispel rumours. To add insult to the injury to the family, many senior Police officers had seen the CCTV footage well before them. Senior Police and the Coroner's staff had seen it but Ms Wynne's family had not. How can this process be right?

The family were also concerned that the inquest system in Western Australia allows police witnesses to stay in the court room while each of them gives their evidence. This means that by the time a witness is called to be questioned they already know what other witness have said and this has the potential to contaminate evidence.

The WA Coroners court is not a culturally safe place for Indigenous people and Ms Wynne's family felt disenfranchised, unwelcome, alienated and intimidated by the presence of a large number of police in full uniform in the room.

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WA Police and WA Health Failures

The family agrees with the Coroner that WA Health Service and WA police failed Ms Wynne. The fact that the Coroner claims that they have learned some lessons and made some improvements gives Ms Wynne's family little comfort and there is little to show for it in the day to day treatment of Aboriginal people and little insight shown by the police witnesses in Court. The family acknowledge that WA Health made changes as a result of the death and were very apologetic at the hearing, but the family would appreciate a formal apology.

Ms Wynne's grandmother Jennifer Clayton said,

"*We are heartbroken to read about failure after failure in the lead up to Ms Wynne's death. How long will it take for the police to learn these lessons and follow through with improvements and recommendations to prevent future deaths?*"

"*We always believed that Officer Williams maintained his leg hold on Cherdeena's back for longer than was necessary but we were never told that the four police didn't even bother to check her breathing when she was so vulnerable and was being held down in a dangerous hold known as the 'prone' position. Shouldn't they care for a young human being? She committed no crime, she was confused, she was not well and very distraught about her baby being removed from her. We know this because she had phoned family members asking for help to get baby back. Ms Wynne just needed help.*

We are heartbroken that four police gave evidence that there was no delay in standing Ms Wynne up from the prone position which the Coroner said was directly contradicted by the CCTV recording. How often does this happen to First Nations families?

We are disgusted that the IAU didn't take compulsory statements from the police involved and that they failed to compare police statements to the CCTV footage that was available to them well before the hearing. Some officers were not even spoken to. The police just don't seem to care about our people when a black death is being investigated.

Have the Police IAU changed their ways to take compulsory interviews of police officers? Do they always check CCTV against police statements now? Have the officers been counselled or disciplined? Have their policies changed? Have the police officers had Cultural Awareness training?

The fact that the police cannot tell me when my granddaughter actually stopped breathing is disgusting and shows so much about the way they failed her.

How do we explain to Ms Wynne's baby daughter and two sons what happened to their mummy? Questions we will never have the answers for. Our hearts go out to her children.

We feel so let down and disheartened by these police, first her dad Warren Cooper died in police custody and now his daughter Ms Wynne both aged 26 years old. This is generational trauma, there is a ripple effect in families and we have had ongoing grief and heartache in our lives which causes loss of faith and trust in the police.

It pains us to think about the terror that Ms Wynne would have felt when she was being restrained by the police. I know that Cherdeena was already afraid of the police because of the way her dad died in their custody.

We are disappointed and unhappy that the Findings do not go as far as we wanted. Stronger findings and recommendations would have helped with some kind of closure and to come to terms with what Ms Wynne went through. These findings break our hearts and don't give us much hope of things ever changing.

I can't stop thinking that my granddaughter would have experienced extreme fear in her last moments of her life and that's a cruel way to die especially when the police are there to serve and protect.

The police knew Cherdeena was unwell and unstable. They just didn't care for her health and well-being. They just treated her like a criminal and took her down.

No one has been held accountable for my granddaughter's death, not even a slap on the wrist but the Coroner has clearly pointed out lots of criticisms of the police and health department of Joondalup hospital.

Justice means more than criticisms, we need accountability. This is not our family's first death in custody and it must stop. Its generational. When will there be accountability for these actions or lack of actions by the police that lead to a death of another human being?

The tightness in our chests, the pain in our hearts and the destroying of our souls just never seems to end. The grief and ache for us goes on and on. We live our lives wondering who will be next?"

Recommendations

Solicitor Karina Hawtrey said "*The National Justice Project had argued for stronger recommendations and are disappointed with the single recommendation about the need for further training. This flies in the face of the serious criticisms that the*

Coroner has levelled at the WA Police and its Internal Affairs Unit. The recurring problems of a lack of safety for First Nations people and those with mental health issues in their interactions with police should have been addressed."

Ms Wynne's family is demanding that:

1. The Police Officers be held accountable for their conduct and failures on 4 April 2019 the conduct and failures of the IAU should be investigated.

2. In future police officers should not undertake Mental Health Checks. A trained mental health team should be called.

3. The IAU should be disbanded and replaced with an independent investigative body outside of the police force.

4. In the meantime, police investigation policies must be reformed and police interviews mandated. There should be transparency in police investigations and a culturally safe, respectful and consultative approach to Indigenous families.

The family called for systemic changes to the Coronial system in WA. They asked:

5. That the Court establish an Aboriginal Practice Policy for inquests, supported by trained Aboriginal staff, just as the Victorian Coroner's Court already has in place;

6. That witnesses not be present in the Court until they have given evidence except with the leave of the Court;

7. That families with a death in custody are funded for representation;

8. That all families have access to CCTV footage that may be used in an inquest well before the inquest starts and with cultural sensibilities taken into account and cultural supports in place; and

9. That lawyers representing a family in a death in custody have access to CCTV footage as part of the brief as early as possible, so they can, if required, have the footage forensically examined.

Ms Wynne did not have a weapon, she was not wanted for criminal activities, was not on the run, she had not committed a crime.

She should have been treated with kindness and compassion. She was unwell and suffering from the removal of her child by authorities. Instead, Ms Wynne was held down and kneed in the back when she stopped breathing. People with an illness should not be treated like criminals.

The WA Police need cultural change and it needs to start at the top. Let's hear someone senior in police acknowledge and address these serious criticisms of the police.

The family want to meet with the Commissioner to hear what he will do about these failures.

The family had asked that the Coroner make recommendations about the unimplemented Recommendations of the RCIADIC and asked that the WA Government immediately audit its policies and procedures to ensure that the RCIADIC Recommendations are adopted. Those Recommendations not only deal with issues relating to the detention and treatment of Aboriginal persons but contain policies and procedures that deal with failures leading to poor health and justice outcomes – the very failures that lead to the death of Ms Wynne.

The family asked the Coroner to recommend that the *Uluru Statement from the Heart* be recognised.

The death of Ms Wynne was not just the death of a young, well-loved and unwell woman who has children who are now without a mother - it was a death which goes to the heart of the problems that confront Indigenous people. Indigenous people are the most incarcerated persons on earth, experience systemic racism and bias in healthcare, and cannot rely on Police to treat them with dignity, humility and care when experiencing a mental health crisis. Not enough is done to prevent these injustices and inequities which lead to preventable deaths at the hands of Police.

For more information call 02 9514 4440.