CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Tristan Naudi
Hearing dates:	13 – 17 May 2019, 30 September 2019 and 1 October 2019
Date of findings:	14 February 2020
Place of findings:	Byron Bay Local Court
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – manner and cause of death – MDMA intoxication – restraint – physiological stress
File number:	2016/18089

Representation:	Ms D Ward, Counsel Assisting, instructed by Mr D Yang, Crown Solicitor's Office Mr D Evenden instructed by Ms A Blair, Legal Aid NSW, for Emma Bell Mr Sebastian De Brennan instructed by Mr T Nikolic, Drayton Sher Lawyers, for Vincent Naudi Ms H Bennett instructed by Mr J Clohesy, Sparke Helmore Lawyers, for the Commissioner of Police, Senior Constable Michael Chaffey, Senior Constable Michail Greenhalgh, Senior Constable Peter Ellis and Senior Constable Kylie Griffith Mr B Bradley instructed by Ms C Blair, Makinson d'Apice Lawyers for the Northern NSW Local Health District and NSW Ambulance Mr C Jackson instructed by Mr J Kamaras, Avant Law, for Dr Lindsay Murray Mr N Dawson, New Law Pty Ltd, for Clinical Nurse Specialist Wendy Longmuir
Findings:	**Identity**: The deceased person was Tristan Francis Naudi. **Date of death**: Tristan died on 18 January 2016. **Place of death**: Tristan died at Lismore Base Hospital. **Cause of death:** Tristan died from an acute cardiac arrhythmia in 3,4-methylenedioxymethylamphetamine (MDMA) intoxication with physical restraint (including prone physical restraint). **Manner of death:** Tristan died while being restrained at Lismore Base Hospital as medical staff were attempting to sedate him.

Recommendations:	***To the Commissioner of the NSW Police Force*** **1. That the NSW Police Force Guidelines on the Management of People Affected by Methylamphetamine and Other Stimulant Drugs be reviewed to ensure consistency with other NSW Police Force policies and training regarding the use of prone restraint.** **2. To the extent that there is any change to the Guidelines referred to in Recommendation 1, that consideration be given to providing a training module on the amended Guidelines, including by reference to the risk factors presently included at Appendix A.** **3. That consideration be given to removing the "Excited Delirium" module from NSW Police training resources given that the 'mental condition' of 'excited delirium' is not recognised in the DSM-V nor ICD-10 and the advice to officers contained therein appears to be inconsistent with the current NSW Health – NSW Police Force Memorandum of Understanding 2018 regarding the transportation of a person detained under the *Mental Health Act 2007* in a police vehicle.** **4. That consideration be given to improving the conditions under which mentally ill or disordered persons might be transported using police vehicles, including through modifications to existing vehicles that may include, but are not limited to:** **(i) Improved air-conditioning or other ventilation.** **(ii) Installation of padding in caged vehicles.**

Non-publication orders	In relation to the manuals listed at Schedule A ("the Manuals"), pursuant to sections 65 and 74 of the *Coroners Act 2009* (NSW), the Court orders: 1. There shall be no publication of the Manuals or information contained in the Manuals. 2. Copies of the Manuals may only be provided to the Acting State Coroner, those assisting the Acting State Coroner, the Officer in Charge of the coronial investigation, and the legal representatives of the sufficient interest parties. 3. The Manuals may be inspected by the following people in the presence of their legal representatives, or in the case where they are unrepresented, in the presence of those assisting the Coroner: a) Ms Emma Bell; b) Mr Vince Naudi; c) Ms Angela Tallon; d) Senior Constable Michael Chaffey; e) Senior Constable Peter Ellis; f) Senior Constable Michael Greenhalgh; g) Senior Constable Kylie Griffith; h) Representatives of the Northern NSW Local Health District; i) Dr Lindsay Murray; j) Dr Rhiannon Edwards; k) Dr Michael Karpa; l) Clinical Nurse Specialist Wendy Longmuir; and m) Ms Carmel Johnstone. 4. In the event that oral evidence given during the inquest contains information contained in the Manuals, there shall be no publication of that evidence. 5. Should an application be made pursuant to s. 65 of the *Coroners Act 2009* seeking access to any of the Manuals, or documents containing information derived from the Manuals, on the Coroner's file, the Commissioner is to be notified of the application and provided not less than 48 hours to inform the Court as to whether the Commissioner wishes to be heard on the application.

	6. The Commissioner is to be provided with not less than 24 hours, after delivery but prior to publication, to review the findings and notify the Court of any application for information not to be published pursuant to Order 1. 7. At the conclusion of the inquest, all copies of the Manuals held by the legal representatives of the sufficient interest parties are to be returned to those representing the Commissioner. Schedule A – "The Manuals" 1. NSW Police Force Handcuffing Manual, Version 5.3; 2. NSW Police Force Weapons & Tactics Policy and Review, Close Quarter Control, Version 2.2; and 3. NSW Police Force Weapons and Tactics, Policy and Review, Weaponless Control, Version 3.1. 8. Pursuant to s.74(1)(b) of the *Coroners Act 2009* the Court orders, until further order, that the following photographs and footage not be published: a. Photos 1 – 17 included in the statement of Senior Constable Daniel Drew (Vol 3, Tab 88) of the coronial brief; b. Any photos included in the statement of Detective Senior Constable Sven Gerber (Vol 3, Tab 89) of the coronial brief; c. DVD footage set out at Vol 1, Tab 22 of the coronial brief, save for the fact that audio taken from the footage may be published. 9. Pursuant to s.65(4) of the *Coroners Act 2009* the Court orders, until further order, that the following photographs and footage not be supplied under s.65(2), taking into account the graphic nature of the material and the fact that the remainder of the Coroner's file is available for access subject to the requirements of s.65: a. Photos 1 – 17 included in the statement of Senior Constable Daniel Drew (Vol 3, Tab 88) of the coronial brief; b. Any photos included in the statement of Detective Senior Constable Sven Gerber (Vol 3, Tab 89) of the coronial brief; c. DVD footage set out at Vol 1, Tab 22 of the coronial brief, save for the fact that audio taken from the footage may be supplied. 10. Pursuant to s.74(1)(b) of the *Coroners Act 2009*, the Court orders that the mobile numbers, home addresses and age of witnesses from NSW Health not be published.

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The Coroner's Act 2009 (NSW) in s. 81(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 Tristan Francis Naudi.

Introduction

1. Tristan Francis Naudi was born on 13 October 1992. He was 23 years old when he died at approximately 11:28pm on 18 January 2016 at Lismore Base Hospital.

2. At approximately 6:30pm on 18 January 2016, Tristan consumed a gummy lolly containing MDMA. As the drug began to take affect Tristan's behaviour began to deteriorate. As the evening progressed he became increasingly unsettled, anxious and eventually aggressive. This behaviour was out of character for Tristan, with his friends describing him as ordinarily calm and laid back.

3. Several calls were made to 000 by Tristan's friends, neighbours and Tristan himself. Police arrived at Tristan's home at approximately 10:00pm and handcuffed Tristan behind his back and placed him in the cage of their Mitsubishi Pajero. Police transported Tristan to Lismore Base Hospital pursuant to s. 22 of the *Mental Health Act 2007* (NSW) and arrived at approximately 10:41pm. Hospital staff had to clear another patient from the isolation room and prepare the room for Tristan before he could be brought inside. Tristan was brought into the isolation room at approximately 10:57pm.

4. Tristan died at Lismore Base Hospital at approximately 11:28pm. Prior to his death, medical staff were attempting to sedate Tristan and had administered 10mg of intravenous droperidol and 10mg of intravenous diazepam. An autopsy report dated 28 April 2016 recorded the direct cause of death as "acute cardiac arrhythmia in 3,4-methylenedioxymethamphetamine (MDMA) intoxication with prone physical restraint".

The nature of an inquest

5. As Tristan died while he was in police custody, an inquest is mandatory pursuant to ss. 23(1)(a) and 27(1)(b) of the *Coroners Act 2009* (NSW) ("the Act").

6. The role of a Coroner, as set out in s. 81(1) of the Act, is to make findings as to the identity of the deceased, the date and place of the person's death, and the manner and cause of the person's death. Section 82 of the Act empowers the Coroner to make any recommendations that are considered "necessary or desirable" in relation to any matter connected with Tristan's death.

7. Tristan's identity and the date and place of his death were not in dispute. The focus of the inquest was on the cause and manner of Tristan's death.

8. An issues list was distributed in advance of the inquest, which provided:

> The inquest will consider the manner and cause of Tristan's death and any relevant contributing circumstances. The matters listed below are expected to be the primary focus of this inquest, but are intended as a guide only. Other relevant issues may arise during the inquest, which will require examination.
>
> In particular the inquest will consider:
>
> 1) Medical evidence relating to cause of death including:
>
> a) Stimulant drug intoxication: the possibility of lysergic acid diethylamide (LSD) consumption and, as revealed on toxicology results, presence of:
>
> 3,4-Methylenedioxymethylamphetamine (MDMA)
> 3,4 Methylenedioxyamphetamine (MDA, metabolite of MDMA).
>
> b) Physiological stress to the body as a result of MDMA toxicity and the later use of prone (face down) restraint.
>
> c) Tristan's prior medical history and the likelihood of any underlying medical condition of relevance to cause of death.
>
> 2) Events at Lismore Base Hospital once Tristan was brought in by Police, including:
>
> a) Who made the decision to bring Tristan from the Police Van into the isolation room, what was discussed at that time and what was observed as Tristan was brought in?
>
> b) Use of restraint once Tristan was in the isolation room including decisions as to how to restrain him, location of Police Officers when restraining him, communication between Police and Hospital staff and the estimated time that Tristan was restrained in the prone position.

9. The hearing commenced on 13 May 2019. During that first week of the inquest, an issue emerged in relation to the non-attendance of an ambulance at 16 Sansom Street, Bangalow on the night of Tristan's death. The matter was

adjourned to enable NSW Ambulance to be joined as a party of sufficient interest, and for further evidence to be obtained. The inquest resumed on 30 September 2019, at which time the Court heard further evidence from witnesses including witnesses from NSW Ambulance.

10. In preparing these findings, I have been greatly assisted by the detailed written submissions of Counsel Assisting as well as the written submissions prepared on behalf of the interested parties.

Background

11. Counsel Assisting prepared a detailed chronology of the events on 18 January 2016, which I propose to adopt.[1]

AM	Tristan was on a day off work. He told Emma, his partner, he wanted to get some acid to take before he went out to the Buddha Bar with Aidan Mulkerrins (flatmate) and another friend, Kyle.[2]
15:03–17:05	Series of SMS messages sent between Tristan (on Emma's phone) and Cheyne Taylor, arranging for Tristan to meet with Cheyne. Tristan was told to bring some "soft lollie things, so we can do them up…just definitely bring some jubes or something…just any sort of soft lollies that will absorb liquid …"[3]
Between 17:05–18:00 approx.	Tristan met with Cheyne and brought gummy lollies home.
Between 18:00–18:30 approx.	Tristan and Aidan took 1 gummy lolly each.[4] The remaining lollies were stored in an ice cream container in the freezer[5] but on later testing were not found to contain any illicit drugs.[6] Tristan later went into the bedroom where Emma was getting ready for work. Emma observed Tristan was in a really happy

[1] Times are approximate: some ICEMS entries depend upon conversations being typed up and inserted into the Incident Log and other times depend upon markings on Lismore Base Hospital CCTV footage.
[2] Tab 35, page 311.9.
[3] Tab 15.
[4] Tab 37, page 323.12.
[5] Tab 51.
[6] Tab 97.

mood and excited. He said he had some acid, he got the acid as soft lollies.[7]

20:00 approx. Aidan and Tristan went to the Buddha Bar but later returned home to Bangalow. Aidan called Jared Vanke (friend) because he felt Tristan was taking it harder and thought it was better to have someone sober to come over and keep watch.[8]

According to Aidan: Over the course of the evening Tristan became almost non-coherent. He couldn't register anything and tried to call Emma. When Aidan went to take the phone to call 000 he saw that Tristan had called the number himself.[9]

Jared arrived at the Bangalow house. Aidan was still concerned that Tristan was behaving very erratically. He couldn't sit still. He was naked. Tristan screamed out and called for Candi (another flatmate). Candi came out of her bedroom with her phone. Aidan and Tristan were standing near the front door. Candi went back into her room and Tristan followed. He went up and held onto Candi quite tight in a kind of bear hug. Tristan was screaming at Candi and she screamed too. Aidan managed to pry Tristan off Candi.[10]

Tristan continued to pace around and then grabbed Aidan's dog, Diego. Tristan was still screaming. Aidan went to sit across the road and waited for the Police to arrive.[11]

According to Jared: Tristan ran towards Candi and crash tackled her to the ground. It looked like Tristan wanted to get Candi's phone so he could talk on the phone. Tristan and Candi both screamed.[12]

Tristan later became extremely aggressive towards Aidan, swinging punches and collecting him around the ribs and side of his stomach.[13]

According to Candi: She was standing in the hallway on the phone to the 000 operator when Tristan came running towards her, grabbed her by the shoulders and forced her into the doorway of her room. She got away from him back into the

[7] Tab 35, page 312.13.
[8] Tab 37, page 324.17.
[9] Tab 37, page 325.20-326.21; Tab 50.
[10] Tab 37, page 327.24.
[11] Tab 37, page 327.25–27.
[12] Tab 38, page 338.27.
[13] Tab 38, page 340.35.

hallway but Tristan followed and tackled Candi to the ground. She dropped her phone. Candi called to Aidan "help me" and curled into the foetal position on the ground. Tristan was on top of her. He was naked, hitting her around the head and neck with his open hands.[14]

21:31 First call to 000 as noted in Incident Log 817297. The call was terminated requiring several call backs.[15]

21:36 000 call leads to ICEMS message to NSW Ambulance from Police.

ICEMS is the "Inter Cad Emergency Messaging System…that allows for electronic messaging between different computer aided dispatch systems. It allows for collaboration and teamwork between response agencies. Where an emergency call is attended by one agency but another is required, the agencies can communicate electronic messages via ICEMS."[16]

ICEMS notification from NSW Police inviting Ambulance to attend said "From Telstra M req pol and Ambo, stated has had drugs. On connection M said hello, stopped responding. Some movement in background, call terminated. On callback inft said something about girlfriend terminated call. On call back inft said needs pol, phone broke up, terminated call. On callback inft gave Loc terminated call. NFI. CHKS OTW."[17]

21:38 Automated "Will attend" message communicated by Ambulance to Police via ICEMS.[18]

NSW Police also send ICEMS message to Ambulance "Will attend".[19]

21:39 Ambulance ProQA generated priority of 2A emergency response (according to NSW Ambulance guidelines, this means that an ambulance should be with the patient within 30 minutes of the case being booked).[20]

Ambulance call taker then rang number recorded in ICEMS message to try and obtain further information on medical condition of patient. Tristan answered the call and when asked

[14] Tab 39, pages 346.12–347.13.
[15] Tab 83, page 935; Tab 50.
[16] Tab 125, page 2.6.
[17] Tab 125, page 2.10.
[18] Tab 83, page 937; Tab 125, page 3.11.
[19] Tab 83, page 937; Tab 125, page 3.12.
[20] Tab 125, page 3.11.

what was going on said "I don't know. I've taken some acid…Can you help me?"[21]

Additional information available to NSW Ambulance meant that ProQA generated a new dispatch code requiring 1C emergency response (most timely ambulance response attending with lights and sirens).[22]

21:42 Ambulance Duty Operations Centre Officer ("DOCO") subsequently downgraded the incident back to a category 2A. The rationale for the downgrade is not recorded in Ambulance records and the DOCO does not recall this incident.[23]

21:45 Incident Log 817414 recorded that BRU19 (the Pajero that ultimately transported Tristan to hospital) acknowledged the job.[24] Inside BRU19 were Senior Constable Michael Chaffey and Senior Constable Michail Greenhalgh.

21:52 Candi had locked herself in the bathroom and called 000. She was put through to NSW Ambulance. Amongst other things she said Tristan "was tripping…he just attacked me…please get someone here…he's outside yelling and screaming down the street…They're coming back to the house I think. Oh god he keeps yelling zero, zero, zero, he needs help…he shocked me a little bit."[25]

During this call Ambulance NSW told Candi "So the Police are gonna be there to help him and then we'll – the ambulance won't be too long after…The ambulance are on their way."[26]

However, no ambulance was on its way. As set out above, the job had been downgraded to a category 2A response and no ambulance had yet begun travelling to Tristan in Bangalow, even under that response category.

As a result of Candi's call to NSW Ambulance, ProQA again generated a new dispatch code (this time also marked with a "V" to signify the potential for danger or violence on site) requiring a 1C emergency response (lights and sirens).[27]

[21] Tab 125, Annexure F.
[22] Tab 125, page 3.14.
[23] Tab 125, page 4.16.
[24] Tab 83, page 944.
[25] Tab 125, Annexure G.
[26] Tab 125, Annexure G.
[27] Tab 125, page 5.22.

21:55 ICEMS message update from Amb-n setting status to urgent.[28]

The 1C response generated by ProQA was again overridden and downgraded to a 2A response by the DOCO.[29] The reason for the downgrade is not recorded in Ambulance records.

??? According to Jared: Tristan had moved outside but then ran inside and got the keys to his kombi van. He ran outside with them and fell face first onto the garden area[30] before tripping and falling onto his side on the pavers.[31] Tristan got into the driver's seat and Jared pulled the door open and wrestled with him and got the keys. Jared then closed the door. The window was open and Jared locked the door by pushing the button down. Tristan couldn't work out how to unlock it.[32] Tristan then jumped into the back of the kombi knocking over the surf boards. Tristan seemed to panic when he realised he was locked in and called "get me out of here". Jared got Tristan to move towards the driver's door and unlocked the door. Tristan pushed Jared with his right hand and tried to get out of the Kombi but his foot got caught in the seatbelt and Tristan fell face forward onto the tar road. Tristan landed heavily on the right side of his face and Jared took the opportunity to throw a towel over him and put his knee on Tristan's back. Tristan seemed to have worn himself out a bit and Jared removed his knee from Tristan's back. Tristan remained lying on the road. He asked "…how far off is help?" and Jared said "It's not long." Police arrived shortly afterwards.[33]

21:57 An entry was inserted into the Incident Log which recorded a call from a neighbour, Hugh Burton. The entry said "Inft can hear multiple M & FM screaming AA – inft can also hear thumping & believes it is physical – can hear people screaming 'Aidan' like they are trying to stop him doing something..."[34]

21:58 Police radio message entered into Incident Log recorded BRU19 having given an estimated time of arrival on scene as "couple of mins."[35]

[28] Tab 83, page 940.
[29] Tab 125, page 5.23.
[30] Tab 38, page 341.41.
[31] Tab 38, page 341.42.
[32] Tab 38, page 341.44.
[33] Tab 38, page 342.46–47.
[34] Tab 83, page 951.
[35] Tab 83, page 951.

21:59 Police radio message in Incident Log "BYR81/M/For BRU19 just had a call from AA neighbour escalating number of persons fighting poss smashed a window that is where the inj has come from."[36]

22:00 BRU19 arrived on scene.[37] NSW Ambulance was advised of this via ICEMS shortly thereafter.[38]

22:03 ICEMS message from BRU19 "Have 1 M here subdued and in the back of the truck going off – still need the ambos to attend."[39]

Tristan was in the cage at the back of the Pajero with the cage door locked but the back door to the Pajero open.[40]

22:04 ICEMS message from BRU19 into log "NFC [probably meaning 'no further cars'] required – M has taken acid – unsure if the ambos are going to be able to get near him – may have to convey him to the nearest hospital."[41]

??? Sometime after Tristan was in the back of the Pajero but whilst Greenhalgh was in in the house checking on Candi, Chaffey recorded Tristan on his mobile phone. He did this so that he could show the footage to doctors to demonstrate how disturbed Tristan's behaviour had been.[42]

22:05 Ambulance CADLink Look Back map shows the ambulance that was en route to Byron Bay from Gold Coast Hospital back in vicinity of Byron Bay ambulance station.[43]

ICEMS message from Amb-n: "Ambos not on the way as yet are Police going to transport."[44]

This was a message from NSW Ambulance asking if Police were going to transport Tristan after advising NSW Police that an ambulance had not yet commenced travelling to the job (for whatever reason). Although the statement of Tony Gately suggested this was a question posed by NSW Police, the ICEMS log records it as being "from Amb-n". The content of the message suggested it was a question being posed by

[36] Tab 83, page 952.
[37] Tab 83, page 952.
[38] Tab 83, page 952.
[39] Tab 83, page 952.
[40] Tab 19, page 105, Q45.
[41] Tab 83, pages 952–953.
[42] Tab 19, pages 105–106, Q47-51.
[43] CADLink Look Back 18/01/16 22:05:30.
[44] Tab 83, page 953.

Ambulance. VKG understood it to be a question being asked by "the ambos"[45] and Gately agreed that his statement was in error in this regard.[46] Finally, Keough's evidence was that he did not send a message "calling off" the Ambulance nor did he say that Ambulance should not attend the Bangalow residence.[47]

22:11 Police [Radio] message entered into Incident Log "NFC – M is in the back of the truck – partner is talking to spvr about poss us conveying this M to the hosp – he is pretty violent."[48]

22:13 ICEMS message from BRU19, update message sent to Amb-n "Don't think the ambos will be able to get near this M – standby – believe it is the spvr on the phone now."[49]

22:14 ICEMS message from BRU19, sent to Amb-n, "Spvr advised us to convey this M to Lis under Section 22."[50]

ICEMS message sent to Amb-n "Ambos not required thanks."[51]

ICEMS status update from Amb-n setting status to "Closed"[52]

22:20 Police [Radio] message entered into Incident Log "BRU19/M/OTW [on the way] to Lis Hosp"[53]

Using the timings recorded in the Incident Log, Tristan had been in the cage in the back of the Pajero for about 17 minutes by this point.

??? Excerpt from VKG recording, BRU19 "I'm just wondering whether it'd be a call just to ring the A & E at Lismore just to let them know we're on our way, ah, with this feller. Just so they're prepared."[54]

VKG response "I think that would be a good idea after what I just heard, no worries." BRU19 "Oh can you hear that?" VKG "Um…it's pretty loud".[55]

[45] Tab 130, Annexure B, page 8.
[46] TN 30/09/19, page 64.49.
[47] Tab 130, page 6.33.
[48] Tab 83, page 954.
[49] Tab 83, page 954.
[50] Tab 83, page 954.
[51] Tab 83, page 954.
[52] Tab 83, page 954.
[53] Tab 83, page 955.
[54] Tab 130, Annexure "B", page 9.
[55] Tab 130, Annexure "B", page 9.

22:28 Message in Incident Log, telephonist: "Lis Hosp advised that they have no rooms avail curr – there will most likely be a big delay"[56]

VKG "Ahh Brunswick 19 I think that might have been you, just for your info, I've just been on the phone to Lismore Hospital, they're pretty full and they don't believe they're going to have any room for him so there might be a bit of a wait with, um, the male in the back of the paddywagon at this stage."[57]

22:31 Speed camera at Bangalow Road recorded BRU19 travelling at 86km/h in 50km/h zone. This was en route to Lismore Base Hospital.[58]

22:41 BRU19 arrived at Lismore Base Hospital.[59] The journey took approximately 21 minutes and Tristan had been in the cage of the Pajero for approximately 38 minutes.

22:45 Sergeant Keough made an entry in the Incident Log "For record: Richmond Clinic ACU have no beds available. Tweed Heads ACU also have no beds but advice received from ACU (Sister Karen) that as Bangalow is within the Lismore health area the POI is to be the taken to Lismore A&E and placed at a location there pending vacancy in Richmond Clinic. Brunswick Heads 19 - conveying drug affected 22 year old male from Bangalow to Lismore Base Hospital A&E for initial medical treatment & then ACU assessment via a Police issue Section 22. Lismore Police to meet and assist Brunswick Heads 19…this info not for broadcast. RECORD ONLY, created by Sgt J Keough – supervisor, Byron Bay."[60]

22:52 Tristan was triaged by Clinical Nurse Practitioner Xanthe Moss.[61]

According to Dr Murray: "it was clear from speaking to the officers and what I could observe from outside the paddy wagon that this man was very, very disturbed … so I could hear loud banging against the walls…it seemed to me he was bashing his head or body against the walls…and I felt just from hearing that and what I, the reports I had from the Police that we, um , that I

[56] Tab 83, page 955.
[57] Tab 130, Annexure "B" page 10.
[58] Tab 9, page 65, Tab 7, page 34.7.
[59] Tab 72.
[60] Tab 83, page 955.
[61] Tab 69, page 821.6; Tab 78, page 872.

did not want him out of the paddy wagon until we were fully prepared to deal with him."[62]

According to Dr Edwards: "I went outside, just to view the patient, just to get an idea of, like, the level of agitation…I saw Tristan in the back of the Police van…I noted he was naked…he had his hands cuffed behind his back…he was kicking up. Like, on the roof of the van. So like, actually kicking his legs right up against the roof…and he was banging his head against the cage door….and sort of shouting, making, not really saying anything coherent. But obviously, visibly, very, like upset and agitated."[63]

CCTV footage from the ambulance bay at Lismore Base Hospital at Tab 72 seems to show the Pajero rocking at certain points.

22:57 BRU19 moved closer to the doors of the vehicle in anticipation of bringing Tristan from the Pajero into the isolation room.[64]

22:58 approx. Tristan was carried from BRU19 into the isolation room at Lismore Base Hospital. By this time he had been waiting in the back of the Pajero for about 17 minutes since arriving at the hospital[65] and had been in the cage in the back of the Pajero for approximately 54 minutes in total.

Tristan was observed to be sweating profusely as he was taken out of the Pajero and carried into the isolation room (however there was no opportunity to formally measure his temperature before he died).

22:59 approx. Dr Karpa inserted cannula into left forearm…Pt calling out incomprehensible words and moving around.[66]

23:00 approx. Dr Edwards administered droperidol 10mg.[67]

23:02 Dr Edwards administered diazepam 10mg.[68]

Tristan non-verbal and not moving. Staff requested that his handcuffs be removed, which attended to by police.[69] Tristan was then turned around to be near oxygen and other supplies.[70]

[62] Tab 58, page 496–497, Q42–45.
[63] Tab 53, page 429, Q22–28.
[64] Tab 72.
[65] Tab 78, page 872.
[66] Tab 78, page 872.
[67] Tab 78, page 872.
[68] Tab 78, page 872.

> According to Dr Murray: "cardiopulmonary resuscitation was commenced with bag-mask ventilation and cardiac compressions with full team in attendance. He was successfully intubated with a cuffed endotracheal tube at first attempt and bag ventilation commenced. Cardiac monitor was attached and he was found to be in asystole. …a total of 7mg of adrenalin was administered over subsequent rounds. The rhythm was always asystole or slow PEA. Further attempts at resuscitation were discontinued after 25 minutes of CPR with no return of spontaneous circulation at any point during that time interval. Extensive bruising to the face was noted during resuscitation attempts (police reported that was present when they arrived) and handcuff injury was also noted."[71]

23:28 Time of death.[72]

Police conduct in placing Tristan in the cage in the back of BRU19

12. As outlined in the chronology above, prior to police attendance Tristan had been physically aggressive to Aidan, Jared and Candi.

13. Tristan was presumably motivated by fear and desperation but there is no doubt that his actions were also aggressive to others. His behaviour was unpredictable.

14. Tristan was also a danger to himself as demonstrated by events after he took the keys to the kombi van. In these circumstances, Jared's actions in taking the keys from Tristan to prevent him from driving off and in restraining Tristan on the ground once he fell from the van, were both brave and caring, driven by an appropriate sense of concern for his friend.

15. As Senior Constables Chaffey and Greenhalgh drove to the scene in BRU19 they had no way of knowing what Tristan was ordinarily like: he was a stranger to them and the scant information available to them prior to arrival suggested they were attending a scene where someone was potentially violent and out of control.

16. Senior Constable Chaffey described what he saw on approach as follows:

> I saw a person laying on the ground with another person on top of them alongside a Volkswagen Combi … he was lashing out … I held onto his arm

[69] Tab 78, page 872.
[70] TN 15/05/19, page 31.30.
[71] Tab 78, page 874.
[72] Tab 78, page 874.

> and tried to talk to him. It was pretty clear that he wasn't, um, comprehending what I was saying he was just randomly yelling out words, random words, um, similar to Triple 0 … tried to stand him up and walk over to the Police truck … then he lashed out, so we grabbed either arm.[73]

17. Senior Constable Chaffey went on to describe how he lent Tristan against the Kombi and applied handcuffs. Senior Constable Chaffey said that Tristan "was naked … very sweaty …starting lashing out with his arms … and legs trying to kick out … so the best way we could restrain him was to put him in the back of the police truck so that he wouldn't hurt himself, or someone else, or us."[74]

18. Senior Constable Greenhalgh described arriving on the scene to see two males on the ground one on top of the other and yelling profanities. He stood Tristan up and then said "What's going on mate?"[75]

19. On Senior Constable Greenhalgh's account, Tristan then lashed out so they grabbed him, struggled with him, handcuffed him and got him in the truck.[76]

20. There was some dispute between Senior Constables Chaffey and Greenhalgh as to the extent that Tristan was resisting as they tried to move him into the Pajero.

21. On Senior Constable Chaffey's version "once he was handcuffed and he wasn't lashing out we were able to walk him to the back of the police vehicle and he actually climbed in to the back of the police vehicle of his own volition."[77]

22. Senior Constable Greenhalgh however said "I remember grabbing him in a full bear hug and having to walk him…I've walked him there."[78] He "wouldn't say it was easy…[n]ot at all" getting Tristan into the Pajero.[79]

23. It is unnecessary to resolve the inconsistency between their accounts. It is not surprising that their recollections differ given all that went on that night.

24. In any event, a number of other witnesses observed or heard the police interaction with Tristan at the Bangalow address.

25. Aidan said that police:

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[73] Tab 19, page 103–104.
[74] Tab 19, page 104–105.
[75] Tab 23, page 142.
[76] Tab 23, page 142–143.
[77] TN 13/05/19, page 33.41.
[78] TN 14/05/19, page 11.29.
[79] TN 14/05/19, page 11.36.

were really good with Tristan from what he could see and hear. I heard the police speaking to Jared and they said they would have to put the cuffs on Tristan and then I could hear Jared sort of explaining that to Tristan … and it was almost like he was letting them but also not letting them. It was kind of hard to explain.[80]

26. Jared witnessed more of a struggle. He said Tristan:

> realised they were there, he pushed me off and faced the police officers who were out of their car. He was in his aggressive stance again. He came towards one of the officers and was yelling out them [sic] … I don't remember what he actually said then but it was the same aggressive scrams [sic] he had been doing all night. The police both grabbed him and had him up against the front of the Kombi. Once the police grabbed his left hand and put a handcuff on. They were in a struggle with Tristan, he wouldn't allow his other hand to be brought around and was struggling with the police … It took both of them to hold him there, they managed to get the handcuffs on him.[81]

27. A neighbour, Carolyn Mortimore, said once the police arrived:

> I saw the police pick him up off the roadway. The police were very gentle. He wasn't fighting them in any way and they didn't have to force him to do anything. The police walked him to the back of the police car and put him in the back … He got into the car with their assistance. The police communicated with him and provided instructions about lifting his legs. I can remember one saying "Get your legs in mate." … The entire incident surprised me with how well the police handled it all. They were calm and assertive throughout it but not scary. Considering the situation, there was almost gentleness in the way they acted.[82]

28. Peter Mortimore said when police got to Tristan (Tristan was still on the ground at this stage):

> They got either side of him and raised him to his feet quite gently. They were talking to him and trying to calm him down … I couldn't see the male resisting too much and at the same time, the police were not applying any force to him. The male was extremely agitated but he didn't seem to be fighting the police much … The officers were calmly instructing him to step up into the back of the police car. They advised him to watch his head as he got in and to lift a leg over into the back. They seemed to have a few problems getting him. He didn't seem to be resisting as such, he was just difficult to handle.[83]

[80] Tab 37, page 328.27.
[81] Tab 38, page 342.47–48.
[82] Tab 43, page 373.10,14.
[83] Tab 44, page 376.10–11.

29. Another neighbour, Pauline Burton, could hear police talking calmly to people in the street[84] whilst her husband Hugh Burton (who had earlier called 000) could hear "continuous yelling and the muttering of voices. I could hear the rational voices of police trying to pull the situation down, not escalate it."[85]

30. Katrina Holt recalled the point where Tristan was in the back of the police van:

> The policeman said to the guy, "Don't hurt yourself mate." I could see he was kicking and thrashing around in the back … At no time did I see police act inappropriately. I actually thought the officer was quite calm considering how violent the male was.[86]

31. Perhaps Tristan was compliant at some times and aggressive at others. This was certainly the case earlier in the evening with Jared and Aidan. Once the police were on scene Jared said Tristan's "aggressive behaviour came in waves two minutes on two minutes off at this time. When he was aggressive he would yell out, kick the walls, then seem to take a breather, he would then become aggressive again. I kept trying to calm him through all of this. I couldn't get through to him."[87]

32. Senior Constable Chaffey gave evidence that Tristan "settled a little bit and then he'd kick out again and he'd settle and he'd kick out again … it was only a matter of like seconds, like 30 seconds or something like that. It was … sort of on a regular basis he'd be kicking out and then yelling…"[88]

33. It was submitted by Mr De Brennan, appearing for Mr Vincent Naudi, that the Court should "not overstate the risk that Tristan presented to other people" as Tristan had, at most, committed what might be described as summary offences rather than strictly indictable offences. Having regard to the evidence summarised above, I am unable to accept this submission.

34. I accept the submissions advanced by Ms Bennett, for the Commissioner of Police, and Counsel Assisting that assessing Tristan's behaviour through the lens of whether he committed summary or indictable offences is unhelpful and unnecessary. The role of the NSWPF is to protect the public and a police officer is permitted to use force as is reasonably necessary for the protection of persons from injury or death, regardless of whether the need for the use of force arises from any criminal act. The evidence indicates that Tristan was aggressive to Jared, Aidan and Candi, and also posed a risk to himself. In these circumstances, whether or not Tristan had committed any criminal

[84] Tab 41, page 361.11.
[85] Tab 45, page 382.10.
[86] Tab 48, page 403.10,12.
[87] Tab 38, page 343.50.
[88] TN 13/05/19, page 37.45.

offences, police had a duty to intervene and to prevent Tristan from harming himself or others.

35. Mr De Brennan submitted that Tristan displayed "moments of lucidity" and that his behaviours were "not so confronting as to be completely unmanageable". Mr De Brennan further submitted that "the need to contain and restrain Tristan should have been subsidiary to his overall welfare".

36. I accept that there were moments during the evening when Tristan was able to briefly answer questions and speak coherently but these moments were relatively fleeting. I find his behaviour overall was erratic and dangerous and needed to be managed somehow.

37. I am unable to accept the submission that "the need to contain and restrain Tristan should have been subsidiary to his overall welfare." This submission presents a dichotomy that didn't exist. It was not inconsistent with Tristan's overall welfare to contain and restrain him. Rather, it was a necessary step in trying to get him the help he needed and protect others from his erratic behaviour.

38. As Mr Evenden pointed out, to the best of knowledge of attending police, placing Tristan in the back of the Pajero was a temporary measure as they expected that an ambulance would attend.

39. In these circumstances, I am satisfied that police acted appropriately in placing Tristan in the back of the Pajero. It is significant to note that the chronology set out above demonstrates that Tristan was in the cage in the back of the Pajero within approximately three minutes of police arriving on scene. This was accomplished without police needing to draw their firearms or batons and without resorting to the use of OC spray or tasers. I accept Counsel Assisting's submission that this was in itself an achievement in the circumstances.

The decision that police would take Tristan to Lismore Base Hospital

The decision to downgrade the incident category

40. The chronology demonstrates that an ambulance was requested to attend the scene at Bangalow but the category (and therefore the response time priority) given to that request was twice manually downgraded by the Deputy Operations Centre Officer (DOCO) at NSW Ambulance.

41. Unfortunately, this long after the event the DOCO does not recall the reason for downgrading the incident category.[89] Accordingly, given the absence of contemporaneous records to explain the decision, neither the Court, nor Tristan's family, will ever know the reason.

42. Tony Gately, Director of Control Centres at NSW Ambulance, inferred that the first decision to manually downgrade from category 1C to category 2A was due to the fact that the ambulance call taker had been able to speak to Tristan when the call taker returned a call from Tristan and therefore knew that Tristan was "conscious and breathing."[90]

43. As the chronology makes clear, Tristan's matter was again scaled up to a category 1C response after Candi's telephone call. It was again manually overridden and downgraded to a category 2A response for reasons unknown. Gately infers, but the Court cannot know that this was due to the suggestion that Tristan was now considered violent and "the DOCO would have been aware that any attending paramedics would need to stand off from the scene until the NSWP had arrived."[91]

44. Even allowing for the fact that the category had been downgraded to 2A, the 30-minute priority guideline was not met. Here the matter became visible to the dispatcher at 21.39 which required, if the Category 2A timeframe was to be met, an ambulance to be with Tristan by 22:09.[92] I accept that the guideline is just that, a guideline rather than an inflexible rule. However, as at 22:09, an ambulance had not yet been dispatched, much less arrived on scene.

45. Mr Gately described the decision to manually downgrade as "not supported by NSWA policy or procedure."[93]

46. In terms of the systemic issues arising from the decision to downgrade the priority given to Tristan's matter, Mr Gately gave evidence that an "unauthorised practice existed for a limited time in the Northern Control Centre whereby some supervisors would, for various reasons and in order to manage resources, override the system manually".[94] However, I accept the evidence of Mr Gately that the local practice of manual overrides has ceased because it is not supported by NSW Ambulance policy or procedure.

[89] Tab 125, page 4.16.
[90] Tab 125, page 4.17.
[91] Tab 125, page 5.23.
[92] TN 30/09/19, page 56.5.
[93] Tab 125, page 4.18.
[94] Tab 125, page 4.18.

The delay in dispatching an ambulance

47. The Court received evidence in the form of CADLink Look Back maps showing the location of NSW Ambulance crews on the night of 18 January 2016.[95]

48. The Bangalow house was in a geographical area typically covered by ambulance vehicles out of Byron Bay and Mullumbimby stations. Ballina was then the next station in the "response order" for Bangalow.[96]

49. There was no crew on at Mullumbimby on the night of 18 January 2016 although two single units were "on call". As at 21:39 (the time that the Ambulance ProQA system generated the 2A emergency response priority for Tristan[97]) they were estimated to be 22.3km and 24.5km away.

50. Ballina had an ambulance crew at Ballina station at 21:39 and 21:52 but that crew had been dispatched to another job by 22:05. Had the Ballina crew been dispatched to Tristan they would not have been available for this job. The evidence does not however, permit me to make findings about whether that Ballina crew should have been dispatched to Tristan. There are simply too many unknown factors that may have influenced that decision and which the Court, unfortunately, cannot know.

51. Two ambulance vehicles were operating out of the Byron Bay station.

52. As at 21:39 one vehicle, Byron Bay 4576, was en route back to Byron from a Gold Coast Hospital. It was estimated to be 41.2km away from Tristan's home.

53. The second vehicle, Byron Bay 4572 was at the station estimated to be 9.6km from Tristan.

54. Submissions on behalf of New South Wales Ambulance emphasised, and I accept, had this Ambulance been dispatched, "this would have left a lack of on-duty cover in the Byron Bay region."[98] Mr Gately infers this was the reason the available vehicle was not dispatched to Tristan.

55. I also note, however that there were no competing 1C category matters awaiting ambulance dispatch as at 21.39.

56. The CADLink Look Back map for 21:52 likewise shows an available vehicle at Byron Bay station at that time which suggests no competing 1C category

[95] Exhibit 8.
[96] Exhibit 8.
[97] Tab 125, page 3.11.
[98] Submissions of 24 November 2019 at [18].

matters were then awaiting dispatch. I accept though, that the information available to this Inquest is provided with the benefit of hindsight. Ambulance staff tasked with decisions to dispatch vehicles on the evening of 18 January 2016 could not have known what competing demands would be placed on the service across that period.

57. Turning to the CADLink Look Back map for 22.05 it shows Byron Bay 4572 still at Byron Bay station but by this time Byron Bay 4576 had also returned. The time of return is unknown. There had been a change in status for Byron Bay 4576 in the meantime. By 22.05 it was marked "On Call (Single)" which Mr Gately inferred might have related to end of shift arrangements.

58. Submissions on behalf of New South Wales Ambulance emphasised the information shared between Police and Ambulance immediately prior to 22.05. This is a specific reference, as set out in the chronology above, to the Police entry into ICEMS at 22:03 "Have 1 M here subdued and in the back of truck going off – still need ambos to attend"[99] followed at 22:04 by another entry from Police "NFC Req- M has taken acid – unsure if the ambos are going to be able to get near him – may have to convey him to the nearest hospital."

59. This information may, or may not, have impacted upon decisions around dispatch to Tristan at 22.05, the evidence is not clear enough to permit me to make a finding either way.

60. It follows, I am not in a position to make any considered findings about whether an ambulance should have been dispatched to Tristan prior to the decision by NSW Police to take him to hospital in a police vehicle. The evidence simply does not permit me to explore the context around particular decisions at anything other than the very general level set out above.

61. I acknowledge the very real concerns expressed by Tristan's family about the non-attendance of ambulance and the fact that if an ambulance had attended, it might have produced a different result for Tristan. It is regrettable that this Inquest has not been able to consider this further.

62. If an ambulance had attended on the evening of 18 January 2016, it might have produced a different result for Tristan or it might not.

63. Counsel Assisting submitted, and I accept, that any number of scenarios might have arisen depending upon matters such as:

[99] Tab 83, page 952.

(a) If the ambulance arrived prior to police whether, given Tristan's presentation, paramedics were willing to commence assessment prior to police attendance. Both Scott Deeth, Acting Director of Clinical Practice at NSW Ambulance, and Mr Gately indicated that paramedics may have had to "stand off" until the scene was secured by police.[100]

(b) If the ambulance arrived after police but before Tristan was placed in the Pajero whether, given Tristan's presentation, paramedics were able to "assess" him whilst police restrained Tristan outside the Pajero.

(c) If the ambulance arrived after police placed Tristan in the Pajero whether, given Tristan's presentation, paramedics were able to do anything other than conduct a visual assessment. This would depend upon the extent Tristan was willing and able to co-operate in a way that permitted him to be safely removed from the Pajero and assessed. Paramedics would not be expected to get into the back of the Pajero to assess Tristan.[101]

Whilst the Court cannot know whether paramedics would have been able to conduct anything other than a visual assessment once Tristan was in the back of the Pajero, it seems unlikely any more detailed assessment would have been possible.

The video footage recorded by Senior Constable Chaffey provides direct evidence of Tristan's behaviour shortly after he was put into the Pajero (Tristan was in the Pajero by about 22:03 and the Pajero departed the scene by about 22:20). Dr Holdgate said "having seen the footage of Tristan, I've never seen anyone as disturbed as Tristan was both in his inability to connect with the conversation around him [which must go to his capacity to co-operate with paramedics had they attended] and his level of physical distress and agitation [which must go to the ability of paramedics to safely assess him]."[102]

(d) If the paramedics who attended were able to conduct a physical assessment, whether Tristan would have co-operated long enough to permit the administration of sedation, followed by a period of monitoring his response and the need for further sedation if required.

On this point, I reject the submission that having Tristan secured in a "small and contained area would have provided ambulance officers with ample opportunity to assess his vital signs and, if deemed appropriate, to

[100] Tab 124, page 2.11; TN 30/09/19, page 75.39.
[101] TN 30/09/19, page 33.33
[102] TN 16/05/19, page 14.20.

potentially jab him with a syringe containing antipsychotic medication so as to calm him down".[103]

Associate Professor Holdgate highlighted the difficulties with this scenario in her evidence and concluded:

> I think it's a big assumption to know whether that [referring to sedation via intramuscular injection] would have worked or not. It entirely depends on whether those drugs were effective. The initial dose of 10 milligrams in him was probably a relatively low dose so I think there would be no certainty that that would or wouldn't have been effective in an intramuscular dose. We just don't know.[104]

What follows from this is that, because intramuscular doses generally take about 15 minutes to "kick in" (if they work),[105] Tristan either would have had to maintain co-operation during that time or be restrained during that time. Even if paramedics were successful in administering intramuscular sedation, their capacity to appropriately monitor Tristan would be limited.

Similarly, Scott Deeth, Acting Director of Clinical Practice at NSW Ambulance, expressed concerns about the ability of paramedics to administer sedation to a patient restrained in the back of a police vehicle:

> Administering medication to a patient held in the rear of a police vehicle who is still exhibiting violent behaviour is problematic. The patient would need to be removed from the vehicle and likely further physically restrained to ensure the safe administration of chemical restraint.[106]

(e) If the paramedics who actually attended were then authorised to administer droperidol (described by Mr Deeth as "the most effective"[107] sedative). If not, they would have had to use midazolam.

64. It is uncontroversial that it would have been desirable for paramedics to attend the Bangalow residence and to make their best attempts to assess and/or treat Tristan.

65. However, I am cognisant of the resourcing limitations facing NSW Ambulance, and the need to factor in operational matters such as ambulance coverage. In these circumstances, the Court welcomes the recent opening of an ambulance station in Pottsville and the provision of additional services in the region. It is

[103] Vincent Naudi submissions at [39(d)].
[104] TN16/05/19, page 17.3.
[105] TN 16/05/19, page 16.39.
[106] Tab 124, page 3.14.
[107] Tab 124, page 2.13.

hoped that this will go some way in preventing a similar situation from occurring in the future.

Sergeant Keough's decision that police would take Tristan to Lismore Base Hospital

66. The decision to have BRU19 take Tristan to Lismore Base Hospital was made by Sergeant Keough. This is clear from the Incident Log,[108] the VKG transcript,[109] and Sergeant Keough's own evidence.[110]

67. Sergeant Keough explained that he directed BRU19 to transport Tristan for the following reasons:

    (a) Tristan's reported violence, drug-affected and non-compliant state meant that it was unlikely that paramedics would be able to get near him;[111]

    (b) Tristan was secured in the cage of BRU19 and it was not safe to open the cage if paramedics had attended. As a result, paramedics would not have been able to administer sedation;[112]

    (c) An ambulance had not yet been dispatched and Sergeant Keough had no information about how long it would take for an ambulance to arrive at Tristan's address;[113]

    (d) Sergeant Keough thought it was important for Tristan to be transported to hospital as soon as possible so that treatment could be administered.[114]

68. Sergeant Keough did not "call off" the ambulance. It was only once he directed that BRU19 should take Tristan to Lismore Base Hospital that the decision was then communicated to NSW Ambulance via an ICEMS message at 22:14.

69. Counsel Assisting submitted that:

> It would obviously have been preferable for an ambulance to attend and attempt an assessment of Tristan. It is possible that this might have made a difference for Tristan. But the fact there was an option for police to wait for an indeterminate period for an ambulance to arrive (with whatever physiological sequela[e] might flow from Tristan's continued restraint in the

[108] Tab 83, page 954.
[109] Tab 130, Annexure B, page 8.
[110] Tab 31, page 247.14; Tab 130, page 5.32.
[111] Tab 130, page 5.32.1.
[112] Tab 130, page 5.32.2.
[113] Tab 130, page 5.32.3.
[114] Tab 130, pages 5.32.4, 5.32.5.

interim) and possibly establish rapport with Tristan and possibly sedate Tristan and possibly transport him to Hospital with police assistance, does not mean Sergeant Keough was wrong in making the decision that he did in the circumstances.

In fact, the decision for BRU19 to transport Tristan to Lismore Base Hospital was sensible in the circumstances that existed on 18 January 2016.

Tristan was a danger to himself and others. He needed help and as at 22:05 help from NSW Ambulance was not yet on its way.

70. In making that submission, Counsel Assisting relied upon the following factors, most of which expand upon the matters raised at [63] above:

(a) Tristan was already safely secured in the back of the Pajero (although this was far from an ideal vehicle for him).

(b) Tristan was still agitated and aggressive.

(c) Paramedics may not have been able to establish rapport and assess Tristan safely even if they had attended. Scott Deeth, Acting Director Clinical Practice, NSW Ambulance watched the DVD of Tristan in the back of the Pajero and expressed the view "Conducting an assessment of a patient exhibiting the behaviour of Mr Naudi is difficult. Had paramedics arrived before the NSW Police, I am doubtful that they would have been able to establish rapport and conduct any type of assessment. They may have assessed the situation and determined to 'stand-off' pending NSW Police arrival."[115] When asked about the situation at hand, that is, with Tristan already in the back of the police Pajero and police present, Mr Deeth said he would expect paramedics to communicate and engage with the patient, attempt to de-escalate and try to conduct an informed assessment. He also noted that if they could not establish a line of communication, safety would be a paramount consideration for the patient, paramedics and bystanders.[116] It is far from clear that paramedics would have been able to establish communication with Tristan.

(d) Paramedics would not have been expected to enter the cage for the purpose of assessing Tristan. Mr Deeth said he would not expect paramedics to do so and any decision to remove Tristan from the cage and restrain him whilst administering sedatives and monitoring their effect would require assistance because of the need to handle the patient in a safe manner.[117]

[115] Tab 124, page 2.11.
[116] TN 30/09/19, page 33.28.
[117] TN 30/09/19, page 33.35.

(e) Associate Professor Holdgate gave expert evidence about medical assistance from the time that Tristan was detained in the Pajero until he reached the hospital. She said:

> It sounds from the description of his agitation and his inability to engage with his surroundings was severe. I don't think it would have been safe for anyone to do anything else. Until he could be contained with some sort of chemical sedation, I don't think it would have been physically possible to actually get close enough to provide any other treatment and certainly not to provide any monitoring or measure of any of his vital signs…it wouldn't have been possible [to cool him down] without containing him first.[118]

(f) In terms of restraining Tristan on a stretcher, Dr Holdgate said "I think it would have been actually very difficult to contain him on a stretcher. I've seen people close to that who have actually caused themselves injury by being restrained on a stretcher and then tipping the whole stretcher over because they're so physically agitated so I think that may or may not have been possible."[119]

(g) Dr Holdgate further said "I think the choice has to be made at the time using the resources you've got for the safety of both him and all the people around him…but the alternative of bringing him in an ambulance with – manacled to the sides or strapped to the sides might have been very dangerous for the drivers, for the ambulance staff, for the police and may or may not have been physically actually possible to do, depending on his level of agitation so that also might have carried significant risks."[120]

(h) Droperidol "was only introduced for use in NSWA in November 2015" and whilst staff from the Northern Rivers Zone had been trained in its use by end January 2016, Scott Deeth could not say whether the paramedics who may have attended on 18 January 2016 would have completed training and been authorised to use the droperidol at that time.[121] They may have been restricted to using midazolam. Neither Dr Holdgate nor Dr Murray suggested that midazolam was a more appropriate sedative for Tristan.

(i) Even if sedation had been administered by paramedics this would have likely delayed Tristan's transport to hospital because "you can't then just

[118] TN 16/05/19, page 10.24.
[119] TN 16/05/19, page 14.26.
[120] TN 16/05/19, page 14.35.
[121] Tab 124, page 2.13.

put him unwarranted [query "unmonitored"] in the back of a police van and he may be too agitated to be put in the back of an ambulance so you would have to wait and see if it works and then that's just prolonging the delay to get to hospital."[122] Further, Dr Holdgate noted that an initial dose of 10 milligrams in a young man of Tristan's size "was probably a relatively low dose so I think there would be no certainty that that would or wouldn't have been effective in an intramuscular dose."[123] However, if sedation had been administered with good effect, the physiological stress Tristan was experiencing would have been reduced.

71. In circumstances where an ambulance had not been dispatched by 22:05, and for the reasons submitted by Counsel Assisting, I am satisfied that Sergeant Keough's decision that police would transport Tristan to Lismore Base Hospital was reasonable. That said, it is uncontroversial that transporting someone like Tristan, who is suffering from an acute behavioural disturbance, in a police vehicle is far from ideal. It would of course have been preferable for Tristan to be transported in an air-conditioned ambulance and, as outlined above, it is possible that this may have resulted in a different outcome for Tristan.

72. The decision that police would transport Tristan to hospital was consistent with the July 2007 Memorandum of Understanding for Mental Health Emergency Response ("2007 MOU"), which was expressed to apply to "persons with a known or suspected mental illness or mental disorder, or who exhibit behaviours of community concern."[124]

73. The 2007 MOU provided:

> Police have obligations to transport, or assist in the transport of, a person to a health care or custodial facility under relevant Acts, legislative orders and warrants.
>
> Police assistance may be required by Ambulance in the pre hospital emergency setting to safely manage and transport behaviourally disturbed patients. This will be particularly relevant with restrained patients in the care of Ambulance, where Police presence is required to reduce the safety risks to the patient and Ambulance Officers.
>
> Police's role in other transport of mentally ill persons is limited to situations where there is assessed serious risk to the person or others such that Police presence (as escort or transport) is required.[125]

[122] TN 16/05/19, page 16.33.
[123] TN 16/05/19, page 17.5.
[124] Tab 31, page 261.
[125] Tab 31, page 268 and see flowchart at page 284.

74. This remains the position under the NSW Health – NSW Police Force Memorandum of Understanding 2018 ("2018 MOU"), which provides:

> Police officers may transport a person detained under the MHA to hospital in a police vehicle. NSWPF policy indicates that such people should be transported in a police caged vehicle. However these vehicles are not designed for such transports and do not offer the ability to effectively monitor persons who have medical issues or serious mental health issues. Police vehicles should therefore be viewed as a last resort for transport.[126]
>
> …
>
> Police vehicles should only be utilised where the person is at risk of serious harm to themselves or others, or where their behaviour presents a threat to public safety, including a risk to paramedics during transport that cannot be safely managed by the paramedics, and the Police vehicle is the safest transport option. It is acknowledged that in remote areas of NSW, other considerations may apply.[127]

75. The Court received into evidence a USB containing an online training module for police in the 2013–2014 training year on "Excited Delirium/Positional Asphyxia". In that module, the Chief Medical Officer for NSW Police indicated that police should not transport someone who they suspect is experiencing 'excited delirium' until the person has been medically reviewed.

76. Sergeant Watt gave evidence that this remains the "preferred methodology" for dealing with someone with 'excited delirium' but acknowledged that it might not be possible in some circumstances.[128]

77. The training module appears to dissuade police from transporting, even as a last resort, a person who they believed was experiencing 'excited delirium'.

78. An issue might arise, particularly in rural and regional areas, where someone might wait for an indeterminate period of time for an ambulance to firstly become available and secondly travel to the incident, even whilst police are on scene and able to contain the person and leave immediately to take them for urgent medical review.

79. In this respect, Sergeant Watt said:

> if I was five minutes away from St Vincent's Hospital, I wouldn't be waiting for an ambulance, because I can have him to medical attention before the ambulance … gets there, … it is a difficult situation, ideally yes they should

[126] Tab 131, page 13.
[127] Tab 131, page 13.
[128] TN 17/05/19, pages 16.35, 16.44.

[wait for an ambulance] but there are circumstances where an alternate methodology designed to get a better result, is acceptable.[129]

80. The training module is inconsistent with the 2018 MOU and accordingly has the potential to mislead. I accept Ms Bennett's submission that there is no evidence that any of the police officers involved in Tristan's case were actually misled by the training module. However, I consider it desirable that the inconsistency be corrected.

The NSWPF Mitsubishi Pajero

81. During the course of the inquest, an issue arose as to the appropriateness of restraining and transporting Tristan in the cage of the Pajero.

82. The caged area of the Pajero does not have air-conditioning. There are only two small fans in the caged area. Senior Constable Chaffey indicated that the cabin of the Pajero has air-conditioning and the fans would suck in a small amount of cool air, but this was not equivalent to being in the cabin.[130]

83. I accept Associate Professor Holdgate's evidence that the poorly ventilated small space in the cage of the Pajero contributed to Tristan's physiological stress, particularly as Tristan had a high body temperature from his response to the MDMA.[131]

84. I also accept that it is likely that Tristan injured himself by struggling and bashing his head and body against the cage in the back of the Pajero. The cage was not padded and Sergeant Watt gave evidence that he was not aware of any NSWPF vehicle having padding in the cage.[132]

85. In relation to the Pajero, Senior Constable Greenhalgh said: "obviously we're only last resort [for transportation], but you know, it's obviously the worst place for someone suffering from mental illness or drug-affected people".[133]

86. Counsel Assisting submitted that the Pajero was not a suitable vehicle. It was hot and cramped and despite the handcuffs, Tristan most likely inflicted further injury on himself because he was able to move around in the cage. Ideally, even if not taken by Ambulance, Tristan would have been safely secured within a large air-conditioned space, where police could monitor him on the trip and where he could have been restrained in a way to limit further injury to himself.

[129] TN 17/05/19, page 16.50.
[130] TN 13/05/19, pages 33.48, 34.8.
[131] TN 13/05/19, page 10.12.
[132] TN 17/05/19, page 39.26.
[133] Tab 23, page 172, Q350.

87. Similarly, Ms Bennett conceded that the Pajero was "not ideal" but noted that it was the only police vehicle available in the area at the time.

88. Evidence was received from the NSWPF that Pajeros are the predominant first-response vehicle in the Tweed Byron Local Area Command (LAC) (as the Tweed Byron Police District was known at the relevant time). The vehicles are suitable for use in the highly diverse terrain within the LAC, including on beaches, mountainous tracks, flooded areas and other remote areas.[134]

89. The NSWPF indicated that a Pajero was not specifically selected and that the officers who accepted the job over the VKG happened to be in a Pajero. Sergeant Keough indicated that the only vehicles patrolling the Tweed Heads, Murwillumbah, Kingscliff, Brunswick Heads and Byron Bay areas on the evening of 18 January 2016 were Pajeros. There was one other vehicle in the Byron Bay area, described in evidence as the "ice-cream truck". However, that vehicle was not on patrol and was for use by the shift supervisor in the event that they needed to attend an incident or job. A Ford Ranger was available in Mullumbimby but it was not on patrol on the night. Sergeant Keough also indicated that Highway Patrol sedans operated within the LAC but those vehicles are not equipped to transport detained persons.[135]

90. In these circumstances, I accept that the use of the Pajero for transporting Tristan to Lismore Base Hospital was far from ideal and it undoubtedly contributed to Tristan's physiological stress. However, it was the only available option at the time because at 22:05 an ambulance had yet to be dispatched. In these circumstances, I am not critical of police for transporting Tristan in the cage of the Pajero.

91. However, in light of the evidence from Associate Professor Holdgate and the concerns expressed by Senior Constable Greenhalgh as well as Tristan's family, the Commissioner of the NSWPF may wish to examine the use of the Pajero and other similar vehicles for transporting mentally ill or drug-affected individuals and may wish to give consideration to how these or other vehicles might be upgraded to ensure that those restrained in the cage are safely transported to hospital.

[134] Tab 129, page 1.
[135] Tab 129, page 1; tab 130, page 4.

The delay in bringing Tristan into the isolation room at Lismore Base Hospital

92. Lismore Base Hospital staff including Dr Murray,[136] RN Culpitt[137] and RN Longmuir[138] were all aware police were on their way with a new patient but they already had another patient in the isolation room.

93. According to the timestamp on the CCTV footage from Lismore Base Hospital, BRU19 arrived at approximately 10:41pm. However, Tristan was not immediately brought into the isolation room.

94. The CCTV footage shows BRU19 moving closer to the entrance to the isolation room at 10:57pm. Tristan therefore spent approximately 16 minutes in the cage of the Pajero after arriving at hospital and before being carried into the isolation room.

95. This was in addition to the time Tristan spent in the cage whilst decisions were being made at Tristan's house for police to take him to hospital (about 17 minutes) and the time it took for BRU19 to travel to Lismore Base Hospital (about 21 minutes). Tristan was therefore in the cage in the back of the Pajero for approximately 54 minutes before being transferred into the isolation room.

96. I accept the submissions of Counsel Assisting and Mr Evenden that this additional period of confinement would have further contributed to Tristan's physiological stress.

97. It follows that the sooner Tristan was safely removed from the cage, the better. In this respect, it is significant to note the opinion of Associate Professor Holdgate that:

> Having seen the video footage of Tristan, I've never seen anyone as agitated as he was and I very much doubt the hospital would have any expectation that he was as ill as he was…it's always a struggle to manage the limited physical space and work out how you're going to move people around safely to prepare a room so even though the ideal would be the room would be vacant and all the staff ready when he arrives, I don't think anyone could have predicted he would have been as distressed as he was.[139]

98. Dr Murray developed a clear plan, which he communicated to Dr Edwards and other staff.[140] The plan involved:

[136] Tab 58, page 496.33–497.52.
[137] Tab 67, page 810.7.
[138] Tab 68, page 816.4.
[139] TN 16/05/19, page 10.50.
[140] TN 15/05/19, page 8.14.

(a) Observing and assessing Tristan while he was in the cage of the Pajero;[141]

(b) Preparing the isolation room, which included moving the patient that was in the isolation room at the time, removing the bedframe and placing the mattress on the floor;[142]

(c) Discussing the use of intravenous droperidol and diazepam with Dr Edwards and instructing a nurse to draw up the medication;[143]

(d) Bringing the patient in once the isolation room was ready. Dr Murray and Dr Edwards both wanted to observe Tristan being brought from the Pajero into the isolation room. Dr Murray said "it would have given me a little bit of feeling how disturbed ... violent, aggressive he was." Dr Murray also wanted to be the person to decide when Tristan would be brought in from the Pajero. He said this was not the usual course but in this case he wanted to "immediately insert an intravenous cannula and sedate him. But I wanted everything ready before it, so we didn't have a long struggle or restraint in the room."[144]

(e) Administering the intravenous droperidol and diazepam as soon as possible under Dr Murray's supervision;[145]

(f) Determining further treatment once Tristan was adequately sedated.[146]

99. In relation to Dr Murray's plan, Associate Professor Holdgate said "I think that's exactly the plan that you would want to enact".[147]

100. In these circumstances, I accept Counsel Assisting's submission that the delay in getting Tristan out of the cage was undesirable but the need to move another patient and prepare the isolation room for Tristan were legitimate considerations for the hospital to take into account.

101. Since Tristan's death, Lismore Base Hospital has moved to a new facility which includes two isolation rooms for use in the Emergency Department, which Dr Murray described as adequate for their needs.[148]

[141] TN 16/05/19, page 22.11.
[142] Tab 54, page 497, Q51–Q52.
[143] Tab 54, page 460; TN 16/05/19, page 22.11.
[144] TN 15/05/19, page 3.7–4.10.
[145] TN 15/05/19, page 8.38; TN 16/05/19, page 22.11.
[146] TN 15/05/19, page 21.18.
[147] TN 16/05/19, page 22.19.
[148] TN 15/05/19, page 17.45.

Transferring Tristan from BRU19 into the isolation room

The decision to bring Tristan into the isolation room

102. When asked how he learnt that the hospital was ready for him to bring Tristan into the isolation room, Senior Constable Chaffey said "I'm not entirely sure but I believe that the, the door to the room that I knew that he will have to go into opened and that, that signalled that we were right to go in there." Senior Constable Chaffey did not recall anyone telling him they were ready for Tristan to be brought in but said that it "could have happened".[149]

103. Senior Constable Greenhalgh assumed that the decision to bring Tristan in "would've been"[150] because hospital staff said they were ready but he had no recollection of the actual direction given.[151]

104. Of the nurses who provided statements in relation to Tristan's death, they were either not in the room themselves when Tristan was brought in (Donna Jelsma,[152] Kim Sterling,[153] April Cupitt,[154] Wendy Longmuir[155]) or cannot assist in determining who, if anyone, gave the direction to police (Xanthe Moss[156]).

105. Rohit Bhagat, a security guard at Lismore Base Hospital, refers to an unidentified female nurse who, on his account, said to one of the police officers "you restrain him down and we will inject him" shortly before the police positioned themselves at the back of the Pajero and opened the door.[157]

106. The CCTV footage appears to show some discussions between police and nursing staff at various points before the Pajero is reversed closer to the door to the isolation room. Unfortunately because the camera is focussed upon the main ambulance entrance rather than the entrance to the isolation room the CCTV does not record Tristan being moved from the Pajero. The footage does seem to capture a nurse in conversation with one officer (most likely Senior Constable Chaffey) as he gets out of the Pajero having reversed it into place.

107. If a direction was made by hospital staff to police to bring Tristan in, hospital records do not record who communicated that direction.

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[149] TN 13/05/19, page 39.9.
[150] TN 13/05/19, page 82.8.
[151] TN 13/05/19, page 82.25.
[152] Tab 65, page 782–783, Q18-Q25.
[153] Tab 66, page 804.8.
[154] Tab 67, page 811.12.
[155] Tab 68, page 817.5.
[156] Tab 69, page 822, Q3.
[157] Tab 74, page 837.15.

108. Based on the evidence, I am unable to determine who made the decision to bring Tristan into the isolation room from the Pajero.

109. Regardless of who made the decision to have Tristan brought into the isolation room, it is clear that this part of Dr Murray's plan was not properly executed. As a result, Dr Murray and Dr Edwards were denied a valuable opportunity to observe Tristan's behaviour as he was brought into the room.

110. I accept, however, the submission of Mr Jackson that other key aspects of Dr Murray's plan as outlined were in fact implemented. This will be discussed further below.

111. Counsel Assisting submitted, and I accept, that it is difficult to generalise from the specific failure to execute Dr Murray's plan on this occasion, in order to draw a conclusion that this was part of a systemic failure on the part of the hospital.

112. In any event, the Northern NSW Local Health District has since implemented a policy entitled "Transfer of a patient from a police vehicle into a gazetted emergency department safe assessment room", which makes clear that "[t]he Nurse in Charge is responsible for advising the Police to enter the emergency department with the patient."[158]

The method of transferring Tristan into the isolation room

113. The evidence differs in relation to how Tristan ended up being placed face down on a mattress in the isolation room with his head facing towards the door.

114. Senior Constable Chaffey said that he reached into the cage of the Pajero and grabbed Tristan's left leg. Tristan at first kicked out and his toes hit Senior Constable Chaffey's face and his heel connected just above the police shirt pocket.[159] Senior Constable Chaffey then grabbed Tristan's left leg whilst Senior Constable Greenhalgh took his right leg. Senior Constable Ellis then stepped in to help on Tristan's right hand side. On Senior Constable Chaffey's account, Tristan "flipped over" as they grabbed his legs and he ended up face down.[160]

115. Senior Constable Greenhalgh said that as they lifted Tristan out of the Pajero he came out feet first[161] and somehow ended up face down.[162] He indicated

[158] Exhibit 7, page 1.3.9.
[159] Tab 19, page 110, Q75–78.
[160] Tab 19, page 110, Q77–78, TN 13/05/19, page 40.16.
[161] TN 13/05/19, page 83.14.
[162] TN 13/05/19, page 83.17.

that prone restraint was not a deliberate choice and agreed that it resulted from the way in which Tristan was removed from the Pajero.[163]

116. Senior Constable Greenhalgh also recalled that "one of the staff", he presumed hospital staff, directed them to put Tristan down on his stomach.[164]

117. Senior Constable Griffith recalled a female voice asking that Tristan be "on his stomach to go into the room to make it easier to put the cannula into his arm."[165]

118. Senior Constable Ellis recalled a discussion between police and hospital staff that included police saying, "We'll carry him facedown … with his legs and by his arms so therefore obviously 'cause he had blood and snot and shit down on his face and obviously we don't want to get a) spat on … b) any blood off him onto us … and then the medical staff, I'm not sure if it was before we lifted him out or got him into the room, requested he be placed facedown."[166]

119. The following entry appears in Senior Constable Ellis' notebook: "I said bring him out face down as he had a nose/mouth injury blood and in his ranting was spitting blood for officer safety and infectious diseases".[167] In cross-examination, Senior Constable Ellis said "it might have just been a mere suggestion, but that's the best way to do it" and maintained that he did not make the decision to bring Tristan into the isolation room face down.[168]

120. Clinical Nurse Specialist Wendy Longmuir was not in the room when Tristan was brought in[169] but gave evidence that patients brought in from a police vehicle are "brought into the room and held down by the shoulders and their thighs and their ankles, if we've got enough people to do that. And that's normally facedown."[170]

121. Mr Evenden submitted that that the Court should find that there was a direction from hospital staff that Tristan be placed face down.

122. In contrast, Counsel Assisting, Ms Bennett and Mr Bradley submitted that the evidence does not allow for any finding as to who made the decision to bring Tristan into the isolation room, or whether a direction was given that he be placed face down.

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[163] TN 13/05/19, page 83.37.
[164] TN 13/05/19, page 84.3.
[165] TN 14/05/19, page 70.38.
[166] Tab 25, page 188, Q69–72.
[167] Tab 26, page 209.
[168] TN 14/05/19, page 64.30, 65.1–8.
[169] TN 14/05/19, page 30.5.
[170] TN 14/05/19, page 27.16, 30.20.

123. I am not persuaded that the evidence permits a finding that Tristan was placed face down because of a direction from hospital staff. I cannot exclude the possibility that, as Mr Bradley submitted, the method ultimately adopted may not have been intentional or planned and may have been the product of a combination of police effort and Tristan's resistance and struggle.

124. Given Tristan's presentation, I am not satisfied that there was anything unreasonable in the manner in which Tristan was brought into the isolation room.

125. Submissions on behalf of Vincent Naudi were critical of the fact that Tristan was brought in face down with his head the wrong way around (facing towards the door), noting that Dr Murray would have preferred that Tristan's head be at the other end of the room.[171] As a result, once Tristan was found not to be responding, he had to be turned around to face the medical equipment.[172] Mr De Brennan submitted that, as a result, valuable seconds were lost. I accept that some seconds must have been lost because of this but I am not critical of that fact given the circumstances confronting police and hospital staff at the time.

126. In this respect, I accept the evidence of Associate Professor Holdgate that:

> I think he was brought in the only way that was physically possible from the description that I've read ... The description I read was that the only way they could extract him from the van was to get his legs first, he then flipped on his face and they then had to take him out backwards and that's how they entered because they were right backed up [against] the door. My understanding [is] that's why he entered the room in the direction. Whether he came in head first or foot first, I don't think it really mattered.[173]

127. Dr Murray gave evidence that because Tristan was handcuffed behind his back, he could not have been restrained on his back as this would prevent the insertion of a cannula. Dr Murray indicated that a short period of prone restraint was required to allow for intravenous access.[174] Dr Murray further stated that while it was possible for police to move the handcuffs from the rear to the font, he considered that it would have been "very dangerous" and would have delayed the administration of the sedation.[175] However, Dr Murray indicated that if Tristan had been brought in with his hands cuffed to the front, then he

[171] Tab 58, page 513.
[172] TN 15/05/19, page 31.30.
[173] TN 16/05/19, page 36.30.
[174] TN 15/05/19, page 21.36.
[175] TN 15/05/19, page 44.4.

would have been restrained on his back or on his side.[176] Associate Professor Holdgate gave evidence to a similar effect.[177]

128. I accept this evidence.

129. As outlined earlier in these findings, it seems to me to have been reasonable for police to handcuff Tristan to the rear when they arrived at Bangalow and when they expected Ambulance to attend. Unfortunately, and as Mr Evenden has submitted, the ramification of that earlier decision was that Tristan came to be restrained face down when he arrived in the Isolation Room.

Restraining Tristan within the isolation room

130. The evidence demonstrates that Tristan still required restraint when he was placed face down on the mattress in the isolation room. This does not appear to be in issue between the parties. The main issue appears to be the manner in which Tristan was restrained.

131. In any event, it is useful to set out the observations of various witnesses.

132. Lloyd Marsh was a bystander across the road from the emergency department entrance. He saw four officers carry Tristan from the Pajero into the isolation room. He said:

> The male had the strength to move all four Police officers quite easily by thrashing his body about. The Police were struggling to walk forwards with the male into the Emergency Department as they were trying to restrain the male…Once they were inside the doors to the Emergency Service Entrance were shut but I could still hear the male yelling, bellowing and screaming.[178]

133. Dr Karpa was, unexpectedly, the first doctor in the isolation room. He inserted the cannula that Dr Edwards then used to administer the droperidol and diazepam. Dr Karpa said that when he went in to help he saw "the doors to that room open and the back of the paddy wagon…and I saw the gentleman who was being restrained um, violently thrashing around."[179] According to Dr Karpa, as Tristan was being carried in he was "out of control…he was violent and he was dangerous."[180]

134. Dr Murray was asked whether, when he entered the isolation room to see Tristan already restrained face down, there were other restraint options

[176] TN 15/05/19, page 44.34.
[177] TN 16/05/19, page 13.1.
[178] Tab 80, page 929.11.
[179] Tab 61, page 749, Q19.
[180] Tab 61, page 755, Q93, Q95.

available. He said "I don't think so…because he was extremely disturbed, he was also handcuffed with his forearms behind his back."[181]

135. Dr Murray also said if Tristan had not been restrained at that point "there would be a high risk of him, without being restrained we would be unable to insert the cannula and get him sedated and whilst so agitated there was a risk of ongoing physical damage/injury."[182]

136. Associate Professor Holdgate noted, and Dr Murray agreed, this would also have put Tristan at risk of cardio-respiratory collapse and multi-organ failure.[183]

137. Dr Murray also said, in relation to the need for continued restraint:

> my priority was to get him, those drugs in and to get him sedated as soon as possible. There was a sweaty forearm, a cannula could be, with a violent movement, could fall out at any moment. If you like there is a window of opportunity to get those drugs in and to sedate this patient before further harm. And that was my focus and then we would look after it, bang, bang, sedated, we'll look after everything else.[184]

Whether there was a knee on Tristan's back

138. There is a dispute as to whether one or more of the police officers placed their knee or knees on Tristan's back.

139. In terms of where police were stationed as they restrained Tristan face down on the mattress, most of the witnesses (with the exception of Dr Karpa) recall two officers at the top end and two on Tristan's legs.

140. According to Senior Constable Chaffey, he had his leg on Tristan's left leg to stop him from kicking around and also had his right hand around Tristan's left wrist and left hand on Tristan's left elbow.[185] Senior Constable Greenhalgh had his leg on Tristan's right leg. Senior Constable Griffith had the shoulder on the left hand side. Ellis was on Tristan's right hand shoulder.[186] Senior Constable Chaffey recalled that Tristan was still moving around (at least initially) and that is why he had to put his hands on Tristan's wrist and elbow.[187]

141. According to Senior Constable Greenhalgh, he initially had Tristan's right leg pulled back "stretching his thigh…I …had my knees down on, I'd say, back of

[181] TN 15/05/19, page 5.11–15.
[182] TN 15/05/19, page 5.19.
[183] TN 15/05/19, page 7.15.
[184] TN 15/05/19, page 21.13.
[185] Tab 19, page 111, Q81; TN 13/05/19, page 43.15.
[186] Tab 19, page 111, Q80.
[187] TN 15/05/19, page 60.45.

his legs, hamstring area probably."[188] At this stage Tristan "was still kicking. I was, with my, body weight and my gun belt I'd be over a hundred kilos, and I was getting lifted."[189]

142. According to Senior Constable Griffith, she had her knees touching Tristan's torso but not on top of him.[190] At a later point she had her hand very lightly on his head every time he moved in her direction[191] but denied putting pressure on the back of his head so that his face was pressed into the mattress.[192] Senior Constable Griffith described Tristan "thrashing around" when police were trying to hold him on the mattress.[193]

143. According to Senior Constable Ellis, he had Tristan (initially at least) "from the chest up"[194] whilst "the main pressure to stop him from kicking out was down sort of from his hips".[195] At some point Senior Constable Ellis then put his knee near the small of Tristan's back[196] resting up against Tristan but with the downward force of his knee on the mattress.[197] There were also times when Senior Constable Ellis had to apply pressure to Tristan's shoulder.[198]

144. Dr Murray "didn't observe direct pressure, going down on the chest, [Tristan] was being restrained at the shoulders … and I remember having a very clear view of the back area, and the arms and the placement of the cannula."[199] He did not see police officers with their knees on Tristan's back: instead he said he had "a picture of the knees being sort of against the body with the force of their upper bodies pinning the shoulders."[200]

145. Dr Edwards observed that "two of the officers were, uh, pressing on his upper thigh…and another two of the officers were at the top end, um, pressing, I think with both hands, onto his shoulder, upper chest area."[201] Tristan was being "firmly restrained"[202] or "very firmly held"[203] prompting Dr Edwards to say, prior

[188] Tab 23, page 150, Q127.
[189] Tab 23, page 151, Q128.
[190] TN 14/05/19, page 73.10.
[191] Tab 27, page 221, Q79.
[192] TN 14/05/19, page 74.26.
[193] TN 14/05/19, page 72.22.
[194] Tab 25, page 190, Q95.
[195] Tab 25, page 191, Q108.
[196] Tab 25, page 191, Q111.
[197] TN 14/05/19, page 54.42.
[198] TN 14/05/19, page 66.17, page 67.48.
[199] TN 15/05/19, page 30.23.
[200] TN 15/05/19, page 23.9.
[201] Tab 53, page 431, Q49, Q50.
[202] Tab 53, page 432, Q57.
[203] Tab 53, page 445, Q195.

to administering the IV medication, to the officers at the top end of the mattress, "Can you please make sure the patient can breathe in that position?"[204]

146. Dr Edwards recalled officers at the top of the mattress kneeling with their knees "probably on the head of the mattress" and she agreed with a question asking whether they had their hands "sort of on the…the shoulder blade, chest area."[205]

147. Whilst none of the officers recalled hearing Dr Edwards say "Can you please make sure the patient can breathe in that position?" this does not mean it was not said. This was a busy and noisy room and people were focussed upon the task at hand such that they may not have heard everything that was being said.

148. Further, Rohit Bhagat, a hospital security guard, recalls the female doctor saying "We can take a little bit of weight of [sic] him."[206]

149. Similarly Dr Karpa recalls saying "Get off the chest, get off the chest"[207] although none of the officers recalled hearing this. As for Dr Edwards, this does not mean that Dr Karpa did not say those words.

150. In addition to these warnings, Senior Constable Chaffey said he said words to the effect of "just be mindful of positional asphyxia."[208] All of the other officers reported hearing this from Senior Constable Chaffey and Dr Karpa heard something similar, although not identical.

151. Other hospital staff observed the restraint. Registered Nurse Longmuir recalls one officer on each shoulder (female officers) and one on each thigh (male officers). She said "I did not observe anything I would consider to be excessive in the restraint and I did not think the police were using any more force than I would have used if I had been involved in the restraint."[209]

152. Clive Guthrie, a hospital wardsman, was only in the room for about 30 seconds but remembered seeing two officers holding the shoulders down and two holding the ankles (his vision of these last two police was partly obscured by the officers closer to Tristan's shoulders). He said "the police at the top part of the male patient had one of their hands on the shoulder blade area and were kneeling on the ground next to the male patient."[210]

[204] Tab 53, page 445, Q197.
[205] Tab 53, page 446, Q205, Q207.
[206] Tab 74, page 838.20.
[207] Tab 61, page 750, Q33.
[208] Tab 19, page 119, Q 141.
[209] Tab 68, page 817.6.
[210] Tab 77, page 852.6.

153. Rohit Bhagat recalled there being a female officer on the patient's left shoulder, male officer on the other shoulder and an officer on each leg, with their knees pressed onto a leg each. Further "while the patient was on the ground he was fighting to get up. He was using his head in a head butting type motion. I don't know if he was fighting or trying to breathe … I saw the police woman push his head down at one stage. She didn't hold his head down."[211]

154. Dr Karpa had a different recollection of how Tristan was restrained. He was the only witness to recall that the police had their knees on the back of Tristan's chest.

155. In his interview with investigating police, Dr Karpa said "they had at least two officers I think, possibly four, with their knees on his chest" and another officer to Dr Karpa's right.[212] Then he said there must have been two officers on the chest, and one on each leg.[213]

156. Dr Karpa recalled that a police officer to his right "who might have been Asian or some dark skinned person" said "careful about something asphyxiation".[214] This corroborates Senior Constable Chaffey's evidence of mentioning something about positional asphyxiation although Dr Karpa said he does not recall the word "positional" being used before "asphyxiation".[215]

157. Dr Karpa said that the officers who had their knees on Tristan's back had "pretty much all their weight on him. And they needed to put all the weight to stop him from moving. And even with that he was still moving."[216] He recalled "two knees, one each side, and they were big blokes and they were just, all the pressure on his chest."[217]

158. During cross-examination, Dr Karpa said that there was one officer on the left-hand side of Tristan's shoulder who had one knee on the back of Tristan's chest and another officer on the right hand side with one knee on the back of Tristan's chest.[218] He thought that both of these officers were male although he conceded he could be mistaken because what he remembered was the knees.[219]

[211] Tab 74, page 837.18–838.18.
[212] Tab 61, page 749, Q26.
[213] Tab 61, page 749, Q27.
[214] Tab 61, page 750, Q33–34.
[215] Tab 61, page 757, Q114–115.
[216] Tab 61, page 756, Q108.
[217] Tab 61, page 758, Q127.
[218] TN 15/05/19, page 51.15–25.
[219] TN 15/05/19, page 52.15.

159. Later in his evidence Dr Karpa said: "where does it say in my evidence that the police officer who was in charge of the left shoulder of this patient had their knee on the chest? …that doesn't mean that it was the person at the top left hand side of the patient who was putting it on there. The other officers were coming from the bottom right-hand side, and that is where they would've got access to the back from."[220] He said there were two quite large male police officers "both coming from the right hand side, but, they had a knee on each side of the chest."[221]

160. In an attempt to clarify Dr Karpa's evidence, Counsel Assisting asked a series of questions, limited to the time that he was inserting the cannula into Tristan's left arm. Dr Karpa's evidence was that at that time there was one officer on the left leg.[222] There was another officer on the right-hand side with his left knee on the right side of the back of Tristan's chest, and his leg then "sort of coming down over the patient's backside."[223] A third officer was on the left-hand side on the shoulder, holding down Tristan's shoulder and arm but with no knee on the chest at all.[224] A fourth officer was on Tristan's right-hand side, midsection but more towards the feet probably.[225]

161. Ultimately, Dr Karpa said "what sticks in my head the most, what I can see most vividly is a … police officer on his back with his knee in his back" but it was possible that there was only one knee.[226]

162. Dr Karpa remained adamant that at least one officer had a knee on the back of Tristan's chest. He said that the "knee being on the chest is something I remember very vividly cause I could see it being a problem".[227]

163. Mr De Brennan submitted that Dr Karpa's evidence should be accepted. He noted that, as a locum doctor, Dr Karpa bore no allegiance to any of the parties concerned. Mr De Brennan further submitted that, despite Dr Karpa being at cross-purposes at times during his evidence, he was decisive in his conviction that one of the officers had his knee on Tristan's back.

164. Similarly, Mr Evenden submitted that Dr Karpa's evidence was internally consistent and consistent with the evidence from other witnesses which was that Tristan was firmly restrained. Mr Evenden submitted that aside from a concession that it was possible that there was only one knee on Tristan's back,

[220] TN 15/05/19, page 69.21–29.
[221] TN 15/05/19, page 70.19.
[222] TN 15/05/19, page 71.48.
[223] TN 15/05/19, page 72.8.
[224] TN 15/05/19, page 72.27.
[225] TN 15/05/19, page 73.3.
[226] TN 15/05/19, page 73.11–23.
[227] TN 15/05/19, page 73.16.

any confusion in Dr Karpa's evidence arose from incorrect assumptions as to where particular officers must have been. In this respect, Dr Karpa said:

> I'm confused about the way it's been presented to me, yes, cause you're talking about this person on the left hand side being a female, putting her knee on the chest. But that's, that's not how I've recalled it in any of my evidence and it's not something that I remember happening.[228]

165. As outlined above, Dr Karpa's evidence shifted on a number of occasions. First, in his interview with police, he suggested that there were two or possibly four officers who had their knees on Tristan's back. Later in his interview, he suggested that there were two knees on Tristan's back coming from opposite sides of Tristan. He reiterated this view in cross-examination but later said that there were two knees coming from the right side. Ultimately, Dr Karpa conceded that it was possible that there was only one knee on Tristan's back. This inconsistency detracts from the reliability of Dr Karpa's evidence notwithstanding Mr Evenden's submission that Dr Karpa may have been confused by incorrect assumptions by various counsel during cross-examination.

166. It is significant that no other witness observed any knees on Tristan's back. In this respect, I accept Mr Bradley's submission that Dr Karpa was focussed on inserting the cannula whereas Dr Murray, who was present in the isolation room at this time,[229] was in charge of Tristan's overall management and supervised the administration of droperizol and diazepam. Dr Murray did not raise any concerns as to the manner of Tristan's restraint. Significantly, in response to a question about who is in charge when police are restraining someone in a hospital setting, Dr Murray said:

> Well the doctor in charge is in charge of the medical care and if, if I was that doctor and I was concerned about the way the restraint was being carried out, then I would communicate that concern to the police and ask them to modify the restraint. That is an approach I have always followed.[230]

167. I accept that if Dr Murray had had concerns about the way in which Tristan was restrained, he would have voiced them.

168. In these circumstances, I prefer the evidence of Dr Murray, other hospital staff members as well as the four police officers to Dr Karpa's. Their evidence was credible and broadly consistent.

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[228] TN 15/05/19, page 70.32.
[229] Tab 53, page 430, Q32.
[230] TN 15/05/19, pages 12.38, 13.24.

169. Accordingly, I am unable to accept the evidence of Dr Karpa that there was a knee or knees on Tristan's back while he was being restrained in the isolation room.

170. Even if one of the officers did have a knee on the back of Tristan's chest for a short period, this was not inconsistent with police policy as set out in the NSW Police Force Handcuffing Manual Version 5.3, February 2014[231] or the NSW Police Force Weapons & Tactics Policy & Review Close Quarter Control Version 2.2.[232]

The use of prone restraint

171. Prone restraint increases the risk of respiratory restriction[233] and physiological stress.[234]

172. Other factors may also contribute to an increased risk. In Tristan's case, Associate Professor Holdgate described the risk in the following terms:

> Face-down restraint has a recognised risk of positional asphyxia and this risk increases with the length of time that the patient is held face-down. Most guidelines recommend no longer than 2-3 minutes in this position. Patients who are drug intoxicated, such as Tristan, may be at greater risk for positional asphyxiation. In addition, Tristan was showing signs of significant physical stress prior to being placed in this position and may have been more susceptible to the effects of lower oxygen levels.[235]

173. Associate Professor Mark Adams, cardiologist, described the risk involved in physical restraint (not limited to prone restraint) as follows:

> … with physical restraint it is likely that there would have been increased physical exertion on the part of Tristan and this may have resulted in increased sympathetic drive, increased blood pressure and temperature leading to increased cardiac demand and increased risk of cardiac arrhythmias. Therefore I think that physical restraint may have indirectly had some contribution to Tristan's death.[236]

174. In contrast to Associate Professor Holdgate on the topic of positional asphyxia, Dr Clifton, forensic pathologist, said that

> The issue of positional asphyxia causing respiratory compromise in the setting of prone restraint is contentious. There have been multiple studies

[231] Tab 115 and see for example page 25, 32.
[232] Tab 116 and see for example page 21.
[233] TN 15/05/19, page 3.36.
[234] Tab 2, page 10.
[235] Tab 113, page 1315.
[236] Tab 112, page 1213.

> exploring respiratory compromise during prone restraint with and without pressure on the back and it has been concluded that the prone position is physiologically neutral and respiratory compromise was never established.[237]

175. Nonetheless, Dr Clifton agreed that restraint was more broadly a likely factor in Tristan's death because "restraint, especially prolonged and active in the context of acute … MDMA toxicity would produce significant physiological stress to the body."[238]

176. I accept Counsel Assisting's submissions that the risks associated with prone restraint needed to be balanced against the risk that, without effective restraint, doctors would not have been able to administer sedation which, given Tristan's disturbed behaviour, would have posed a serious risk itself. In this respect, I accept Associate Professor Holdgate's evidence that:

> There's a risk. At that stage everything is a risk. Leaving him untreated is a huge risk. The actions required to treat him carry a huge risk.[239]

177. Similarly, in her report, Associate Professor Holdgate said:

> Essentially the treating clinicians were faced with the dilemma of leaving Tristan untreated, causing significant injury to himself and a risk to others, and likely to clinically deteriorate with eventual cardiorespiratory collapse and multiorgan failure, or actively treating him with immediate sedation but knowing that this required him to be held still in a potentially dangerous position while the drugs are administered.[240]

178. I accept that prone restraint is a valid choice in circumstances that compel its use, provided that it is only used for as short a period as possible.

179. However, Mr Evenden submitted that no clinical staff took any steps to limit the duration of the restraint, other than their obvious efforts to sedate Tristan as soon as possible. It was also submitted that Tristan's restraint in the isolation room was impacted by the unplanned manner in which he was brought in.

180. Similarly, Mr De Brennan referred to Associate Professor Holdgate's report, in which she opined:

> My main concern regarding Tristan's care was the movement of him from the van to the isolation room and being placed in face-down restraint without appropriate planning and without the senior medical staff aware that this was happening. Because of the high risk associated with placing Tristan in

[237] Tab 2, page 10.
[238] Tab 2, page 10.
[239] TN 16/05/19, page 9.12.
[240] Tab 113, page 1319.

> restraint, particularly face-down, this process should have been carefully planned so that Tristan was brought into the isolation room only after all necessary medications had been drawn up, all staff fully briefed regarding their role in restraint and administering medications, and appropriate preparation to place Tristan on cardiorespiratory monitoring as soon as he was sedated.
>
> It appears that the uncoordinated movement of Tristan into the isolation room led to him being restrained for longer than necessary while drugs were still being drawn up and with no preparation for post-sedation care. As senior medical staff entered the room Tristan was already in face-down restraint despite no apparent discussion between police and senior medical staff about how the process of achieving sedation should be managed.
>
> The level of restraint required to keep Tristan still enough to receive medications was understandably high, and the use of the brief period of face-down restraint was not unreasonable. But the importance of limiting this restraint to the shortest possible time to minimise the risk of respiratory restriction in a patient who was already demonstrating high levels of sympathetic overdrive was not appreciated.[241]

181. I address the evidence as to any delay in drawing up the medications at [187]ff. I address the evidence as to whether the risk of respiratory restriction was not appreciated at [195]ff.

182. Dr Murray said the following:

> All I can say is I'm very aware of the danger of prone restraint. But that I thought that it was essential in this situation and everything that I did was to try and minimise the time of prone restraint and the time from being removed from that paddy wagon to being adequately sedated so that we could remove the handcuffs and get him out of the prone position, monitor and look after him. And everything I did was directed from that from the beginning.[242]

183. Dr Murray also said that "we don't like the prone [position] unless there … is no alternative" but in Tristan's case he "felt there was no alternative."[243]

184. In terms of the possibility that once Tristan was in the isolation room, police might have removed the handcuffs so Tristan no longer had his hands behind his back, Dr Murray said:

> That was a possibility but I would judge that it would be very dangerous to do so and would've delayed the time for the administration of the sedation,

[241] Tab 113, pages 1319–1320.
[242] TN 15/05/19, page 22.20.
[243] TN 15/05/19, page 36.19, 36.23.

because once the cuffs were removed, given his behaviour, there may have been an ongoing struggle; there was a risk of someone being hurt, and then it could be quite time consuming to get them back on.[244]

185. Associate Professor Holdgate agreed that it would not have been safe to remove the handcuffs because Tristan was "so difficult to contain because he was so agitated".[245]

186. It is unclear how long Tristan was restrained in the prone position. The CCTV footage suggested that Tristan was removed from the Pajero shortly after it reversed closer to the door at 22:57. This was largely consistent with the Hospital progress note that recorded Tristan being brought into the isolation room at 22:58.[246]

187. Dr Karpa saw Tristan being carried into the room and moved to insert the cannula once Tristan was restrained on the mattress. The progress notes record Dr Karpa inserting the cannula at 23:59 (presumably a typographical error which should read 22:59).[247]

188. Dr Karpa recalled a delay between the cannula being inserted and the medication being drawn up. In his interview with police, he said that by the time he inserted the cannula, Tristan had probably been in the isolation room for "several minutes". He said that the medication had not been drawn up by the time he inserted the cannula.[248]

189. However, Clinical Nurse Specialist Wendy Longmuir recorded a nursing progress note that suggested she drew up the medications outside the isolation room (consistent with Dr Murray's explicit plan[249] that the medication be ready before Tristan was brought in) and carried them into the isolation room as Dr Karpa was inserting the cannula. That note also recorded the droperidol being administered by Dr Edwards at 23:00 and the diazepam being administered at 23:02.[250]

190. Clinical Nurse Specialist Longmuir also gave evidence that "the medication was drawn up and ready to go by the time they had the cannula in". She remembered this because she was "standing in the room with it in [her] hands".[251]

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[244] TN 15/05/19, page 44.4.
[245] TN 16/05/19, page 13.10.
[246] Tab 78, page 872.
[247] Tab 78, page 872.
[248] Tab 61, page 750, Q31–Q32.
[249] TN 15/05/19, page 8.10.
[250] Tab 78, page 872.
[251] TN 14/05/19, page 44.42. See also tab 68, page 818.

191. Dr Murray did not think there was a delay.[252] Nor did Dr Edwards recall a delay.[253]

192. The evidence indicates that Tristan was restrained face down in the isolation room for approximately four minutes. The cannula was inserted at 22:59. The droperidol was administered at 23:00 and the diazepam was administered at 23:02. The slight delay between the administration of the droperidol and diazepam is explained by the saline flush.[254] Associate Professor Holdgate accepted that this timeframe was reasonable and noted that:

> It more than likely may have been less than that. The common approach would be to inject, flush and then immediately inject the second drug so I think two minutes would probably be the maximum difference between the two drugs being administered.[255]

193. The weight of the evidence, which I accept, is that the medication was ready by the time Dr Karpa inserted the cannula. Accordingly, I am satisfied that there was no significant delay in the administration of sedation.

194. Dr Murray could not have known precisely how long Tristan had been restrained in the prone position because he was not present when Tristan was brought into the isolation room. When Dr Murray was asked about the fact that he was missing the vital piece of evidence as to how long Tristan had been restrained, he said:

> I can't see how if I'd been, if someone had told me the number of minutes, it would have changed my actions from the point I entered that room.[256]

195. Dr Murray's first priority was sedation.[257]

196. Counsel Assisting submitted that Dr Murray was keenly aware of the risks in Tristan's case, including the risk of "sudden death occurring during prone restraint".[258]

197. Dr Murray was an impressive and thoughtful witness and I accept his evidence that he was aware of the risks associated with prone restraint and that he took steps to minimise the amount of time that Tristan was restrained face down.

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[252] TN 15/05/19, page 20.2
[253] Tab 53, page 432.
[254] TN 15/05/19, page 6.14.
[255] TN 16/05/19, page 4.38.
[256] TN 15/05/19, page 22.30.
[257] TN 15/05/19, page 32.4, 35.45.
[258] TN 15/05/19, page 21.22.

198. In these circumstances, I do not find that there was anything unreasonable about the way in which Tristan was restrained while he was in the isolation room.

Policies and Guidelines on the use of prone restraint

Health Guidelines

199. I accept that the way in which Tristan was restrained was largely consistent with Health guidelines, memorandums and policies at that time including:

(a) Memorandum of Understanding Mental Health Emergency Response, July 2007, NSW Health, Ambulance Service of NSW, NSW Police Force. "Restraint" was addressed at part 7.3. Whilst it did not specifically refer to prone restraint, the memorandum did not prohibit its use provided it was "consistent with the policies and procedures applying to the respective agencies."[259]

(b) Health Policy Directive, Aggression, Seclusion & Restraint in Mental Health Facilities in NSW, PD2012_035, which also applied to the "care of mental health consumers in Emergency Departments that are declared mental health facilities"[260] and specifically addressed restraint and seclusion processes at page 9 and following. This directive specifically provided: "Face down restraint should only be used if it is the safest way to protect the patient or any other person. If face down restraint is used, it will be time limited. The maximum time a person will be held on the ground in face down restraint is approximately 2-3 minutes to allow sufficient time to administer medication and/or remove the person to a safer environment."[261]

Although Mr Evenden accepted that prone restraint was a valid choice in the circumstances, he submitted that it should have been for no more than two to three minutes, or substantially less given Tristan's risk factors.

Obviously this would have been preferable but I accept that Tristan's presentation necessitated prone restraint for a slightly longer period. As referred to above, I accept the evidence of Dr Murray that he was "very aware of the danger of prone restraint" and trying to "minimise the time of prone restraint".[262]

[259] Tab 31, page 276.
[260] Exhibit 3, page 1.
[261] Exhibit 3, page 10.
[262] TN 15/05/19, page 22.20.

(c) Health Policy Directive, Principles for Safe Management of Disturbed and/or Aggressive Behaviour and the Use of Restraint, PD2015_04 which contemplated the use of prone restraint but only as a last resort and for the shortest period possible.[263]

200. The Ministry of Health Guideline Management of Patients with Acute Severe Behavioural Disturbance in Emergency Departments GL2015_007 took a different approach. Whilst the Guideline made clear that it "does not replace clinical judgment", it also read: "Avoid restraining patient in a prone position as it places the patient at high risk of respiratory restriction".[264]

201. Counsel Assisting submitted that this appears to be inconsistent with the abovementioned policy directives that permit prone restraint although only where necessary and for a short period of time.

202. However, Mr Bradley submitted that the document makes clear that "[t]his is a Guideline only" and it does "not replace clinical judgment". Mr Bradley further submitted that the Guidelines are to be read subject to the two health policy directives referred to above, being PD2012_035 and PD2015_004, and in any event the word "avoid" is not prohibitive in effect but is ordinarily read as having a cautionary effect.

203. I accept that the Guideline is only a Guideline however, if it is meant "to guide" then it seems sensible that it guide in a way consistent with the health policy directives.

204. I do not propose however, to make a recommendation relating to this Guideline, particularly in circumstances where the Ministry of Health is not a party of sufficient interest in these proceedings.

Police Guidelines

205. The NSWPF Handcuffing Manual and the Weapons & Tactics Policy and Review Close Quarter Control policies both permit prone restraint if it is reasonably necessary.

206. Sergeant William Watt, a Senior Operational Safety Instructor, said the following in his statement:

> … there are very few outright prohibitions on the use of any technique, and even where there are, there is an acceptance organizationally that breaching

[263] Exhibit 3, page 9.
[264] Tab 59, page 593.

> a policy may be appropriate in specific circumstances in order to prevent a significantly worse outcome.[265]

207. In response to a question about whether there is a time limit as to how long it is safe for police to restrain someone in the prone position, Sergeant Watt said:

> To be fair, that's because I am not aware of any safe time limit and it's – and fundamentally the struggle continues as long as the struggle continues, if I haven't got them under control for whatever purpose I need them under control and that takes, five, eight, ten minutes, then it's difficult to put a time limit and say okay after two minutes you can't use the prone restraint technique anymore, it's practically impossible.[266]

208. The weight of the evidence is that the use of prone restraint by police is permitted if it is reasonably necessary in the circumstances.[267] Having regard to the evidence of Associate Professor Holdgate and Dr Murray about the need for Tristan to be restrained given his level of agitation, I am satisfied that police acted in accordance with the abovementioned policies.

209. The NSWPF Guidelines on the Management of People Affected by Methylamphetamine and Other Stimulant Drugs ("NSWPF Guidelines"), however, advised police to "[a]lways ensure that the person is not in the prone position as this can also increase the risk of positional asphyxia."[268] Although Ms Bennett submitted that this is just a guideline, Sergeant Watt accepted that it reads as an outright prohibition.[269]

210. The inconsistency between the NSWPF Guidelines and the manuals and training that Sergeant Watt gave evidence about was described by Sergeant Watt as "extremely" undesirable and potentially confusing.[270] I accept Sergeant Watt's evidence in this respect.

211. The NSWPF Guidelines otherwise provide useful information about the way that MDMA use can affect pain tolerance and lead to an increased risk of positional asphyxia. They helpfully identify additional risk factors that might contribute to increased demand for oxygen when an individual is highly stressed.[271]

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[265] Tab 121, page 18.30.
[266] TN 17/05/19, page 28.30.
[267] TN 17/05/19, page 4.37, 7.49.
[268] Tab 119, page 12.
[269] TN 17/05/19, page 7.24.
[270] TN 17/05/19, page 7.28.
[271] Tab 119, page 23.

'Excited delirium'

212. The 2013-2014 training package focused on 'Excited Delirium' which the Chief Medical Officer described as a "mental condition".

213. Dr Glen Smith, Consultant Clinical and Forensic Psychiatrist prepared an expert report, in which he observed that excited delirium "is a controversial diagnosis considered to be a sub-category of delirium also known as 'agitated delirium'."[272]

214. Dr Smith indicated that excited delirium is not recognised in either of the "two most widely used classification systems in psychiatry" being the DSM-5 and the ICD-10 although it is recognised as an entity in some literature and by the American College of Emergency Physicians.[273]

215. Dr Smith further observed:

> In my opinion, the concept of ExDS does not assist in understanding the manner or cause of Tristan's death more than the recognised diagnosis of substance-intoxication delirium according to the recognised criteria of DSM-5 and ICD-10, the well-established classification system in psychiatry.[274]

216. Counsel Assisting submitted that police officers tasked to respond to a person like Tristan, with aggressive and disturbed behaviours, are unlikely to have the luxury of time to consider, from their lay perspective, whether or not the person is experiencing the "mental condition" of 'excited delirium'. Their much more immediate concern will be on containing the behaviour in a way that minimises risk to the person involved, the public and the officers themselves. This seemed to be acknowledged in part two of the training module which noted that it is unlikely officers will be able to evaluate a person displaying this behaviour.

217. In these circumstances, Counsel Assisting queried the utility of a training module on 'excited delirium' which said nothing about whether a person experiencing such symptoms might be at increased risk of serious injury or death if subject to prone restraint. That is, there was no attempt to link the information within the 'excited delirium' module to the risk factors set out in the NSWPF Guidelines.

218. The 'excited delirium' module included a separate 'positional asphyxiation' module which provided a few short references to potential risk factors such as drug and alcohol use. However, there was nothing within that module that

[272] Tab 113A, page 13 of report.
[273] Tab 113A, page 13 of report.
[274] Tab 113A, page 14 of report.

directly linked with the specific risk factors set out in Appendix A of the NSWPF Guidelines.

219. The absence of a link between the information contained in the module and the risk factors in the NSWPF Guidelines is likely because the 'excited delirium' module was produced for the 2013-2014 police training year and therefore pre-dates the Guidelines which were published in February 2014. Accordingly, it appears that the module is outdated.

220. Counsel Assisting submitted that this seems like a missed opportunity to reinforce a consistent message about risk factors when restraining someone who is experiencing disturbed behaviour (whether experiencing 'excited delirium' or otherwise) and may well be lost on busy officers amongst the "endless" information they are required to familiarise themselves with.

221. I respectfully agree with Counsel Assisting's submissions.

'Excited delirium' in other jurisdictions

222. The existence of 'excited delirium' as a syndrome was considered in the *Inquest into the Death of Odisseas Vekiaris* (Coroner Jamieson, Coroners Court of Victoria, 18 December 2015). Her Honour ultimately found that 'excited delirium' and 'excited delirium syndrome' are neither appropriate nor helpful for ascribing a medical cause of death. Her Honour also recommended that Victoria Police remove from its training materials/literature any reference to "excited delirium" or "excited delirium syndrome" until such time as it is recognised by Australian medical professional bodies.[275]

223. Coroner Jamieson was able to draw upon the resource of the Coroners Prevention Unit (established in Victoria in 2008) to research and provide a background discussion paper on 'excited delirium'. This assisted Coroner Jamieson by providing

> relevant information from the point of view of those who believe that Excited Delirium exists and is a valid medical cause of death however, the report equally highlighted that some experts do not recognise Excited Delirium as a medical conditions nor is it recognised by most professional medical associations.[276]

224. The lack of a similar research facility as the Coroners Prevention Unit in this state means that it falls to the Counsel Assisting team to try and source relevant evidence via experts such as Dr Smith. This is, unfortunately, an expensive and ad hoc approach to identifying and researching systemic issues

[275] Inquest into the death of Odisseas Vekiaris, Finding into death with inquest, pages 52–53.
[276] Inquest into the death of Odisseas Vekiaris, Finding into death with inquest, page 7.

linked to this Court's power pursuant to s. 82 of the *Coroners Act 2009* to make recommendations in the interest of public health and safety.

Cause of death

225. Dr Clifton, then Forensic Pathology Registrar, recorded Tristan's direct cause of death as "acute cardiac arrhythmia in 3,4-methylenedioxymethamphetamine (MDMA) intoxication with prone physical restraint" in the autopsy report dated 28 April 2016.[277]

226. Dr Clifton observed:

> This is a complex and difficult case involving 3,4-methylenedioxymethamphetamine (MDMA) intoxication causing an acute behavioural emergency necessitating the use of restraint by NSW Police. There are a range of potential causes of death without definite evidence that any of these causes either alone or in combination caused the death.[278]

Stimulant drug intoxication and physiological stress

227. Tristan believed he had taken LSD but toxicological testing revealed he had consumed MDMA. Tristan's post-mortem blood sample showed 0.16mg/l of MDMA and 0.03mg/l of 3,4-methylenedioxyamphetamine (MDA), a metabolite of MDMA.[279]

228. John Farrar, consultant forensic pharmacologist, initially opined that Tristan had ingested a drug consistent with LSD but at a level below the laboratory limit of detection. He opined that the distribution of LSD in the lollies may have been uneven such that Tristan consumed a full recreational dose but that the quantity of LSD in the remaining lollies was below the laboratory's detection limit.[280]

229. Mr Farrar later conceded that the clinical signs Tristan exhibited were also consistent with the consumption of MDMA.[281]

230. It is theoretically possible that Tristan consumed LSD. However, in circumstances where the remaining lollies did not contain LSD (or any other drug), there is no basis to conclude that Tristan had also consumed LSD.

231. Tristan was not a first time user of MDMA. Emma said "I also know that Tris has taken MD (MDMA) in crystal form and cocaine. He would use these kinds

[277] Tab 2, page 8.
[278] Tab 2, page 9.
[279] Tab 2, pages 9, 18; Tab 111, page 1176.
[280] Tab 110, page 1164.
[281] Tab 110A, page 1.

of drugs probably once a fortnight."[282] Indeed, Tristan had taken "probably a point" of MDMA on the evening of 17 January 2016.[283]

232. According to Aidan, he had "seen Tristan take cocaine and also MDMA on his days off. He would vary his intake to sometimes once a week or fortnight". However, Aidan had seen Tristan take MDMA "each weekend for several weekends in a row when he's in social gatherings more than when he's at home."[284]

233. Tristan's past history with MDMA use is relevant because Professor Jones, Specialist Physician and Clinical Toxicologist, said in oral evidence:

> It's rather paradoxical situation with MDMA that in many drugs of abuse, more exposure over time leads to tolerance but in the MDMA case, in respect of cardio toxicity, in fact repeated uses of MDMA may increase the susceptibility to toxic effects, in particular the arrhythmogenic effects of the drug so I guess what I'm saying to you is there's a lot of complexity when it comes to MDMA and its toxic effects.[285]

234. It is possible that Tristan died as a result of MDMA toxicity. In this respect, Professor Jones indicated that "the type and/or severity of stimulant/toxic effects mediated by MDMA are unpredictable … As with every illicit drug, both the dose and purity of the MDMA changes substantially [from dose to dose].[286]

235. Professor Jones opined that the presence of 0.16mg/l of MDMA and 0.03mg/l of MDA in Tristan's post-mortem blood sample is consistent with ingestion in the order of 50-75mg of MDMA. As the toxicity of MDMA is unpredictable, Professor Jones indicated that this could "represent a recreational, toxic or fatal dose".[287]

236. To this end Professor Jones noted "it remains unclear 'why some people seem to have acute, even fatal, reactions to doses that are commonly tolerated in others'."[288]

237. In terms of factors that might influence the toxicity of MDMA, Professor Jones referred to "dose, ambient temperature, dancing/other activity, the genetic, physiological and pathophysiological nature of the user and the co-exposure to other substances."[289]

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[282] Tab 35, page 316.27.
[283] Tab 35, page 316.27.
[284] Tab 37, page 321.8.
[285] TN 16/05/19, page 39.34.
[286] Tab 111, page 1176.
[287] Tab 111, page 1176.
[288] Tab 111, page 1191.
[289] Tab 111, page 1176.

238. Although the evidence does not exclude the possibility that Tristan died as a result of MDMA toxicity, I am not satisfied, on the balance of probabilities, that this was the cause of Tristan's death. In this respect, Professor Jones agreed in cross-examination, Tristan had consumed a relatively low dose to result in death.[290] Similarly, Mr Farrar opined that while MDMA toxicity contributed to Tristan's death, it was not the sole cause.[291]

239. Counsel Assisting submitted that MDMA was implicated in Tristan's death. At the very least, the drug triggered the following series of cascading events: Tristan's uncharacteristically disturbed behaviour leading to the physiological stress prior to police attendance; the need for restraint once police attended Tristan's home; the further physiological stress arising from a period of confinement in the cage in the back of BRU19; and a final period of prone restraint whilst sedation was administered at hospital. I respectfully accept Counsel Assisting's submissions.

240. Counsel Assisting's submissions are supported by the evidence of Professor Jones and Associate Professor Adams, which I accept. In her expert report, Professor Jones said "[b]ut for MDMA exposure that night, Mr Naudi would not have been expected to have developed cardiac arrest and die".[292] Further, in cross-examination, Associate Professor Jones said:

> I can't exclude the cause of death being MDMA cardiovascular toxicity. The mechanism fits. The timing fits and potentially, because of the environmental factors of fear, of adrenalin, of more adrenalin, possibly the restraint, a degree of hypoxia, I still believe that there's enough evidence there that MDMA has played a significant contribution to Mr Naudi's demise.[293]

241. Similarly, Associate Professor Adams said:

> MDMA is a powerful sympathetic driver of the heart but so is all of the other things that came subsequent to taking that. Such as the physical efforts and the restraint and all of these things and even without MDMA, it's possible to die just from that level of sympathetic stress … And in this case … it might not have just have been the MDMA but certainly that was a contributor and probably contributed to those psychological effects that then led on to further sympathetic drive from the distress and stress …[294]

[290] TN 16/05/19, page 55.25.
[291] Tab 122, page 7 of report.
[292] Tab 111, page 1193.
[293] TN 16/05/19, page 55.11.
[294] TN 16/05/19, page 58.10.

Tristan's prior medical history and the likelihood of any underlying medical condition of relevance to his cause of death

242. Associate Professor Adams excluded the possibility that an electric shock Tristan sustained in 2014 was in any way relevant to his death in 2016.[295] He also effectively excluded (although this is not definitive) the presence of long QT syndrome.[296]

243. Dr Clifton, Professor Jones and Associate Professor Holdgate all agreed that it was unlikely that undiagnosed long QT syndrome or an allergic reaction to the sedative medication were factors that contributed to Tristan's death.[297]

244. I accept the evidence of the experts in this respect.

Respiratory or cardiac arrest

245. There is a disagreement between the experts as to the precise cause of Tristan's death.

246. Associate Professor Holdgate opined that "the fact that he was noted to be blue/purple when he was turned over and that his initial cardiac rhythm was asystole is more suggestive of a primary respiratory arrest followed by a secondary cardiac arrest".[298]

247. In lay terms, Associate Professor Holdgate explained that:

> When they first monitored his heart there was no sign of any electrical activity, [which] is commonly what you see when a cardiac arrest occurs preceded by respiratory arrest. In other words, breathing stops before the heart stops beating.[299]
>
> …
>
> Okay so the term cardiac arrest medically means that the heart has stopped effectively pumping blood around the body so the person won't have a pulse and there's two electrical things that can happen that causes the heart to do that. One is the heart can have no electrical activity. That's what the asystole or more commonly in adults, the heart can have disorganised electrical activity called ventricular fibrillation which is the type of cardiac arrest we mostly see when people have a primary heart problem so asystole in adults are where the heart is not beating and has no electrical activity. It very rarely happens as the first

[295] Tab 112, page 1212.
[296] Tab 112, page 1215.
[297] Tab 2, page 11; TN 16/05/19, page 46.32; TN 16/05/19, page 7.31.
[298] Tab 113, page 1316.
[299] TN 16/05/19, page 5.6.

> event and normally is the response of the heart to a lack of oxygen to the heart. So in adults we mostly see that because the patient has not been able to breathe or has had some reason they haven't had oxygen delivery prior to the heart stopping beating, so the first thing that happens is they don't get enough oxygen because they're not breathing effectively and then the heart is placed under stress because it doesn't get oxygen and actually just stops beating all together. As distinct from a primary heart problem where the heart itself is diseased or problematic or has something wrong with it where it starts fibrillating in a disorganised manner and then the breathing stops secondarily to that because the brain isn't getting enough oxygen to tell the body to breath[e].[300]

248. Associate Professor Holdgate thought it was very unlikely that the cardiac arrest came about through ventricular tachycardia and fibrillation progressing to asystole.[301] She noted that, for someone with a young and healthy heart, the deterioration from a ventricular dysrhythmia to asystole usually takes more than four or five minutes.[302]

249. In coming to this conclusion, Associate Professor Holdgate relied upon the observations of Dr Edwards and Dr Karpa of discolouration to Tristan's neck and chest when the handcuffs were removed and he was turned over onto his back.

250. Dr Edwards said that when Tristan was turned onto his side, she "noted his neck to be [a] blue, purple colour."[303] In her interview with police, Dr Edwards later said "he looked like he'd been, it was like, hypoxic."[304]

251. Dr Karpa said that Tristan's "chest to face [was] purple … in a triangular pattern." He said there was a "definite delineation between that and the rest of his skin."[305]

252. For completeness, I note that Dr Murray did not observe that Tristan had a purple chest.[306]

253. Associate Professor Holdgate conceded that "we can't say for sure which was the primary event".[307] She thought that what Dr Edwards and Dr Karpa

[300] TN 16/05/19, page 6.7.
[301] TN 16/05/19, page 12.32.
[302] TN 16/05/19, page 20.1.
[303] Tab 53, page 433, Q65.
[304] Tab 53, page 451, Q260.
[305] Tab 61, page 763, Q181–182, Q190.
[306] TN 15/05/19, page 28.28.
[307] TN 16/05/19, page 20.35.

described was more suggestive of a primary respiratory arrest followed by secondary cardiac arrest but could not be definitive about it.[308]

254. Professor Jones and Associate Professor Adams instead favoured a diagnosis of a primary cardiac arrest. For Professor Jones this was because once Tristan was found to be unresponsive the first rhythm that was detected was asystole. Professor Jones was careful in her evidence to say however, that it was not impossible for Tristan's death to have occurred the other way around, being a respiratory arrest followed by cardiac arrest.[309]

255. In her report, Professor Jones opined that:

> There seems little doubt that Tristan Naudi died from a sudden cardiac arrhythmia, with a documented asystolic cardiac arrest on cardiac rhythm strip. This would be an unusual spontaneous occurrence in a young adult with a structurally normal heart. MDMA is known to cause cardiac arrhythmias and is the most likely cause in this case. It is likely that the initial arrhythmia was ventricular fibrillation … which later evolved into asystole … and finally electro-mechanical dissociation.[310]

256. Similarly, Associate Professor Adams opined that:

> … the mostly likely cause of Tristan's death on 18 January 2016 was a fatal cardiac arrhythmia and this was most likely a ventricular arrhythmia such as ventricular tachycardia (VT) degenerating to ventricular fibrillation (VF) and then asystole. This is supported firstly by the autopsy findings (or lack of physical pathological changes) which are typical of a death due to cardiac arrhythmia where the problem (electric disorder) is physiological and not visible once death has occurred. Secondly the clinical scenario where there was sudden unresponsiveness and lack of pulse and breathing efforts is also typical of a death due to a serious arrhythmia such as VT or VF. Lastly the microscopic changes seen in the heart at autopsy are similar to those described previously in cases on cardiac death associated with MDMA intoxication.[311]

257. Associate Professor Adams agreed with Professor Jones that a primary cardiac arrest was more likely because the first rhythm detected was asystole. He said "[Tristan] was a young man and quite fit as well and I wouldn't expect him to be becoming asystole very quickly from hypoxia."[312]

258. He further said:

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[308] TN 16/05/19, page 35.6.
[309] TN 16/05/19, page 42.12.
[310] Tab 111, page 1192.
[311] Tab 112, page 1214.
[312] TN 16/05/19, page 44.40.

> Usually if it's a primary respiratory arrest, if it's due to physical things such as restraint or choking, it would be usual to observe a period of real respiratory distress, attempts to get your breath rather than just suddenly becoming unresponsive.[313]

259. In terms of the evidence that Tristan was struggling up to a very short time before he became non-responsive Associate Professor Adams said:

> I think there's an issue that when someone stops struggling after they have been struggling, if it's a purely respiratory problem, normally when you turn them over and feel their pulse, they would not be in asystole but rather have a very slow heart rate. Perhaps fast to start with but slow after minutes and this would gradually degenerate.[314]

260. Similarly, Associate Professor Adams said, in response to a question about Dr Karpa's evidence that when someone arrests they normally turn white or grey:

> I think the problem is … you can't know when this cardiac arrest happened … because he wasn't being – didn't have cardiac monitoring on is my recollection at the time so … if it had just happened and you turned the person over and … say for instance you were monitoring the patient, you noticed that he became asystolic or went into ventricular fibrillation, when you turn the person over and they were already cyanotic, yeah, I totally agree. It would suggest a respiratory cause but if that had been going on for a minute or two without the knowledge of it and unless someone was feeling his pulse the whole time or monitoring his ECG, it's impossible to tell.[315]

261. Thus whilst Associate Professor Holdgate favoured a different specific cause of death to Professor Jones and Associate Professor Adams, none were able to be definitive.

262. Associate Professor Adams gave evidence that the blue or purple discolouration observed by Dr Edwards and Dr Karpa, which Associate Professor Holdgate relied upon in forming her opinion, is not a "particularly reliable technique to judge one thing from the other". He said that people with "a primary cardiac arrest will often be quite dusky and suffused in their upper body" because there is an "impairment of venous return to the heart because … it's not pumping".[316]

263. Dr Clifton gave evidence that there was nothing at autopsy to indicate that a respiratory arrest was the cause of Tristan's death but she could not exclude it either.[317] In this respect, Associate Professor Holdgate agreed that someone

[313] TN 16/05/19, page 42.19.
[314] TN 16/05/19, page 51.38.
[315] TN 16/05/19, page 50.40.
[316] TN 16/05/19, page 43.25.
[317] TN 16/05/19, page 63.4.

could suffer a respiratory arrest with asystole without having any evidence of that at autopsy and said, "you'd expect in that situation a heart may well have been completely normal".[318]

264. Dr Clifton further acknowledged that if there was something preventing someone from breathing, this could result in a primary respiratory arrest followed by a secondary cardiac arrest. However, Dr Clifton noted that, in the forensic literature, it has not been established whether any sort of prone restraint with pressure on the back is something that compromises respiratory function.[319]

265. Mr Evenden submitted that the evidence of Associate Professor Holdgate that Tristan suffered a primary respiratory arrest should be accepted.

266. In contrast, Ms Bennett, Mr Bradley and Mr Jackson submitted that the evidence of Professor Jones and Associate Professor Adams that Tristan suffered a primary cardiac arrest should be accepted.

267. Counsel Assisting submitted that the Court is not in a position to determine whether Tristan suffered a primary respiratory or cardiac arrest.

268. None of the experts were definitive in the views they expressed and they each conceded in cross-examination that it would not be possible to exclude either a primary respiratory arrest or a primary cardiac arrest. In these circumstances, I am unable to determine, on the balance of probabilities, whether Tristan suffered a primary respiratory or cardiac arrest. In lay terms, I am unable to determine whether breathing stopped before the heart stopped beating or whether the heart stopped beating first.

269. As Associate Professor Adams acknowledged, in the absence of cardiac monitoring, it is impossible to definitively establish whether a respiratory or cardiac arrest was the primary cause of Tristan's death.

Prone restraint and positional asphyxia

270. It was submitted by Ms Bennett that there is no sound evidentiary basis for the Court to find that positional asphyxia or the use of prone restraint was a contributing cause to Tristan's death.

271. It is uncontroversial that the physical restraint experienced by Tristan contributed to his death. For example, Associate Professor Adams said:

[318] TN 16/05/19, page 6.28.
[319] TN 16/05/19, page 63.32.

> Nevertheless, with physical restraint it is likely that there would have been increased physical exertion on the part of Tristan and this may have resulted in increased sympathetic drive, increased blood pressure and temperature leading to increased cardiac demand and increased risk of cardiac arrhythmias.[320]

272. As Ms Bennett submitted, the physical restraint experienced by Tristan included:

    (a) the physical restraint undertaken before police arrived at Tristan's house;

    (b) handcuffing by police;

    (c) transporting Tristan to hospital in the Pajero;

    (d) transferring Tristan from the Pajero into the isolation room; and

    (e) the approximately four minutes of prone physical restraint in the isolation room.

273. Counsel Assisting correctly submitted that the evidentiary basis for reliance on prone restraint comes from the uncontested evidence that that is how Tristan was being restrained when Dr Edwards and Dr Karpa separately commented upon the weight being applied to him and when he was observed to be unresponsive.

274. In this respect, Dr Clifton gave evidence that:

> The reason for that is that this man had an arrhythmic event or a cardiac arrest of whatever mechanism at that time because it was a perfect storm of events and one of those events was prone physical restraint. You have an agitated, drug-affected person whose heart rate is high, whose [sic] very confused and aggressive at times who has a heightened sense of awareness at that time because of what's going on because of the drugs, because the adrenalin of what's going on and he's being restrained which causes further stress, physiological, emotional, what not. I cannot exclude the prone restraint as having a role in him developing an arrhythmia at that time.[321]

275. I accept Dr Clifton's evidence notwithstanding that it was based upon clinical information provided to her rather than the findings of her autopsy report. It is

[320] Tab 112, page 1213.
[321] TN 16/05/19, page 72.35.

evident that Tristan's death was caused by a "perfect storm" of a number of factors, including MDMA intoxication with the attendant pathological process of "stimulant cardiovascular effects including an elevated heart rate and blood pressure, producing an increased physiological strain on the heart" as well as physical restraint, including in the prone position, which produced additional "significant physiological stress to the body."[322] Accordingly, I am satisfied that physical restraint, including prone physical restraint contributed to Tristan's death.

276. Mr De Brennan submitted that positional asphyxia arises from the evidence of Dr Edwards and Dr Karpa. However, Dr Clifton makes plain that "the issue of positional asphyxia causing respiratory compromise in the setting of prone restraint is contentious".[323] Similarly, Professor Jones noted that the existence of positional asphyxia remains "highly controversial".[324] In these circumstances, I do not propose record positional asphyxia as a direct cause of Tristan's death.

277. Counsel Assisting submitted that the cause of death should be recorded as "Acute cardiac arrhythmia in 3,4-methylenedioxymethylamphetamine (MDMA) intoxication with physical restraint (including prone physical restraint)". I accept that this represents a fair summary of the cause of Tristan's death.

The need for recommendations

278. Counsel Assisting, Mr De Brennan and Mr Evenden submitted that I should make various recommendations addressed in turn below.

The NSWPF Guidelines

279. Counsel Assisting submitted that I should make the following recommendation to the Commissioner of Police:

> That the NSW Police Force Guidelines on the Management of People Affected by Methylamphetamine and Other Stimulant Drugs be reviewed to ensure consistency with other NSW Police Force policies and training permitting the use of prone restraint, but only where reasonably necessary.

280. Ms Bennett submitted, on behalf of the Commissioner of Police, that a recommendation to this effect is unnecessary given the evidence of Sergeant Watt that he would bring the existence of this inconsistency to the attention of his superiors.

[322] Tab 2, page 10.
[323] Tab 2, page 10.
[324] Tab 111, page 1190.

281. Notwithstanding this, there is no evidence before me as to what review process, if any, might occur or what the result of any review process will be. In these circumstances, I consider that it is desirable to make the proposed recommendation.

282. As Counsel Assisting submitted, this is not to suggest that prone restraint should be encouraged. Rather, police material should consistently emphasise that it is permissible only if it is reasonably necessary in the circumstances.

Training

283. Counsel Assisting proposed the following recommendation in relation to training for police officers:

> To the extent that there is any change to the Guidelines referred to in Recommendation 1 (outlined at [279] above), that consideration be given to providing a training module on the amended Guidelines, including by reference to the risk factors presently included at Appendix A.

284. Similarly, in submissions on behalf of Emma Bell, Mr Evenden proposed the following recommendation:

> That consideration be given to developing and delivering a mandatory training package for all police officers other than commissioned officers, in relation to restraint and the risks of sudden death through positional asphyxia, and including scenario-based training.

285. I am sympathetic to what Senior Constable Greenhalgh described as the "endless"[325] information that officers are asked to read or consider in training, given the almost endless range of scenarios that they might be asked to respond to in the course of their job. However, as Counsel Assisting submitted, there is little point in having guidelines if police officers are not aware of the useful information contained with them. Here the directly involved officers were generally unable to identify risk factors that may lead to an increased risk of positional asphyxia.[326]

286. This is significant because as both Counsel Assisting and Mr Evenden submitted, Appendix A to the NSW Police Force Guidelines on the Management of People Affected by Methylamphetamine and Other Stimulant Drugs already provides useful information to officers on risk factors.

287. The Commissioner similarly opposes the recommendation as unnecessary.

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[325] TN 14/05/19, page 3.2
[326] TN 13/05/19, pages 59.6 and 60.11, TN 14/05/19, page 62.28,

288. I consider that it is desirable to make the recommendation as proposed by Counsel Assisting outlined at [283] above.

Excited Delirium

289. Counsel Assisting proposed the following recommendation in relation to the 2003-2004 police training module on 'Excited Delirium':

> That consideration be given to removing the "Excited Delirium" module from NSW Police training resources given that the 'mental condition' of 'excited delirium' is not recognised in the DSM-V nor ICD-10 and the advice to officers contained therein appears to be inconsistent with the current NSW Health – NSW Police Force Memorandum of Understanding 2018 to the extent that the MOU contemplates that police officers may transport a person detained under the *Mental Health Act 2007* to hospital in a police vehicle as a last resort.

290. The Commissioner opposes the recommendation on the basis, inter alia, police do not diagnose conditions but rather recognise behavioural symptoms. Accepting that police do not diagnose, it is not clear to me why the module needs use the phrase "excited delirium" at all.

291. I consider that it is desirable to make the recommendation as proposed by Counsel Assisting outlined at [289] above.

Restraint in a hospital setting and for the purpose of sedation

292. Mr Evenden submitted that I should make the following recommendations:

> That consideration be given to developing a specific policy that governs restraint by police officers within a hospital setting.
>
> That consideration be given to developing and delivering training for police officers in relation to restraint for the purposes of sedation, including consideration of the need for any interagency training for the purposes of managing persons experiencing a mental health crisis or acute behavioural disturbance.

293. I do not propose to make the recommendation. Although a worthwhile goal, I accept submissions from Counsel Assisting that "restraint within a hospital setting will depend upon many factors including the resources available in each particular setting and clinical decisions from the doctor in charge" such that "it is difficult to see how a … policy could be flexible enough to cover a broad range of potential scenarios and facilities yet specific enough to be useful."

NSWPF Mitsubishi Pajeros

294. Mr Evenden proposed the following recommendation in relation to the vehicles used to transport people who are mentally ill or drug-affected:

> That consideration be given to improving the conditions under which mentally ill or disordered persons might be transported using police vehicles, including through modifications to existing vehicles that may include, but are not limited to:
> (i) Improved air-conditioning or other ventilation.
> (ii) Installation of padding in caged vehicles.

295. A similar recommendation was proposed by Mr De Brennan:

> That any and all vehicles of a similar make and design to BRU19 be retired by NSW Police and replaced with vehicles that are safe and humane. In particular, it is recommended that NSW Police consider the procurement of vehicles that have:
> (a) greater space for those in police vehicle custody;
> (b) improved comfort including the provision of vehicles with cushioning and/or padding for those suffering from an acute behavioural psychosis and/or similar conditions whether relating to their mental health and/or serious drug or alcohol intoxication/affectation.
> (c) greater ventilation and/or air-conditioning in the area where prisoners/detainees/mental health patients are being kept; and
> (d) are consistent with Australia's human rights obligations.

296. Counsel Assisting submitted that, assuming that police involvement in transporting mentally ill or disordered persons from place to place is increasing, the need to consider the appropriateness of vehicles used for that purpose is clear. However, Counsel Assisting considered that recommendations should be informed by specific evidence, including why the Pajero was used on this occasion (because it was a multi-purpose vehicle and police expected an ambulance to attend), the total length of time Tristan spent within the vehicle (about 54 minutes, a substantial portion of which involved the door of the Pajero open), the length of the journey between Bangalow and Lismore Base Hospital (about 21 minutes) and the opportunities to observe Tristan whilst in the vehicle.

297. Having regard to the fact that Tristan survived both the journey to hospital and a further period of confinement whilst waiting to be transferred into the isolation room, Counsel Assisting did not support the making of this recommendation.

298. Similarly, in submissions on behalf of the Commissioner of Police, Ms Bennett indicated that the Court does not have evidence, including appropriate expert evidence, as to any "ideal" or obtainable police vehicle. Accordingly, it was submitted that the recommendation has no evidentiary basis.

299. I accept the submissions made with regard to any proposed recommendations regarding the use of the Pajero to transport Tristan. Whilst there is insufficient evidence before me to as to the "ideal" vehicle to be used, I consider that it is desirable for a recommendation to be made in the terms proposed by Mr Evenden.

Body cameras

300. In submissions on behalf of Vincent Naudi, Mr De Brennan submitted that I should make the following recommendation:

> That consideration be given to mandating that, where practicable, police deployed to incidents said to be related to alcohol or other drug intoxication wear body worn camera footage.

301. Sergeant Watt gave evidence "from [his] personal point of view" in relation to the use of body cameras. He indicated that he thought that "they're a good idea" and that the footage captured could be used as case studies for training purposes.[327]

302. However, this issue was not considered in detail during the course of the inquest and does not arise on the evidence. Accordingly, I do not propose to make this recommendation.

Pill testing

303. Mr De Brennan proposed a recommendation in relation to pill testing. As this issue was not explored during the course of the inquest, I do not propose to make this recommendation.

Findings required by s. 81 of the *Coroners Act 2009* (NSW)

304. The findings I make under s. 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The deceased person was Tristan Francis Naudi

[327] TN 17/05/19, pages 36.40, 37.4.

Date of death
Tristan died on 18 January 2016.

Place of death
Tristan died at Lismore Base Hospital.

Cause of death
Tristan died from an acute cardiac arrhythmia in 3,4-methylenedioxymethylamphetamine (MDMA) intoxication with physical restraint (including prone physical restraint).

Manner of death
Tristan died while being restrained at Lismore Base Hospital as medical staff were attempting to sedate him.

Recommendations pursuant to section 82 *Coroners Act 2009*

305. For the reasons stated above, I make the following recommendations to the Commissioner of the NSW Police Force:

1. That the NSW Police Force Guidelines on the Management of People Affected by Methylamphetamine and Other Stimulant Drugs be reviewed to ensure consistency with other NSW Police Force policies and training regarding the use of prone restraint.

2. To the extent that there is any change to the Guidelines referred to in Recommendation 1 (outlined at [279] above), that consideration be given to providing a training module on the amended Guidelines, including by reference to the risk factors presently included at Appendix A.

3. That consideration be given to removing the "Excited Delirium" module from NSW Police training resources given that the 'mental condition' of 'excited delirium' is not recognised in the DSM-V nor ICD-10 and the advice to officers contained therein appears to be inconsistent with the current NSW Health – NSW Police Force Memorandum of Understanding 2018 regarding the transportation of a person detained under the *Mental Health Act 2007* in a police vehicle.

4. That consideration be given to improving the conditions under which mentally ill or disordered persons might be transported using police vehicles, including through modifications to existing vehicles that may include, but are not limited to:
   (i) Improved air-conditioning or other ventilation.
   (ii) Installation of padding in caged vehicles.

A health response to MDMA use

306. Tristan's case highlights dilemmas posed for police, ambulance and medical staff when tasked to help people intoxicated by stimulant drugs. There are no simple solutions to the complex dilemmas posed.

307. In 2018, the NSW government established a Special Commission of Inquiry into the Drug 'Ice'. The Special Commission considered both crystal methamphetamine use and other amphetamine type stimulants. I understand the Special Commission has recently reported to the Governor, although the report is not available at the time of these reasons.

308. Nonetheless I have read with interest submissions on behalf of Counsel Assisting that Inquiry,[328] including recommendations as set out below:

> Counsel Assisting recommendation 2
> As a matter of priority, a whole of NSW government AOD policy be developed.[329]
>
> Counsel Assisting recommendation 3
> A NSW Drug Action Plan be developed.[330]
>
> Counsel Assisting recommendation 31
> (A)s a matter of priority, NSW Health investigate the development of behavioural short-stay units within or co- located with emergency departments for the management of patients with acute severe behavioural disturbance, including by:
>
> - developing a model of care, including guidance on design requirements, staffing and arrangements for telehealth input between metropolitan and regional, rural and remote locations;
> - prioritising funding for required capital works to support Local Heath Districts in implementing this model of care;…[331]

309. As Counsel Assisting this Inquest submitted, should these recommendations ultimately be accepted and implemented (particularly recommendation 31) there is the prospect that in the future, behaviourally disturbed patients like Tristan, in need of targeted intervention in specifically designed spaces, will be better served by the public health system.

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[328] https://www.iceinquiry.nsw.gov.au//assets/scii/closing-submissions/Counsel-assisting-closing-submissions.pdf.
[329] CA2, page 9.
[330] CA3, page 10.
[331] CA31, page 44.

Closing remarks

310. On the final day of the hearing, Emma Bell, Tristan's partner, and Angela Tallon, Tristan's sister, shared their memories of Tristan. Each spoke lovingly and movingly about the real Tristan, the one they knew and loved, rather than the aspects of Tristan's life that were necessarily the subject of this inquest.[332] As Angela noted, to attempt to articulate how the loss of Tristan has affected his family "is truly an overwhelming and … impossible task".[333]

311. When Emma first met Tristan she noticed his kind heart and gentle nature. On the night they met, he kept her company and made sure that she got home safely. Tristan had a sentimental and beautiful soul. He was passionate about his job as an apprentice chef and driven to excel in that career. Emma remembers that Tristan was rarely without his charismatic smile and that he was always able to make his friends and family laugh.[334]

312. Angela spoke about how Tristan simply made the world better by being in it. His infectious smile, his cheeky witty humour had a way of lighting up any room. His positive carefree outlook on life set him off exploring on many adventures in his Kombi, Marley, and making life-long friends along the way. "No shirt, no shoes, no worries".

313. Angela described Tristan as full of potential, and a person who "achieved many great things against all odds".[335] He dreamt of travelling and surfing around the world and with his continued hard work this dream was almost in reach.[336]

314. I wish to thank Emma and Angela for their courage and generosity in sharing, so beautifully, their memories of Tristan. It is clear that Tristan continues to be deeply loved and missed by those who knew him best. The unexpected nature of his loss, at a young age, has only deepened the pain surrounding it. I acknowledge that while there will be some relief for Tristan's family in the inquest concluding, their grief will continue.[337]

[332] TN 1/10/19, page 4.25.
[333] TN 1/10/19, page 27.5.
[334] TN 1/10/19, page 4.29 and page 4.42-4.28.
[335] TN 1/10/19, page 6.38.
[336] TN 1/10/19, page 7.13.
[337] TN 1/10/19, page 8.10.

315. I would like to thank Counsel Assisting, Ms Donna Ward, and her instructing solicitor, Mr David Yang, for the enormous amount of work they put into assisting me in this inquest. On behalf of the Coroner's Court of NSW and the Counsel Assisting team, I offer my deepest sympathy and most respectful condolences to Tristan's loved ones and his many friends for their heartbreaking loss.

Magistrate Teresa O'Sullivan
State Coroner
14 February 2020
Byron Bay Local Court