STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Kevin Michael Norris
Hearing dates:	26, 27 June; 19, 20 October 2017
Date of findings:	27 October 2017
Place of findings:	NSW State Coroners Court Glebe NSW
Findings of:	Magistrate Michael Barnes, State Coroner
Catchwords:	Death in police custody; methylamphetamine toxicity; positional asphyxia; safe custody of drug affected prisoners; paramedic care of police prisoners
File number:	2015/11170
Representation:	**Counsel Assisting the Coroner**, Mr Peter Aitken, instructed by Mr James Loosley, Crown Solicitor's Office **Counsel for the Ambulance Service of NSW**, Mr Mark Lynch, instructed by Ms Karen Kumar and Mr Les Sara, Hicksons Lawyers **Counsel for the NSW Police Commissioner**, Mr Ray Hood, instructed by Ms Alaana Wooldridge, Office of the General Counsel, NSW Police Force **Counsel for Senior Constable David McManus, Sergeant Darren Farr and Joel Gray**, Mr Brent Haverfield, instructed by Mr Ken Madden, Walter Madden Jenkins Solicitors **Counsel for Sergeant Catherine Schmidt**, Mr Joseph Klarica, instructed by Mr Greg Willis

Findings:	**The identity of the deceased** The person who died was Kevin Michael Norris. **Date of death** Mr Norris died on 11 January 2015. **Place of death** He died in the Bowral Hospital, Bowral, New South Wales. **Cause of death** The cause of death was the combined effects of methylamphetamine toxicity, a violent struggle and positional asphyxia. **Manner of death** Mr Norris' death occurred in police custody as a result of misadventure

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The Coroners Act in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Kevin Michael Norris.

Introduction

1. On 11 January 2015, shortly before 9.00 pm, Kevin Norris, 38, stormed out of the house he shared with his partner in Mittagong. A few minutes later he entered the local McDonald's outlet and began acting in a manner that caused staff to call police.

2. When two female officers responded, he did not comply with their reasonable commands and violently resisted them when they tried to take him into custody. With the assistance of two members of the public, Mr Norris was brought under control.

3. He was carried into a police van and driven to Bowral Police Station where an ambulance crew was waiting. He was carried into a holding cell and lost consciousness soon after.

4. Mr Norris was transported by ambulance to the Bowral Hospital but did not regain consciousness before he was declared dead at 10.20 pm.

The inquest

5. An inquest is required by law to be held as Mr Norris' death appears to have occurred while he was in police custody. The inquest must be presided over by a senior coroner.

6. Section 81 of the *Coroners Act 2009* requires a coroner presiding over an inquest to confirm that the death occurred and make findings as to:-

    - the identity of the deceased;
    - the date and place of death; and
    - the manner and cause of the death.

7. Under s. 82 of the Act a coroner may make such recommendations considered necessary or desirable in relation to any matter connected with the death, including in relation to public health and safety.

8. In this case, there is no doubt as to the identity of the deceased person, nor the date and place of his death. The inquest focused on attempting to ascertain the proximate and underlying causes of Mr Norris' death and to considering whether the police and the ambulance officers who interacted with him in the last hour of his life did all that was reasonable to prevent his death.

9. The inquest considered various aspects of police procedures and whether the officers involved adhered to them. It also examined the actions of the ambulance officers who attended at the Bowral Police Station and the circumstances of Mr Norris' physical deterioration.

10. For those unfamiliar with this jurisdiction, it may be of assistance for them to know that an inquest is not a forum for determining civil liability, or for apportioning blame. It is an opportunity to expose the facts of the matter, with a focus on considering any steps that might be taken to prevent similar deaths occurring, or to otherwise improve public health and safety and the administration of justice.

The evidence

Social history

11. Kevin Norris was born on 24 April 1976 at Camden. He had one sister and two brothers, one half-brother and one step-brother. He did not do well at school and left after grade 9.

12. He enjoyed what he described as a "*great childhood*" with both parents working in responsible positions. Although they separated when he was 7, they retained shared custody. He described his mother as "*beautiful*".

13. He moved out of home at 14 and became an apprentice jockey, later working as a stable hand at Rosehill. Later he attended TAFE and gained the qualifications necessary to become a roof tiler.

14. He first smoked marijuana at 13 and first took amphetamines when he was 16. He also drank heavily in his teens. This drug and alcohol abuse was to continue throughout his life. Whether it precipitated the chronic mental health problems described below or combined with it independently is unclear, but together this dual diagnosis resulted in Mr Norris having only intermittent employment and itinerant residential accommodation. It also hindered his forming lasting intimate relationships.

15. Mr Norris had been convicted of a number of relatively minor criminal offences from the age of 14 involving larceny, break and enter, possession of stolen goods, drug possession, property damage, assault and driving with a suspended licence.

16. Mr Norris continued to have contract with both his mother and father who provided him with emotional and financial support.

17. At the time of his death he had been living in a *de facto* relationship with Raylene Waters whom he had met in 2006. They formed a relationship and he moved to Goulburn to live with her soon afterwards.

18. While they were living together, from time to time, Mr Norris got casual work in the area with a tiling contractor.

19. They separated because of Mr Norris' drug abuse and his on-going need for in-patient psychiatric treatment. They resumed cohabiting about two years before his death. At Ms Waters' instigation they moved to Gunning where she was from because she considered it less likely that he would abuse drugs there because of limited availability.

20. While they lived at Gunning Mr Norris continued to work as a tiler in Canberra.

21. The couple and Ms Waters' 15 year old daughter moved to Mittagong only a few weeks before Mr Norris' death. They moved because it was easier for Mr Norris to get to a new job he had obtained in Penrith.

22. Ms Waters was adamant that Mr Norris had abstained from hard drugs during the period of their reconciliation, although he continued to smoke marijuana and drink alcohol.

23. Although Mr Norris had a life troubled by mental illness and drug abuse, it seems he was making a sustained effort to get his problems under control until he had a relapse in the days before his death. It is clear he had a loving relationship with his partner and his parents. I offer them my sincere condolences.

Medical history

24. Mr Norris had a long history of mental illness. As a child he engaged in behaviours that fit the definition of conduct disorder and he reported auditory hallucinations from that time onwards.

25. As an adult he had numerous involuntary and voluntary in-patient admissions to psychiatric facilities. Once discharged he invariably abused illicit drugs and discontinued his medication. Increased psychosis soon followed.

26. He was diagnosed with schizophrenia and drug induced psychosis.

27. He engaged in at least two episodes of reactive aggression which resulted in serious non-lethal physical violence, both associated with psychosis and drug abuse. These occurred in 2009 and 2013 respectively.

28. At the time of his death Mr Norris was the subject of a Community Treatment Order that required that he receive monthly depot injections of Invega Sustenna, an antipsychotic used to treat schizophrenia, and to take daily doses of Seroquel 200 mg.

29. In early December, the management of his treatment was transferred from the Goulburn Community Mental Health Service to the Bowral Community Mental Health Service (CMHS).

30. On 24 December 2014, Mr Norris was reviewed at home by his new case manager and a clinical nurse consultant from the Bowral CMHS. He was administered his depot injection of Invega Sustenna and subject to a mental health risk assessment. He was found to be suffering from no psychotic features and he willingly engaged with the mental health workers. It was planned for him to be seen by a psychiatrist for a routine review in due course. There were at that stage no acute concerns about his mental health.

Events preceding the death

31. Mr Norris came home from work on Friday 9 January 2015 and it was immediately apparent to his partner that he was under the influence of illicit drugs. He was playing loud music and was very restless. Ms Waters demanded to know if he had any drugs and searched him as best she could without finding any. He refused to take his daily dose of Seroquel.

32. His presentation deteriorated further the next day. He appeared disassociated and did not seem to understand his situation. He was making incoherent comments with religious references.

33. Ms Waters was so concerned that she rang his mother who came to the house and agreed that Mr Norris was under the influence of illicit drugs and that he was psychotic. His mother asked him if he wanted to go to hospital but he refused.

34. It seems Mr Norris again stayed awake all Saturday night and he again refused to take his daily dose of Seroquel.

35. The next morning, as previously agreed, Mr Norris drove Ms Waters' daughter to St Mary's to collect her boyfriend and to bring him back to Mittagong. The daughter said Mr Norris was quieter than usual on the trip.

36. On the way back he stopped at two houses in Tahmoor, he said to purchase marijuana. On both occasions when he got back into the car, he told his partner's daughter that he had been unsuccessful.

37. When he got back home he continued to be remote and distracted in his behaviour. He made bizarre and unfounded suggestions to his partner concerning her fidelity and other matters and insisted on playing music very loudly continuously.

38. In the evening things deteriorated further, with Mr Norris yelling and throwing things around the house. He demanded Ms Waters give him her phone saying he wanted to call the police. She refused to give it to him and he grabbed her roughly by the hair. Her daughter came out of her room and yelled at Mr Norris to leave her mother alone.

39. He let go of Ms Waters and ran out the door. As he did so, Ms Waters called the police. As he ran off, Mr Norris yelled out that he was going to report to police that he had been assaulted.

Mr Norris is arrested

40. Ms Waters' 000 call was received at 8.49 pm. She told the operator she spoke to that her partner, who she named, had assaulted her and that he was on "*ice*" and out of control.

41. Mr Norris must have gone almost directly to the McDonald's fast food outlet diagonally opposite their townhouse because only a minute and a half after his partner had called police, the manager of the McDonald's outlet also called police.

42. The manager, Danny Craker, reported that a customer had come in claiming to have been assaulted and requesting that police be called because it was *"a life and death situation".* Mr Craker formed the view that Mr Norris was drug affected – he was unsteady on his feet and had some whitish foam around his mouth.

43. While Mr Craker was in the back of the store calling police, Mr Norris became increasingly agitated, gesturing at staff and making deranged comments. One staff member gave him a glass of water and he went and lay down along some seats a little away from the main serving counter.

44. One of the staff members who had observed Mr Norris' behaviour went and found Mr Craker while he was still on the phone to police and reported that Mr Norris was agitated and becoming aggressive. This was also relayed to police and the manager requested assistance.

45. The information obtained from the call by Ms Waters and the call by Mr Craker was broadcast to all police working in the Bowral District. Senior Constables Amy Finch and Lisa Avnell acknowledged the first incident and headed towards Ms Waters' residence.

46. As they were making their way there, information provided by Mr Craker was also broadcast over the police radio and Senior Constables Finch and Avnell were redirected to McDonald's as it was correctly assumed that both calls related to the same individual.

47. After completing the phone call Mr Craker went to the front of the store to see where Mr Norris was. He found him lying down along the seats in the dining section of the café. Mr Norris had a cup of water in his hand and he was yelling out words to the effect; "*We are all going to burn in hell!"*

48. Other customers became apprehensive about Mr Norris' behaviour and left the store.

49. About a minute after Mr Craker went to speak to Mr Norris, he stood up and walked into another part of the café that was closed. Mr Craker attempted to stop him by grabbing his wrist but Mr Norris did not take any notice, nor did he react to the attempt to stop him.

50. Mr Norris walked behind the counter in the closed area and sat down on the floor. He apparently noticed customers leaving because he yelled out "*No one leaves"*. He then apparently changed his mind and told two customers they could leave but insisted that the McDonald's workers must stay.

51. Mr Craker continued to try and reason with Mr Norris asking him to come outside but he was ignored. Mr Craker signaled to another customer who was nearby to call the police. The customer obliged. That call was received at 8.56 pm.

52. Mr Norris remained sitting on the floor behind the counter until police arrived. That arrival is recorded in the police radio transcript as occurring at 8.57 pm.

53. Senior Constable Finch said that when she and Senior Constable Avnell walked into the McDonald's store she observed Mr Norris sitting on the floor behind the serving counter. He appeared to be drinking a cup of liquid. She said words to the effect "*Hey mate, how are you going? We have received information that you have been abusing staff and being disorderly. It is time to leave".*

54. Senior Constable Finch said that as she was saying this Mr Norris stood up. He appeared agitated and distressed. He repeatedly said, *"Shoot me! Shoot me!*" although at times she thought he may have said he was going to shoot her.

55. He wasn't coherent and appeared to be in a psychotic state. He then said "*OK I will go* ". Senior Constable Finch attempted to grab his right wrist to escort him out but he refused to leave. He began to pull away from her walking backwards, still behind the counter.

56. Both officers grappled with Mr Norris, trying to bring him under control. They were unsuccessful. In the struggle his shirt came off and he moved around behind the main serving counter. At this point Mr Norris adopted a fighting stance and both officers said he made some comment about wanting to fight them.

57. The officers continued to try and negotiate with Mr Norris but drew their oleoresin capsicum (OC) spray canisters just in case. That precaution was well warranted but it proved inadequate in that he suddenly launched himself at them, flailing punches at Senior Constable Finch in particular, and despite both discharging OC spray at his face from close range he continued with his attack.

58. Senior Constable Avnell was knocked to the ground and Mr Norris continued his attack on her colleague raining punches on her head and upper body. He

grabbed her by her hair with one hand and while holding her down he continued punching into her head with his other. He swung her around slamming her head against the cash registers.

59. At one point the officers seemed to get the upper hand and they had Mr Norris down on his haunches, but they were unable to completely gain control of him and he was able to get to his feet and continue the attack.

60. Because this happened in the confined space behind the serving counter, Senior Constable Avnell could not go to the assistance of her colleague. She was blocked from getting at Mr Norris by his swinging Senior Constable Finch back and forth across the passage way.

61. Senior Constable Avnell drew and discharged her conducted electrical weapon (TASER) at Mr Norris. The prongs stuck into his body and Senior Constable Finch claimed she felt current pass through him to her but the device had no effect on Mr Norris. As discussed later it was subsequently found the device malfunctioned due to poor maintenance.

62. The officers were not succeeding in gaining control of Mr Norris and Senior Constable Finch was in danger of sustaining very serious injuries when, fortunately, two bystanders came to their assistance.

63. The violent struggle between the two police officers and Mr Norris was witnessed by two young men sitting in their car waiting for their takeaway order to be filled.

64. One of the men, Harry Stephens, reported seeing the officers unsuccessfully attempt to subdue Mr Norris using OC spray and a TASER. Mr Stephens saw Mr Norris throwing punches at both officers. Mr Stephens got out of his car and rushed into the store to help. At about the same time another unidentified male member of the public joined in.

65. Mr Stephens said that when he got into the store Mr Norris still had hold of Senior Constable Finch's hair and was continuing to punch her. He and the other male member of the public got Mr Norris' hands away from the officer and grabbed hold of Mr Norris in a headlock. He says that about this stage Mr Norris appeared to "*give up*". He slumped to the floor and was lying face down.

66. Mr Stephens and the other male got hold of Mr Norris' hands and held them behind his back. One of the female police officers then handcuffed Mr Norris. At this point two other police officers arrived and the civilians stepped back.

67. At around 9.00 pm, Senior Constable David McManus was at the Bowral Police Station when he heard the job requiring assistance at McDonald's Mittagong broadcast via the police radio. He heard the car crew comprised of the two female officers accept the job and he also acknowledged it and indicated that he would provide backup.

68. When he heard the radio broadcast that indicated the incident was escalating, he and his partner Constable Joel Gray expedited their travel towards Mittagong.

69. On arrival at McDonald's, Senior Constable McManus found the two officers and two civilians restraining Mr Norris on the ground behind the service counter. He noticed that Mr Norris' hands were handcuffed behind his back. He recalled one of the male civilians kneeling near the head of Mr Norris and Senior Constable Finch kneeling around the mid-section of Mr Norris' back. He said in his statement, however, that he did not recall her knees being in contact with Mr Norris; rather she was kneeling next to him while holding his arms.

70. Senior Constable McManus took over from the civilian near Mr Norris' head. He crouched with his shins and knees across Mr Norris's shoulders and upper back. Senior Constable McManus was adamant that he kept his weight off Mr Norris but "*hovered*" above him so that if he tried to roll or get up the officer could restrain him using his weight.

71. He said Mr Norris was struggling and squirming and trying to roll over. He allowed Mr Norris to roll over on his left side so he was not flat on his stomach. Senior Constable McManus said that he was conscious about not putting weight on Mr Norris that would prevent him from breathing.

72. Shortly after the first two back up officers arrived, two highway patrol officers, Senior Constable Dennis Rutland and Senior Constable Tyrone Halliday also entered the store.

73. Mr Norris continued to struggle and yell out. Five officers picked him up and carried him out of the store in a horizontal position and placed him on the ground in the car park near where the police vehicles were parked. Civilians present confirm that he was still conscious and calling out incoherently at that stage.

74. Other police had arrived including Acting Inspector Catherine Schmidt, the Duty Officer, and Sergeant Darren Farr, the Shift Supervisor.

75. As Mr Norris was carried out of the fast food outlet, the CCTV vision shows the cartridge and wire from the Taser being trailed behind him.

76. While Mr Norris was lying on the ground, civilians onlookers in the car park heard Mr Norris calling out "*Help me, Help me, Help me*" as he was placed on the ground, Sergeant Farr and Senior Constable Rutland also said that Mr Norris continued to swear and abuse police while he was lying on the ground.

77. He was searched while on the ground and nothing of interest was located.

78. An ambulance had earlier been called to examine Mr Norris for the adverse effects of the OC spray and the TASER but it was determined to be more

effective to take Mr Norris to Bowral Police Station and have the ambulance, which was also coming from Bowral, meet them at the station.

79. Constable Gray and Senior Constable McManus, with the assistance of other officers, picked Mr Norris up and slid him into the caged pod on the back of the police vehicle that the first responders had arrived in.

80. Senior Constable McManus says Mr Norris immediately rolled over onto his back and as the door was being closed he kicked out at it.

81. At 9:21 pm, Constable Gray drove the vehicle with Mr Norris in it to the Bowral Police Station.

82. The Duty Officer and the Shift Supervisor briefly went into McDonalds and then Acting Inspector Smith drove the two female senior constables to Bowral Hospital to enable them to have a precautionary examination. The other officers drove the various police vehicles back to Bowral Police Station.

At the police station

83. At the station, the truck carrying Mr Norris was backed into the vehicle dock, the door to the pod was opened and Mr Norris was lifted out feet first. When the van door was opened Mr Norris was lying on his front. He was pulled out so that his feet touched the ground but he does not appear to be able or willing to support his own weight and so three officers carried him into the charge room.

84. His hands were behind his head in a position that suggested that during the journey he had passed his handcuffed wrists below the soles of his feet bringing them in front of himself.

85. A number of the officers claimed to have heard him mumble something while he was being carried in. According to Senior Constables Rutland and Halliday, Mr Norris said that he wasn't going to "*play up*" as he was carried out of the vehicle and his handcuffs were repositioned in the charge room. Senior Constable McManus said that Mr Norris made no effort to stand and did not resist as he was carried out of the police vehicle and into the charge room. An ambulance officer who observed the officers carrying Mr Norris into the charge room said that Mr Norris appeared to be struggling as he was carried in and heard police officers twice tell him to "*relax*" before he was placed on the charge room floor.

86. When Mr Norris was carried into the charge room he was placed on the floor outside the holding dock so that his handcuffs could be readjusted. The handcuffs are taken off and reapplied with his hands behind his lower back. The CCTV vision shows no movement by Mr Norris while this was occurring. An ambulance officer who was present in the charge room stood to one side.

87. A minute after Mr Norris had been brought into the charge room, he was slid and pushed into the holding dock that was 175cm wide and 99 cm deep and accessed via a door that was 67cm wide. There was a bench seat running along the length of the back wall and transparent Perspex panels across the front.

88. Initially, Mr Norris was placed on the floor of the dock. One officer then picked him up and placed him on a bench seat but Mr Norris almost immediately toppled over onto his right hand side before slumping down onto the floor where he sat on his bottom with one foot under him and the other leg in front of him with his back up against the end wall beside the bench seat.

89. He can be seen to be in some discomfort until he is able to free his left foot which was pinned under his buttock. He then straightened his left leg so that both of his feet are then straight out in front of him. Slowly while moving his legs in a restless fashion, his hips moved away from the wall and he slid lower until he was almost flat on his back with the back of his head pressed against the wall and almost at right angles to the upper surface of his chest. At this stage he seems to be supporting the weight of his upper body on his elbows.

90. Gradually the movement in his legs subsides and he is still with his chin on his chest and his head held in an upright position as a result of it being against the end wall of the dock.

91. The last apparently purposive movement is seen at 2 minutes and 45 seconds after he was put into the holding dock. At about this stage the ambulance officers had begun preparing to enter the dock.

Medical treatment

92. Two ambulance officers were at the police station when Mr Norris was brought in. Those officers had originally been dispatched to Mittagong McDonalds to attend to a patient who was reported to have been sprayed with OC spray and shot with a TASER after a call from police on the scene made at 9.04 pm. However, before they could leave Bowral but while they were on their way, they received a computer message indicating the case location had moved to the Bowral Police Station.

93. They arrived there at about 9.14pm. The ambulance officers were David Brignall, an intensive care paramedic, and Glenn Ambrose, an ambulance officer. The police transporting Mr Norris had not yet arrived there.

94. They carried an ECG heart monitor/defibrillator and oxygen equipment into the police station and waited for about 5 minutes until Mr Norris was brought into the charge room.

95. Mr Brignall saw Mr Norris being placed on the floor so that his handcuffs could be repositioned. He believed he had to wait unit the Shift Supervisor,

Sergeant Farr told the ambulance officers it was safe for them to examine the prisoner.

96. Mr Brignall asked the shift supervisor, Sergeant Farr, what he wanted them to do with the patient. Sergeant Farr said; "*If he needs to go the hospital that's fine".* Mr Brignall was also told that the two officers involved in Mr Norris' arrest had been taken to hospital and that it was suspected Mr Norris may have been on "*an ice bender."*

97. This made Mr Brignall very apprehensive and he was pondering how he would examine Mr Norris.

98. After Mr Norris had been in the dock for about 2 and a half minutes, Mr Brignall walked over to the dock and crouched down so that he was near eye level with Mr Norris. He asked him his name. He said Mr Norris turned his head and looked at him but did not reply.

99. Sergeant Far who was retrieving the detail of the original call for assistance from Mr Norris' partner told the paramedic that the prisoner's name was Kevin. The ambulance officer called out *"Kevin, can you tell me what's happened today".* Mr Norris did not reply.

100. According to Mr Brignall, at this stage Mr Norris was breathing without respiratory distress and he appeared normally perfused.

101. Mr Brignall stood up and asked Sergeant Farr if he thought it was safe for him to go into the dock. Sergeant Farr agreed that it was and said; "*He doesn't look real good*".

102. Mr Brignall noted that Mr Norris had slipped so far down the wall that his chin was now resting on his chest. In his first statement Mr Brignall said he thought Mr Norris was unconscious but in evidence he changed that to say he wasn't aware whether Mr Norris was unconscious until he entered the cell and tried to rouse him..

103. Approximately 3 minutes and 20 seconds after Mr Norris had been placed in the dock, Mr Brignall entered it and examined him. He first rubbed his torso and got no result. He then commenced to place on Mr Norris' chest the Red Dot monitoring electrodes that would be used to connect the ECG to enable Mr Norris' heart rhythm to be read.

104. Mr Brignall noticed that Mr Norris was not breathing. He felt for a carotid pulse and found none. This occurred 3 minutes and 40 seconds after Mr Norris had been placed in the dock. Mr Brignall then continued adhering the Red Dots.

105. While this was happening, a police officer moved Mr Norris' legs out through the doorway of the dock.

106. Mr Brignall could not measure the prisoner's blood oxygen saturation level or take his blood pressure because Mr Norris still had his hands cuffed behind him. Nor could chest compressions be commenced.

107. Mr Norris was moved partially out of the dock while Mr Brignall continued to apply the ECG traces.

108. A minute after it was established that Mr Norris had no pulse he was dragged out of the dock into the charge room, the handcuffs were removed and a bag valve mask was applied to Mr Norris' face to provide positive pressure ventilation to the patient.

109. A police officer commenced chest compressions and while the paramedic continued to use the resuscitation bag and mask with oxygen to provide him with ventilation.

110. Of concern is that nearly two minutes elapsed between Mr Brignall ascertain that Mr Norris did not have a detectable pulse and the commencement of compressions.

111. Mr Norris was cannulated and intubated and given a total of 5mg of Adrenalin in 1 mg increments. He also was given Naloxone in an attempt to revive him.

112. According to Mr Brignall, the cardiac monitor showed that Mr Norris' heart rhythm was "*slow and wide*." A minute or so later he was shown to be in asystole. At no time at the police station was his heart rhythm one that could be helped with defibrillation.

113. Mr Brignall intubated Mr Norris and established that the endotracheal tube was correctly placed and that he was being effectively artificially ventilated. A stretcher was brought into the room and Mr Norris was loaded onto it, taken into the ambulance and driven to Bowral Hospital.

114. He arrived at the hospital at 9.58pm and was taken to the emergency department where medical and nursing staff took over the resuscitation. Bowral Hospital records record Mr Norris being admitted at 10:03pm and record his time of death as 10:20pm. There appears to have been only one brief instance of a shockable cardiac rhythm (at 10:05pm) during resuscitation attempts at the hospital and at all other times, Mr Norris' cardiac rhythm was shown to be in asystole.

Expert evidence

Autopsy evidence

115. On 14 January 2015 an internal and external autopsy was conducted on the body of Mr Norris by Dr Rebecca Irvine, an experienced forensic pathologist. Prior to undertaking the autopsy she reviewed the video footage of his arrest and his incarceration at the Bowral police station.

116. Dr Irvine expressed the view that there were no instances during the video footage where Mr Norris was placed in a dangerous restraint. She also observed that Mr Norris appeared to be consistently moving until just before he was removed from the dock.

117. She found two distinct round lesions in the central and left chest area consistent with TASER marks.

118. Within the lateral right antecubital fossa there were probable puncture marks.

119. There were multiple but superficial external blunt force injuries over various parts of his body, but there were no gross injuries to the skull or any other part. No injuries were identified on or within the neck. None of the injuries were life threating or likely to cause loss of consciousness.

120. Internal examination identified no disease that would be expected to contribute to his death.

121. Biochemical examination of vitreous fluid and blood found nothing of clinical significance.

122. Toxicological examination of blood collected when he was admitted to the Bowral Hospital and at post mortem revealed methylamphetamine levels of 0.58 mg/L and 0.6 mg/L respectively.

123. Dr Irvine concluded that the concentration of methylamphetamine in Mr Norris's blood may have been responsible for his death. She observed:

> *It is generally thought that in the absence of another obvious cause of death, any detectible blood concentration may be an explanation of sudden and unexpected death. Methylamphetamine is strongly associated with both bizarre behaviour and sudden and unexpected death.*

124. When she gave evidence, Dr Irvine referred to the significant overlap between the nontoxic, the toxic and the lethal blood concentrations of the drug.

125. Dr Irvine was subsequently asked further questions by those assisting me with a view to eliciting her opinion about other possible causes of death. In particular she was asked whether the position of Mr Norris's neck and body after he slid down the wall in the dock could have led to him suffering positional asphyxia.

126. Dr Irvine provided a supplementary report in which she expressed the view that Mr Norris' neck was not flexed to the point that there would be significant compromise of his airway.

127. She found support for that analysis by the fact that when Mr Norris was in the most prone position with his neck fully flexed he was being observed by the ambulance officer Mr Brignall whom she expected would have observed respiratory distress or compromise were it occurring.

128. Dr Irvine acknowledged that if positional asphyxia had occurred she would not expect to find evidence of it at autopsy.

129. Dr Irvine noted that until just before he was removed from the dock Mr Norris was moving his legs indicating that he was conscious and therefore he would be able to adjust his body to avoid the effects of positional asphyxia. However, when giving evidence at the inquest she acknowledged that the final movements of Mr Norris' seen on the CCTV may have been agonal twitching.

130. She also acknowledged that there is a continuum of altered levels of consciousness that cannot be assessed simply by observation of leg movement and body tone.

131. Dr Irvine indicated that she thought it likely that Mr Norris was already unconscious when his neck flexion may have caused asphyxia. For her, the real question was what caused the unconsciousness.

Toxicology evidence

132. Those assisting me also obtained a report from Professor Olaf Drummer, an eminent forensic pharmacologist and toxicologist, who reviewed the autopsy report, toxicology report and the Bowral Hospital records. Professor Drummer also gave evidence at the inquest.

133. He noted that deaths due to methylamphetamine toxicity are uncommon and that most reported deaths involved cases in which blood concentrations of the drug at levels of or greater than 2.0 mg/L.

134. He said in his report;

> *I am of the view that Mr Norris did not die from toxicity associated with methylamphetamine or indeed a combination with cannabis. The blood concentrations were not remarkable and as outlined earlier the factors that might be associated with methylamphetamine and cannabis toxicity were not present.*

135. Professor Drummer went on to say;

> *This does not mean that methylamhetamine could not have contributed (in a minor way) in some way to a death, perhaps caused by increased anxiety and stress associated with his agitated behaviour and or presence of excited delirium and perhaps associated with some unknown degree of postural asphyxia.*

136. He confirmed at the inquest that in his view, absent other factors it is unlikely the drug would have caused the death by itself.

Emergency medicine

137. The court was also assisted by two reports from and the oral evidence of Dr John Vinen, an emergency medicine physician.

138. Dr Vinen viewed the material in the brief including the CCTV recorded vision at McDonald's and the Bowral Police Station.

139. Dr Vinen reviewed the literature relating to a number of possible explanations of the medical cause of Mr Norris's death.

140. He particularly focused on airway obstruction and noted *"airway obstruction unless rapidly recognised and effectively managed will result in the rapid development of hypoxia followed by respiratory and cardiac arrest."*

141. He noted that among the criteria to diagnose positional asphyxia included the victim being in a position that does not allow for adequate respiration, an example of which is flexion of the head onto the chest.

142. Reviewing the CCTV from the police station, Dr Vinen suggested that, after Mr Norris slid down the wall, his neck was markedly flexed forward and that soon after no further movement was seen from him. Dr Vinen noticed that soon after this occurred the ambulance officer entered the dock and found Mr Norris did not have a pulse and was not breathing.

143. Dr Vinen expressed the view that Mr Norris's behaviour at McDonald's was due to methylamphetamine intoxication-induced excited delirium which led to the subsequent events. In his initial report he suggested that the restraint process in McDonald's contributed to the outcome - the neck restraint by the two male civilians and the restraint on the floor prevented Mr Norris from breathing adequately. This he suggested led to Mr Norris becoming hypoxic and hypercapnic (inadequate oxygen and elevated carbon dioxide in his blood). He also speculated that Mr Norris may have had difficulty breathing during transit when he was lying face down with his hands handcuffed behind his back.

144. However, before he provided a second report and gave evidence Dr Vinen reviewed the evidence of eyewitnesses and accepted that Mr Norris was conscious when he was carried out of McDonald's and when he was carried into the charge room at the police station. This led him to conclude that even had Mr Norris been rendered unconscious by the restraint, he had quickly recovered and there was unlikely to be any residual effect of that loss of consciousness that contributed to the death.

145. However, Dr Vinen remained of the view that by the time he reached the police station it seemed likely that Mr Norris was dehydrated and exhausted

and that he would have developed lactic acidosis as a result of an extreme interaction with police.

146. He was firmly of the view that the level of amphetamine in Mr Norris' blood was not high enough to explain his death – in his view the lethal level was 1.4 mg/L and above. However, that did not mean that the drug intoxication did not contribute to the death as the diminished level of consciousness it may have produced allowed his airway to be obstructed.

147. Dr Vinen said he had no doubt that Mr Norris' airway was compromised from the time he slumped downwards with only the tops of his shoulders and his head against the wall with his neck flexed forward on his chin. "*If he was not unconscious when he slumped to his final position he would have become unconscious within a short period of time followed by cardio respiratory arrest".*

148. He was adamant that flexion of the neck so that the chin is on the chest will result in airway obstruction in an unconscious patient.

149. He wrote in his first report that:

The position Mr Norris was lying in directly contributed to his death, the other contributing factors were:

- *Decreased level of consciousness due to the effects of the events at McDonald's and hypoxia due to positional asphyxia in the cell.*

150. He stood by this when giving evidence.

Conducted electrical weapons (TASER) policies and testing

151. The NSW Police Force Standard Operating Procedures (SOPs) relating to the use of TASERs state that a spark test must be performed whenever a TASER is taken by a police officer for operational use and at least once each week. A spark test involves the officer depressing the trigger of the device for a full 5 second cycle to verify it is working, the battery is adequately charged and to ensure the components in the high voltage section of the TASER are energised on a regular basis.

152. The TASER log from Bowral Police Station showed that a spark test had been performed at 6:00pm by Senior Constable Avnell on the TASER (TASER 4) that was deployed against Mr Norris at Mittagong McDonald's.

153. The SOPs also require that all TASERs are to be given an "*extended spark test*" every month to ensure there has been no degradation of the battery during the preceding month. An extended spark test is performed by placing the TASER battery under strain by completing a minimum of six spark tests in a row.

154. Following Mr Norris' death, TASER 4 was returned to the NSW Police Force Armoury for further review and testing. On 30 September 2015, Senior Armourer Christian Halbmeier performed an extended spark test on TASER 4, involving two separate pulse rate tests and a total of 12 trigger activations. Mr Halbmeier recorded that the pulse rate test failed on all 12 trigger pulls and concluded that TASER 4 had malfunctioned at Mittagong McDonald's due to battery degradation.

155. Mr Halbmeier found no evidence that an extended spark test had been performed on TASER 4 because he was unable to review the audiovisual footage that would normally record the testing being performed and downloaded to police servers. He believed the audiovisual recording and downloading errors were also likely caused by battery degradation. Mr Halbmeier said that it was possible that either the extended spark test had been performed on TASER 4 but not recorded and downloaded to the server or alternatively, the test had not been conducted by officers as required under the SOPs.

Prisoner transport policies

156. The NSW Police Force handbook section outlining procedures relevant to escorting and transport prisoners specifies that "*detainees are to be transported by a single officer only if this is unavoidable*". Police guidelines on the management of people affected by methylamphetamine further stipulate that when transporting a person who is affected by methylamphetamine, officers must ensure that they "*continuously observe the person*" because "*stimulant users can experience a rise in body temperature and dehydration which could lead to unconsciousness*"

Analysis conclusions and recommendations

157. The issues brought into focus by the circumstances of Mr Norris' death are:

- The medical cause of his death;
- The malfunctioning of the conducted electrical weapons (TASER);
- The transport of him by a single officer;
- The assessment of him at the police station; and
- The provision of first aid.

Cause of death

158. The pathologist who undertook the autopsy, Dr Irvine, came to the conclusion that the cause of Mr Norris' death was methylamphetamine toxicity because tests revealed he had substantial amounts of the drug in his blood when he died; he exhibited symptoms of being intoxicated by it and no other cause of death could be found at autopsy – that is she found no disease or injury that was likely to have caused the death.

159. In those circumstances, Dr Irvine was inclined to attribute the death to *any* level of methylamphetamine because her view is there is such a great overlap between nontoxic, toxic and lethal blood concentrations of the drug.

160. However, she did not exclude the possibility that factors such as stress, dehydration, and/or electrolyte derangements contributed to Mr Norris losing consciousness with a resulting positional asphyxia precipitating a fatal arrhythmia. Dr Irvine was firmly of the view that positional asphyxia did not cause the unconsciousness that preceded Mr Norris' death.

161. Professor Drummer agreed there was little direct correlation between the blood concentrations of methylamphetamine and a fatal outcome but in his view it was *"most unlikely that this drug was the cause of death in this case."* His view was based on his extensive experience and review of the relevant literature which indicated most deaths were associated with far higher levels than found in Mr Norris' peri-mortem blood.

162. He was of the view that methylamphetamine intoxication may have contributed in other ways to the death.

163. Dr Vinen also considered the level of methylamphetamine was too low to be the sole cause of the death. He considered that the position Mr Norris was lying in in the minutes before his death predisposed him to the risk of positional asphyxia. Further, the biochemical effects of the drug when combined with the stress and exhaustion from the prolonged struggle at McDonald's and while Mr Norris was being transported to the police station may have combined to cause a fatal arrhythmia.

Conclusion

164. Based on the expert evidence given at the inquest, I don't consider methylamphetamine toxicity alone caused Mr Norris' death. Had he taken the same amount of the drug but remained in his house and avoided any violent interaction, I consider it unlikely he would have died on that night.

165. I consider his respiration was compromised by the extent to which his neck was flexed onto his chest at a time when he was already in oxygen deficit due to the earlier prolonged struggle with police at McDonald's and with wrestling the handcuffs from behind his back while being transported. In my view this led to his losing consciousness.

166. The extent to which the various other factors combined to precipitate a cardiac arrest cannot be quantified or even precisely identified, in my view. I can find no more than that methylamphetamine toxicity; positional asphyxia and the effects of a violent and prolonged struggle combined to cause the death.

TASER failure

167. The failure of the TASER to operate effectively had the potential to increase the risk of injury to the officers involved and Mr Norris, if the officers were forced to resort to more lethal means to protect themselves.

168. The tests undertaken after the events identified the source of the malfunction to be battery deterioration. As described earlier in this report, there were in place procedures which should have caused this to come to attention.

169. It seems that one of them, an extended spark test, may not have been undertaken because in Mr Halbmeier's opinion it is likely that had it been done, the fault would have been made apparent.

170. There is uncertainty about whether an extended spark test had been done when stipulated because another procedure, a monthly download of the files from the device was attempted but it too failed and this was also not detected.

Conclusion

171. The TASER used by one of the officers involved in responding to Mr Norris was defective in a number of ways. The tests designed to bring this to attention were probably not undertaken as required.

172. Newer devices have now been brought into service. In the short term this should eliminate the problem that caused the malfunction but if the testing regime is not scrupulously attended to there is a risk that similar problems will occur in future.

Recommendation 1 – Review of TASER testing

173. *It is recommended that the NSWPF further investigate why the defects in the TASER used in this case were not detected before the death occurred and take remedial action either in the form of improvements to the data download software (if this is possible and still necessary) or in officer training.*

Transport to police station

174. The policies described earlier in this report required that when a person in Mr Norris' condition was being transported in the pod of a police truck an observer should have accompanied the driver of the vehicle in the cabin.

175. All officers at the scene should have been aware of this. In particular, those officers with supervisory responsibility, the Shift Supervisor and the Acting Duty Officer should have ensured that the policies were complied with. This failure should be drawn to their attention to minimise the likelihood of a recurrence. In this case the failure to comply with the policy does not seem to have had any negative consequences but that would not always be the case.

Assessment at the police station

176. There is no doubt that Mr Norris' conduct at McDonald's was reprehensible, atrocious: he engaged in an unprovoked sustained violent assault of the two female officers who had reasonably sought to persuade him to leave the premises.

177. That he was psychotic and drug affected is an explanation but not an excuse: he chose to consume the substances that are likely to have precipitated the breakdown of his capacity to reason and from his long history of drug abuse and mental illness he would have known that this was likely to happen.

178. However, the emergency services personnel who were required to respond to Mr Norris also had to take into account that he was psychotic and drug affected. The apparent crimes he had committed before he was arrested did not mean that he was entitled to a lower standard of care after it. When assessing the adequacy of the subsequent response by police and ambulance officers to Mr Norris' health care needs and his safety in custody, the risk he posed to the safety of others was clearly relevant.

179. Those involved in assessing him were also well advised to take into account that methylamphetamine-affected persons can suddenly become violent after a period of apparent quiescence.

180. It is essential when considering the appropriateness of an individual's actions that preceded a critical incident or a sentinel event to guard against hindsight bias – exaggerating or distorting what the individual should have foreseen at the time because the assessor knows the outcome. However, if improved performance is to result it is equally important that another cognitive error – confirmation bias – is also addressed.

Responsibilities of the police

181. The provisions of Parts 9 and 16 of the *Law Enforcement (Powers and Responsibilities) Act 2002* (LEPRA), the regulations made under the Act and the NSWPF Code of Practice for Custody, Rights, Investigation, Management of Evidence (CRIME) place responsibilities on police to safeguard the welfare of persons taken into police custody.

182. The responsibilities generally fall on the custody manager but that role is defined to include whichever officer is at a particular time in control of and responsible for the care of a prisoner.

183. In this case, when Mr Norris was carried into the charge room at Bowral Police Station, the designated custody officer, the Shift Supervisor, had not yet returned to the station. Accordingly, the senior officer present was responsible for ensuring the requirements of the Act, the regulations and the Code of Practice were complied with.

184. Mr Norris' handcuffs were removed because on the journey to the police station he had managed to manoeuvre them to in front of himself but they were then reapplied with his hands again secured behind his back.

185. His safety to be held in the dock was not assessed by the police officers involved in doing that and the ambulance officers who were present were not invited to examine him.

186. I accept the evidence that to do this effectively, Mr Norris would have needed to have been unshackled and unrestrained. I accept that at that stage it was not unreasonable to refrain from doing so in view of his then quiet recent violence.

187. He was instead put in the holding dock with handcuffs on. The evidence of Acting Sergeant Hall, the acting principal tutor in Safe Custody Course at the NSW Police Force Specialist Skills Unit, Field Support Command, Education and Training Command, and the Acting Duty Officer indicated that should not be done unless there was a good reason for it. None was apparent in this case. It is relevant because I am of the view that it made it more difficult for Mr Norris to protect his airway as his level of consciousness diminished.

188. When he was put in the dock, it was immediately apparent that Mr Norris was severely affected by a drug or some other incapacity – he was unable to sit upright on the bench on which he had been placed, he fell to the floor and slid down the wall. He failed to respond normally to questions or conversation.

189. His condition was such that the Code of Conduct for CRIME called for him to undergo a medical assessment or to be sent to hospital.

190. This did not happen promptly, primarily because the police officers and the ambulance officers were waiting to see whether Mr Norris would refrain from further violence.

191. When the substantive custody manager returned to the station he gave priority to establishing Mr Norris' identity.

192. The paramedics said they were waiting for the custody manager to indicate it was appropriate for them to enter the dock to examine Mr Norris and it is clear that the senior paramedic took steps to facilitate this by seeking to establish some rapport with him by crouching near his head and trying to speak to him through the Perspex front of the dock.

Conclusion

193. In view of obvious signs that Mr Norris was severely intoxicated and the very significant change in his presentation during the time he had been in custody, the custody manager should have given more active consideration to whether he needed to be examined by the paramedics sooner.

194. Although Mr Norris had been violent at McDonald's, there was a sufficient number of police available at the police station to restrain him if that became necessary. I readily accept, however, that the custody manager could not have foreseen the rapid further deterioration that led to Mr Norris' death. It is a stark reminder of the precarious health of drug-affected prisoners.

Recommendation 2 – Learning from bad outcomes

195. *I recommend that the CCTV from within the charge room and the sad outcome of this case be incorporated in the Safe Custody training material when the curriculum is next revised.*

Paramedics

196. The paramedics had been summoned to examine Mr Norris because he had been sprayed with OC and tasered – a routine call out. They were told the patient had been very violent and was probably under the influence of methylamphetamines.

197. In accordance with their training their first priority was to ensure their own safety. The police officers who had custody of Mr Norris were also conscious of that and decided they would wait an undetermined length of time to see if Mr Norris exhibited any further violence before he was examined.

198. In those circumstances the paramedics should not be criticised for delaying the physical examination of Mr Norris. As noted, the senior paramedic sought to progress that assessment by trying to speak with Mr Norris through the Perspex.

199. However, the CCTV vision shows that for much of the time before the senior paramedic entered the dock he and his colleague were not observing Mr Norris. It may be that his deterioration into unconsciousness would have been noticed sooner had they done so. It may also be the case that the paramedics had concluded that Mr Norris was drug-affected and not at risk and therefore failed to sufficiently consider the risks of that condition.

200. I am also concerned that when it was clear that Mr Norris had probably suffered a cardiac arrest – he wasn't breathing and a pulse could not be detected – there was unnecessary delay in commencing appropriate resuscitation.

201. That could not happen until Mr Norris was removed from the dock and his handcuffs removed. I am confident that had the paramedics requested police to do so, both of those things would have happened much sooner.

Conclusion

202. I accept that paramedics are trained to plan their responses and to avoid rushing even in an emergency but the delay in commencing chest compressions in this case far exceeded what would be expected and was

inconsistent with their training and protocols. I accept the evidence that the delay is unlikely to have had a bearing on the outcome.

Recommendation 3 – Reminder of cardiac arrest protocols

203. *The paramedics involved in this case failed to demonstrate sufficient urgency in their response to a known cardiac arrest. This suboptimal performance should be drawn to their attention for remedial purposes. I recommend that their line supervisor do so promptly.*

Findings required by s81(1)

204. As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

205. The person who died was Kevin Michael Norris.

Date of death

206. Mr Norris died on 11 January 2015.

Place of death

207. He died in the Bowral Hospital, Bowral, New South Wales.

Cause of death

208. The cause of death was the combined effects of methylamphetamine toxicity, a violent struggle and positional asphyxia.

Manner of death

209. Mr Norris' death occurred in police custody as a result of misadventure

210. I close this inquest.

Magistrate M A Barnes
State Coroner