**CORONERS COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Michael Peachey |
| **Hearing dates:** | 14-15 February 2022, 6-7 April 2022, 11-12 April 2022, 13-14 October 2022, 17-20 October 2022, 12-15 December 2022, 11-12 April 2023, 10 May 2023, 4 September 2023. |
| **Date of findings:** | 28 November 2024 |
| **Place of findings:** | NSW Coroners Court – Gunnedah<br>NSW Coroners Court - Lidcombe |
| **Findings of:** | Magistrate Elizabeth Ryan, Deputy State Coroner |
| **Catchwords:** | CORONIAL LAW – Death as a result of police operation — First Nations death – restraint of person in the prone position – was the response of police and ambulance officers appropriate, and consistent with policy and training – recommendations. |
| **File number:** | 2021/144151 |
| **Representation:** | Counsel Assisting: K Stern of Senior Counsel with J Caldwell and E Forsyth of Counsel, instructed by the NSW Crown Solicitor's Office.<br>The Peachey family: J Styles of Counsel instructed by the Aboriginal Legal Service.<br>The NSW Commissioner of Police: K Burke of Counsel instructed by NSW Police Force Office of General Counsel. |

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| | NSW Ambulance and the Hunter New England Local Health District: B Bradley of Counsel instructed by Norton Rose Fulbright<br><br>NSW Ambulance Paramedics K Summers, D Baker, B Wilton and H Hausfeld: T Berberian of Counsel instructed by McCabes Lawyers.<br><br>Senior Constables A Gough and S Douglas, and Probationary Constable L Smith: P Madden of Counsel instructed by WMJ Lawyers.<br><br>Dr Kiran Chandra: B Epstein of Counsel instructed by Meridian Lawyers.<br><br>Registered Nurse Heather Franke: P Robertson, NSW Nurses & Midwives' Association. |
| **Findings:** | **Identity**:<br><br>The person who died is Michael Peachey.<br><br>**Date of death**:<br><br>Michael Peachey died on 20 May 2021.<br><br>**Place of death**:<br><br>Michael Peachey died at Gunnedah, NSW.<br><br>**Cause of death**:<br><br>Michael Peachey died of cardiac arrest due to cardiac arrhythmia, on a background of prone restraint (some of which was weighted); the administration of droperidol and midazolam; and a period of exertion in which he suffered the effects of oleoresin capsicum spray, taser discharges and psychosis.<br><br>**Manner of death**:<br><br>Michael Peachey died as a result of a police operation. |
| **Recommendations:** | **To the NSW Commissioner of Police**<br><br>1. That the Commissioner consider:<br><br>a) formulating an independent policy on restraint which provides clear guidance to officers of the NSW Police Force about the risks of prone restraint, the ways in which to mitigate those risks, and the importance of moving a person from the prone position as soon as possible, particularly in cases where there has been acute behavioural disturbance and emergency sedation; and |

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| | b) providing specific mandatory training to NSW Police Force officers on the above.<br><br>2. That the Commissioner consider:<br><br>a) providing further guidance material in the NSW Police Force Handbook, on the importance of having regard to information provided, and concerns expressed by, family members or others close to the person about the person's behaviour, including changes in that behaviour, in determining whether a person appears to be mentally ill or disturbed for the purposes of section 22 of the Mental Health Act 2007; and<br>b) providing additional training to NSW Police Force officers in the above.<br><br>**To the NSW Commissioner of Police, and the Commissioner and Chief Executive of NSW Ambulance**<br><br>3. That NSW Ambulance and NSW Police Force consider carrying out interagency training and/or development of guidance material, which would focus on the respective roles of the two agencies and the need for communication, where both agencies attend a scene involving acute behavioural disturbance, prone restraint and emergency sedation.<br><br>**To the Chief Executive Officer of the Hunter New England Local Health District**<br><br>4. That the Hunter New England Local Health District consider the introduction of polices for following up voluntary patients who present to an emergency department with symptoms of mental illness or disturbance, but leave without having received a medical assessment. |
| **Non-publication orders** | Orders prohibiting publication of certain evidence pursuant to section 74(1)(b) of the *Coroners Act 2009* (the Act) have been made in this inquest. A copy of these orders, and orders made pursuant to section 65(4) of the Act, can be found on the Registry file. |

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*Section 81(1) of the Act 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 Michael Peachey.*

## Introduction

1. Michael Peachey was 27 years old when he died on the night of 20 May 2021. He was a proud First Nations man and a member of the Gamilaraay Clan of the Kamilaroi Nation.

2. Michael died in Gunnedah, during a prolonged episode in which police officers were attempting to restrain him. It is most likely that at the time, Michael was in the grip of an undiagnosed psychosis. An inquest into the tragic circumstances of his death is mandatory, pursuant to sections 23 and 27 of the Act. These sections require that an inquest be held where a person dies '*in the custody of a police officer'* or '*as a result of a police operation'*.

3. Michael's young death in such traumatic circumstances has brought profound grief to his family. Michael was the father of a three year old boy Dwayne, and he was much loved by his own father Stephen, his sisters and brothers, his former partner, and his large extended family of cousins, aunt and grandmother.

4. Nothing compares to the grief a family suffers at the loss of a loved one. But Michael's death impacted many others who were drawn into the crisis that night. Two police officers in particular were very closely involved. Without doubt the situation they faced was volatile and unpredictable, and for much of it they had to manage without the help of police or medical backup. The tragic outcome has left them deeply shaken.

5. Nevertheless Michael's young life was lost amidst decisions which they and others made that night. This is why the response which the attending police and ambulance officers made to Michael's crisis was closely examined in the inquest. This is hard, because it is an examination made with the benefit of hindsight, and far removed from the chaos and confusion of that harrowing night.

6. But a hindsight examination is truly the work of the coronial inquest. This was recognised in the submissions on behalf of one of the interested parties:

> *' … hindsight is important as it can assist the Court and interested parties to learn lessons from events and to moderate future risk'.*

7. Furthermore, this inquest focused not only on the police and health response that night, but also in the days which led up to Michael's tragic death. Michael's family knew that his mental health was disintegrating, and they were full of anguish and fear. They desperately wanted to get help for him and they made many attempts to do so. For the sake of other families, Michael's family need to know if anything could have been done in those last critical days to prevent his tragic death.

8. The manner in which police and health agencies can best respond to people in severe distress is a very live issue. Our current model is based on an expectation that police officers will be the first responders to mental health crises. Yet there are real challenges with this approach. It places a high demand on police resources. And in many cases police officers, who are not trained mental health professionals, are not the appropriate people to respond to those who are in severe distress. Michael's case bears out these concerns.

9. I am aware that within the NSW Police Force, reviews are underway to explore other models of responding to mental health-related incidents. This process will involve consultation with multiple groups of people including police, health and ambulance services, and those who provide and those who receive mental health care.

10. I sincerely hope that this process will lead to an approach which better serves the needs of people like Michael and his family.

11. In the meantime, the inquest into Michael's death examined the police and ambulance response to his deteriorating mental health over his last days. As will be seen, I have identified certain shortfalls in the way police and ambulance officers interacted with Michael over this period, and the decisions which they made. But I have made this evaluation in full acknowledgement of the very challenging circumstances within which these tragic events unfolded. Furthermore, I make it with the sincere aim of finding ways to better support both the people who suffer mental health crises, and the responders who come to their aid.

12. Michael's family, who have suffered the loss of a beloved son, brother, cousin and father, deserve no less.

**The issues at the inquest**

13. The issues which emerged from the tragic circumstances of Michael's death were numerous and complex. They were examined over a hearing of twenty days, which was held in both Gunnedah and Lidcombe. The court heard oral evidence from thirty-one witnesses including members of Michael's family, other

eyewitnesses, and many NSW police officers, ambulance officers, and hospital staff. Their encounters with Michael in his last few days were closely examined.

14. The witnesses also included a number of expert witnesses. Their specialised knowledge was of great assistance in understanding the medical and policing issues which faced the responders and Michael's family that night, and in the days leading up his crisis.

15. As the case proceeded certain issues which had been highlighted for examination emerged as of greater prominence, while others receded in importance.

16. I have structured these findings in five parts.

17. Part A summarises what happened in the forty hours before Michael's death. During this time he had numerous interactions with family members, hospital staff, and officers of NSW Police and NSW Ambulance. These events provide essential context to the tragic climax of his death on the night of 20 May 2021. Thus Part A examines:
    - the weeks leading up to Michael's death, during which Michael's family saw a sharp decline in his mental health
    - the early morning of 19 May 2021, when Michael inexplicably drove his father's car onto local railway tracks. This prompted the involvement of police officers and NSW Ambulance officers
    - the morning of 19 May 2021, at Gunnedah Hospital
    - the afternoon of 19 May 2021, when Michael had a further interaction with police officers
    - the morning of 20 May 2021, when members of Michael's family sought police help in getting him mentally assessed
    - the evening of 20 May 2021, when Michael had a fraught encounter with police officers outside his father's home, followed by a prolonged struggle inside a home further down the street. This is the place where Michael died.

18. Part B deals in detail with the events of the evening of 20 May 2021, which culminated in Michael's death.

19. Part C provides analysis and findings as to the following issues:

    a) whether it was appropriate for the attending police officers to attempt to restrain Michael outside his father's house

    b) whether it was consistent with NSW Police Force policy and training for the police officers to maintain Michael in the prone position

c) whether the attending ambulance officers administered medication in an appropriate manner

d) whether the ambulance officers adequately monitored Michael for signs of clinical deterioration

e) whether the ambulance officers ought to have communicated to the police officers the risks of maintaining Michael in the prone position

20. Part D examines whether it is possible to identify the cause of Michael's death.

21. Part E deals with the question of whether any recommendations are necessary or desirable, connected with Michael's death.

**Expert witnesses**

22. The witnesses who provided expert opinions at the inquest were:

a) Dr Isabel Brouwer, forensic pathologist, Department of Forensic Pathology Sydney;
b) Professor Stephen Cordner, forensic pathologist, Emeritus Professor at the Department of Forensic Medicine, Monash University;
**c)** Dr Andrew Ellis, forensic psychiatrist and Clinical Director of Forensic Mental Health within the Justice Health and Forensic Mental Health Network;
d) Dr Tanya Ahmed, consultant psychiatrist;
e) Associate Professor Mark Adams, specialist cardiologist, Head of Department of Cardiology at Royal Prince Alfred Hospital, Sydney;
f) Professor Alison Jones, pharmacologist and toxicologist and Executive Director of Sunshine Coast Health Institute;
g) Adjunct Associate Professor Tony Hucker, Critical Care Paramedic, and Director of Patient Safety and Quality with Queensland Ambulance Service;
h) Mr Sean Mutchmor, National General Manager of Quality, Safety and Professional Practice for the Australian College of Rural and Remote Medicine;
i) Associate Professor Jason Bendall, Director of Medical Services at NSW Ambulance, staff specialist anaesthetist at Hunter and New England Local Health District [HNELHD].

23. Evidence was also given by Sergeant William Watt and Chief Inspector Matthew Hanlon. Sergeant Watt is an Operational Safety Instructor of many years' experience. His role includes developing and delivering training to NSW police officers in the lawful use of force, as well as the use of alternative techniques.

24. Chief Inspector Hanlon was at the time of the inquest the Manager of the NSW Police Force Mental Health Intervention Team, which provides policy and training to frontline officers in relation to mental health and suicide interventions.

25. These two senior police officers gave evidence on whether the actions of the involved police officers were in accordance with NSW Police Force training and policy. The court also took the opportunity to hear their expert opinion on whether specific changes to NSW Police Force policy and training might help to reduce the risk of such tragedies occurring in the future.

**Michael's life**

26. Born on 24 January 1994 at Moree Hospital, Michael was the eldest child of his parents Stephen Peachey and Belinda Davis.

27. Michael had seven younger sisters and brothers: Rebecca, Ben, Joe, Brooke, Vincent, Chantelle and Breeanna. The children grew up in Moree, where their father supported his family with his work as a truck driver.

28. A healthy boy, Michael loved swimming, fishing and BMX bike riding. At the inquest his cousin Jtaya Davis recalled happy days with Michael and her other Peachey cousins:

> *'We were cooked little kids. Funny as … …. Michael was the leader of us, definitely not a follower in any way. He was always getting US into trouble. But not Mike … The first born boy could do no wrong and he knew that was the case'.*

29. With great affection, Stephen also remembered his eldest son as *'a great kid'; 'a little bit of a class clown and a joker, always happy and making jokes*'. For Ben Peachey, his older brother Michael was '*the uplifting person, the person to look up to'*.

30. But tragedy came to the family in 2012 when their mother Belinda took her life. Belinda's own mother Frances Stephens said that losing Belinda was *'crushing for the whole family, her youngest child was only nine months old'*. Ms Stephens had endured a similar tragedy when her son Nathan, who suffered from schizophrenia, took his own life a few years earlier.

31. After his mother died, 18 year-old Michael stepped up to help his father with the younger children. As Stephen recalled it: *'I ran the show but Michael was the captain'.*

32. But the loss of his mother was a heavy blow for Michael. He had started an apprenticeship with a builder and he was loving his work. Although he went on to complete his apprenticeship and he kept working, Michael began using marijuana, which according to his sister Rebecca he smoked every day. In 2017 he began smoking methamphetamine as well.

33. Michael became a father himself on 20 February 2018. He had met Victoria Hoyt in their teenage years and they started living together. Michael loved his baby Dwayne, and his father and his grandmother said he '*wanted to be the best he could for his son'*.

34. But despite his happiness in this new role, Michael's life was taking a downward path. Between 2016 and 2020 he was convicted of offences which included drug driving. His relationship with Victoria suffered, and she and Dwayne moved to Inverell where her family lived.

35. In late 2019 Michael moved from Moree to Gunnedah, to join his father and his sisters. In October that year he visited a GP Dr Syed Ghazi and was prescribed medication to help treat depression and panic attacks. Significantly, Dr Ghazi's notes made mention of Michael hearing voices and possibly having hallucinations.

36. Then in 2021 Michael was again charged with drug driving and he was disqualified from driving. This affected his ability to work and to visit his son in Inverell, deepening his low mood.

37. In the four weeks before his death, Michael's mental stability dramatically worsened. His strange behaviour filled his family with alarm and concern. According to expert evidence heard at the inquest, Michael had most likely begun to suffer psychosis.

38. Many members of Michael's family provided statements to assist the inquest, and some gave oral evidence. But Michael's heartbroken father Stephen was too distressed to complete his evidence. And at the close of the evidence Michael's cousin Jtaya spoke with aching sadness about life without her cousin and close friend:

> *'Since his death everything has changed. Mostly for the worst, I don't think any of us love life too much anymore …… I miss my cousin more than anyone here can understand. I miss watching him be a Dad, a brother, a grandson, a cousin. I miss my mate!'*

39. Victoria wrote about the little boy she shared with Michael, and how it felt explaining that his father wasn't there:

*'Seeing families together, kids playing with their dads, parents attending school things plus events out of school reminds me that's something Dwayne and I no longer have …. explaining [these] things puts the biggest lump in my throat cause I know Michael would do anything to be here.'*

40. Michael's death at such a young age has left enduring pain for a family who loved him deeply.

**The *Mental Health Act 2007***

41. Before turning to the critical events of 19 and 20 May 2021, I will briefly outline the provisions of the *Mental Health Act 2007* (the MHA 2007) which empower police and ambulance officers to take a person to a facility to receive a mental health assessment. On 19 and 20 May 2021 there were a number of occasions when police and ambulance officers had to decide whether they should exercise these powers in relation to Michael.

42. Section 20 of the MHA 2007 empowers an ambulance officer to take a person to a declared mental health facility if the officer believes on reasonable grounds that the person appears to be mentally ill or mentally disturbed, and that it would be beneficial to the person's welfare to be dealt with in accordance with the MHA 2007.

43. The corresponding police power under section 22 is in somewhat different terms. Police officers may take a person to a declared mental health facility if a person appears to be mentally ill or mentally disturbed, and it would be beneficial to the person's welfare to be dealt with in accordance with the MHA 2007, rather than otherwise in accordance with the law.

44. However, for police there is an additional requirement that the police officer must believe on reasonable grounds that:

*' …the person is committing or has recently committed an offence or that the person has recently attempted to kill himself or herself or that it is possible that the person will attempt to kill himself or herself or any other person or attempt to cause serious physical harm to himself or herself or any other person.'*

45. As can be seen, an officer is not legislatively prevented from using section 20 or section 22 in circumstances where the person is willing to be transported to a mental health facility on a voluntary basis. Nevertheless, section 68 of the MHA 2007 sets forth the principles which are to guide such decisions. These principles include:

- that people receive care in the least restrictive environment which enables such care to be given
- that any restrictions on the liberty of persons, and any interference with their rights, dignity and self respect is to be kept to the minimum that is necessary in the circumstances.

46. The principle of '*least restrictive care'* played a significant part in the decisions which police and ambulance officers made on 19 and 20 May 2021.

## PART A: THE DAYS LEADING UP TO MICHAEL'S DEATH

47. In 2021 Michael was sharing a house at 2 McDonagh Place Gunnedah with his sister Rebecca Peachey and her partner Marlee Thomas. Also living there were Rebecca's son Cooper and Michael's little sister Breeanna, who was nine years old.

48. In a house a few streets away at 17 Herbert Street, Michael's father Stephen lived with Michael's brothers Ben and Vincent and his sister Chantelle. Next door at number 15 were Michael's maternal grandmother Frances Stephens, his aunt Kylie Craig, and his cousin Jtaya Davis. Ms Craig's younger children also lived there.

49. These family members were close to Michael. With great sadness, frustration and regret they told the story of his last weeks. All spoke of a marked change in Michael's behaviour over this period. Equally striking is their evidence that Michael had never before behaved in these ways, even when he was under the influence of cannabis or methamphetamine.

50. Michael's father Stephen noticed that he did not seem to be himself. He was smoking a lot of marijuana and spending most of his time in his bedroom. Stephen tried to get his son out of the house, taking him into town each afternoon to buy pizza.

51. Rebecca too noted that Michael was not like his usual self, which was '*always loud and usually laughing and constantly making jokes'.* Ben said that his brother was keeping to himself a lot. They thought Michael was depressed about not being able to visit his son Dwayne, due to the loss of his driver's licence.

52. As the days passed, more worrying symptoms began to surface. Michael started to utter strange things, telling Rebecca he was *'not a puppet for anyone and*

*there is no strings attached'.* He spoke of eagles guiding his way and voices in his head, and he swung between moods of depression and hysterical laughter.

53. Michael's grandmother Frances Stephens became fearful:

> '*Michael was not right. His eyes looked empty …he was talking about demons and the only way to kill a demon was to eat one'*.

54. Jtaya Davis was deeply worried about her cousin. She described him visiting her, then running back to his home where she found him sobbing on his bed:

> '*Then he sat up and started looking at his skin, saying 'I'm free' ... He was looking at himself like he was someone or something else'.*

55. Michael told Jtaya he was going '*to eat her with no mouth and no teeth'*, that he was a monkey king and had created the universe, and that he would take everyone to hell with him.

56. Rebecca and Jtaya also observed that Michael was frequently making a triangular symbol with his hands whilst breathing slowly and heavily. According to Rebecca, Michael would *'zone out'* while he was making this symbol. In video footage shown at the inquest, Michael can be seen making this gesture on many occasions. Jtaya surmised it was a symbol associated the Illuminati, a name given to entities who are said to control major world events.

57. Yet Michael seemed able to move in and out of this abnormal behaviour. In her evidence Jtaya commented that when police officers were present his behaviour, although still not right, was less bizarre.

58. These reports of behavioural disturbance were noticed by forensic psychiatrist Dr Andrew Ellis, when he reviewed the coronial material. Dr Ellis had been asked to assist the inquest by providing his expert opinion on what the evidence revealed about Michael's mental health, in the weeks and days leading up to his death.

59. Dr Ellis cautioned that he had never met Michael. Nevertheless having reviewed the material he considered there was *'reasonable medical certainty'* that in the month prior to his death Michael was suffering a psychotic episode. This was characterised by:

> *' … hallucinations (multiple reports of hearing voices and seeing animals), adopting unusual postures (staring, prayer positions, hand positions), delusional beliefs (grandiose and magical beliefs, as well as likely persecutory beliefs ….), social withdrawal and disorganised behaviour … …*

*He had a genetic liability to psychotic conditions with a relative suffering from psychosis, and potentially his mother suffering from a mental disorder prior to her suicide.'*

60. Dr Ellis thought it was possible Michael had been developing '*an insidious psychotic condition'* for several months. In his opinion a potential cause or contributor was his heavy use of cannabis, which can induce psychosis or worsen an underlying condition such as schizophrenia.

61. Dr Ellis' evidence and that of other specialists will be described in more detail later in these findings.

**The morning of 19 May 2021**

Michael drives his father's car onto railway tracks

62. On the day before he died, at about 4.00am Michael walked to his father's house and asked to borrow his car to buy some milk. When he got the car however he drove it onto local railway tracks, where its rear wheels became stuck. Michael then got out of the car and approached a train driver who was sitting in the cabin of a stationary train. Michael asked him for a lift. The train driver noticed that Michael kept using his hands to form '*some sort of circle'* in front of his body.

63. Disturbed by Michael's behaviour, the train driver rang '000'. He told the operator that Michael was not abusive, but appeared to be under the influence of drugs or alcohol.

64. In the meantime Michael walked back to his father's house. To Stephen's alarm he told him he had crashed his car, and that he himself was a Pharaoh.

65. Soon afterwards two police officers arrived at Stephen's house to speak with him. They were Sergeant Brett Roden and Senior Constable Christopher Guinery. Sergeant Roden has been a police officer for over 25 years, most of which he has served in rural and regional areas. Over this period he has attended a substantial number of mental health-related incidents.

66. The police officers asked Michael why he had driven the car onto the railway tracks. Michael responded that:

    ' … *something was just telling me that I had to do them things that I've done … I feel like I'm where I need to be now*'.

    He added that after leaving the car he had:

' … *climbed up the tree. And then I thought this is where I got burnt, you know what I mean'*.

He had decided to leave the car there because '*something told me I shouldn't have stayed there too long'.*

67. At the inquest Sergeant Roden described Michael's conduct as '*certainly bizarre behaviour'*. Senior Constable Guinery agreed that '*something wasn't right there'.* Nevertheless, neither officer considered that his behaviour met the threshold to take him to a facility for a mental health assessment, pursuant to their powers under section 22 of the MHA 2007.

68. However, both officers thought it would be appropriate to ask paramedics to perform a mental assessment of Michael, given their greater expertise in such matters. Senior Constable Guinery used his police radio to request an ambulance.

<u>The attendance of the ambulance officers</u>

69. Just before 6.00am, two NSW Ambulance paramedics came to Stephen's house to assess Michael. They were paramedics Hayley Hausfeld and Bronwyn Wilton, who were both based at Gunnedah. They found Michael to be '*calm and happy to chat'*. He told them he had been hearing *'fun voices',* but the voices were not telling him to hurt himself or anyone else. He also told them he had been using marijuana on a daily basis, and had already had two joints that morning.

70. The two paramedics discussed Michael's presentation, and concluded that he did not meet the criteria to be involuntarily transported to a mental health facility, pursuant to their powers under section 20 of the MHA 2007. It was unclear to them if he was suffering a mental illness or disturbance. But of greater significance was that they saw no sign that Michael intended to harm himself or anyone else.

71. Importantly too, Michael appeared to be quite happy to comply with their suggestion that he come with them to hospital for a mental health assessment. This, both paramedics thought, would be the most appropriate response having regard to the '*least restrictive care'* principle. Accordingly, Michael got into their ambulance and they took him to Gunnedah Hospital.

72. Stephen Peachey felt relieved that Michael was to have a mental health assessment. He told the court that he knew something was not right with his son, and he hoped that this intervention might lead Michael to what he felt was much needed drug rehabilitation.

73. Neither the police officers nor the ambulance officers who attended that morning used their respective powers under the MHA 2007 to take Michael to a mental health facility. I will pause here to examine the appropriateness of these decisions.

Was the response of the ambulance officers appropriate?

74. The court heard evidence on this issue from the three paramedics experts named in paragraph [22] above, and from psychiatrists Dr Andrew Ellis and Dr Tanya Ahmed.

75. These experts offered differing opinions as to whether the paramedics ought to have found that Michael's behaviour was that of a mentally ill person. His behaviour, and the indications that he was following the command of voices, caused Dr Ellis and Adjunct Associate Professor Hucker to conclude that he did meet this definition. However Mr Mutchmor did not agree, noting that Michael was reportedly alert, had voiced no intention to harm himself or others, and was willing to go to hospital with the ambulance officers.

76. Ultimately the submissions of Counsel Assisting made no criticism of the paramedics' decision not to use their section 20 powers. This was in part due to the effect of NSW Ambulance *Protocol MH3: Enacting s20 and s81 of the Mental Health Act 2007* [Protocol MH3]. This Protocol, current as at 19 May 2021, is designed to guide the response of paramedics to persons suffering a mental health episode.

77. Paragraph 2 of Protocol MH3 states that paramedics may enact section 20 of the MHA if:

    - they have determined that a patient appears mentally ill or mentally disturbed and would benefit from going to hospital, and
    - *the patient is unwilling to be transported to hospital voluntarily* (my italics).

78. Since Michael was *not* unwilling to be transported to hospital, paramedics Hausfield and Wilton concluded that it was not open to them to use section 20.

79. When informed of Protocol MH3, Adjunct Associate Professor Hucker agreed that it inserted a requirement that a patient be unwilling to be transported to hospital. He noted that there was an inconsistency between the above Protocol, and the terms of section 20 itself. Section 20 does not require that a patient be unwilling to be transported to hospital before the section can be enacted.

80. Incidentally, and notwithstanding Michael's willingness, Adjunct Associate Professor Hucker thought there would have been advantages had the paramedics utilised section 20. He pointed to the risk that with a voluntary transportation, there is nothing to prevent an unwell patient from changing their mind upon arrival at hospital and deciding to leave without being assessed. This is in fact what happened that morning, as will be seen.

81. Like Adjunct Associate Professor Hucker, Dr Ellis was of the view that Michael's behaviour in driving a car onto railway tracks provided grounds to conclude that he was a '*mentally ill person'*. Nevertheless he concurred with Mr Mutchmor that it was appropriate for the paramedics not to have exercised their section 20 powers, because Michael was clearly willing to be taken to hospital for an assessment. Dr Ellis commented that:

> *' .. it is most desirable that [a] person suffering from a mental illness … engage with treatment voluntarily where possible.'*

82. In light of Michael's willingness to go to hospital, and having regard to the opinions of Dr Ellis and AA Professor Hucker on this point, I do not express criticism of the paramedics' decision not to exercise their power under section 20 of the MHA 2007. I accept the submission of Counsel for the paramedics, and the submission of Counsel Assisting, that their actions were consistent with their training and were compliant with Protocol MH3.

83. Nor should there be criticism of the paramedics' decision to take Michael to Gunnedah Hospital rather than Tamworth Base Hospital. On the one hand, as a rural base hospital Tamworth Hospital is better resourced to deal with mental health patients. By contrast, and as noted by consultant psychiatrist Dr Tanya Ahmed in her report, Gunnedah Hospital is:

> *' … a small district 48 bed rural hospital which would experience considerable challenges in managing complex mental health patients'.*

84. Dr Ahmed went on to explain:

> *'There are well-documented and longstanding challenges unique to rural and remote emergency departments. They generally lack after hours and sometimes in hours specialist mental health care. …. There is an expectation that these departments continue to deal with high-risk presentations without adequate training, support specialist input and safety measures.'*

85. In hindsight, and as events at Gunnedah Hospital unfolded, it can be concluded that Tamworth Hospital would have been a preferable destination for Michael.

Its higher level of resourcing meant that it is more likely that he would have been seen by a doctor that morning.

86. But I accept that at the time, there were sound reasons why the two paramedics settled upon Gunnedah Hospital instead. As Paramedic Hausfield pointed out in her evidence, Tamworth Hospital was an 80 kilometre drive away, and Michael's family support was in Gunnedah.

Was the response of the police officers appropriate?

87. Should the police officers have detained Michael on the morning of 19 May 2021 for the purposes of a mental health assessment?

88. Despite Michael's bizarre behaviour, Sergeant Roden had found him to be '*calm, compliant', 'quite rational and coherent'.* He did not think that Michael was mentally ill or mentally disturbed. Senior Constable Guinery likewise thought this was the case, but on the basis that it did not appear that Michael intended to harm himself or others.

89. As I have noted, both Dr Ellis and Adjunct Associate Professor Hucker formed the view that Michael could have been considered a mentally ill person. So too did Chief Inspector Matthew Hanlon, the then Manager of the NSW Police Force Mental Health Intervention Team.

90. In his statement Chief Inspector Hanlon considered that Michael's actions in driving a car onto a railway '*would be sufficient under section 22 (1)(a) to detain Mr Peachey for the purposes of undergoing an assessment under the Mental Health Act'.* However Chief Inspector Hanlon added that the officers' failure to exercise their section 22 powers was rectified by their decision to call an ambulance for Michael instead.

91. Based on this evidence, Counsel Assisting submitted that the court could consider that *'the criteria in section 22 of the MHA were satisfied that morning'.* However noting the police officers' decision to arrange a paramedic assessment, Counsel Assisting added this:

> '*It is not submitted that the police officers should (as opposed to could) have utilised the power in section 22 …'*

92. On behalf of the NSW Commissioner of Police, Ms Burke rejected the proposition that Sergeant Roden and Senior Constable Guinery *'could'* have concluded that Michael's condition satisfied section 22. She asserted that Dr Ellis and Adjunct Associate Professor Hucker had viewed the events through the

'*prism*' of highly qualified mental health professionals, as compared with the *'street level judgement'* which a police officer must rely upon in this situation.

93. I accept that police officers are not expected to apply the expertise of qualified mental health clinicians. However it is significant that Chief Inspector Hanlon was also of the view that the section 22 criteria were met.

94. As to this, Ms Burke submitted that Chief Inspector Hanlon's opinion was the product of '*a hindsight perspective'* and was not based on what the two involved police officers had actually observed and heard.

95. That Chief Inspector Hanlon was not present at the scene is obvious. But this fact cannot disentitle him from applying his policing expertise to assess the police response, and to reach a conclusion as to its appropriateness. Chief Inspector Hanlon is a highly qualified and experienced officer, who drew upon his own extensive experience as an operational police officer and trainer. His opinion is deserving of significant weight.

96. I will note at this point, that at the inquest Chief Inspector Hanlon gave valuable evidence on this and other relevant policing issues. In my view he gave careful consideration to the matters upon which he was qualified to comment, and provided balanced, thoughtful and future-focused evidence about the increasing complexities of modern day policing.

97. The weight of the evidence indicates that there was a basis for the two police officers to have found the section 22 criteria met.

98. But this is not to say that the circumstances compelled this conclusion, as Counsel Assisting acknowledged. Chief Inspector Hanlon and Dr Ellis agreed that in circumstances where the two police officers knew that Michael was willing to accompany the ambulance officers to hospital, their decision not to use their coercive powers was appropriate.

99. I accept their opinion, and find that it was appropriate for the two police officers not to have used their powers under section 22 that morning.

100. I now return to the events of the morning of 19 May 2021.

<u>Events at Gunnedah Hospital</u>

101. Michael was taken by ambulance to Gunnedah Hospital, arriving there at about 6.11am. Most unfortunately, he left almost two hours later without having received a mental health assessment. The inquest examined whether the care

and treatment Michael received at the hospital was adequate, and whether hospital staff ought to have undertaken follow up action after he left.

102. On 19 May 2021 Gunnedah Hospital's sole doctor on duty was Emergency Registrar Dr Kiran Chandra. He had on call access to other health practitioners, and he was also able to use a video link to seek advice from an on call mental health specialist.

103. Dr Chandra lived close to the hospital, and his usual practice was to review Emergency Department [ED] patients each morning between 7.00am and 7.30am. On the morning of 19 May 2021 however, Dr Chandra did not arrive at hospital until about 8.00am. The previous night he had worked until after midnight, and again on an on call basis from 1.00am to 3.30am. On his understanding, when hospital staff worked late into the evening they were permitted to come into work a little later the next morning, in order to manage fatigue.

104. When Michael's ambulance arrived at Gunnedah Hospital's ED, Paramedic Wilton made some observations of his vital signs, which were not abnormal. She then led Michael into an empty room and left him resting on a bed to wait for the doctor. A nurse performed a mental health triage, assigning Michael a triage category of 4. This meant that he was to be seen by a medical officer within an hour.

105. At 7.00am Michael's care was transferred to Registered Nurse Heather Franke. She and Nursing Unit Manager Tracy Anderson were rostered for the morning shift. They were made aware that Michael had driven a car onto the railway tracks that morning, and that he had said he was hearing his own voice telling him to do '*fun things'*.

106. By 7.35am Dr Chandra had still not arrived, and Michael was becoming restless and agitated. He was given some Panadol and Nurofen after he complained of a toothache. Michael repeatedly told nursing staff that he wanted to go home and get his marijuana. Seeking to calm him, Registered Nurse Franke and a colleague spent some time encouraging him to settle down and wait for the doctor.

107. As time passed, Michael's agitation increased and the nursing staff became concerned. He was described as pacing, swearing and getting close up to Registered Nurse Franke's face. The hospital had no onsite security, and Registered Nurse Franke considered there was '*a threatening tone in his manner of speaking'*. She rang Dr Chandra at 7.45am, telling him '*I think you should come soon'*. He replied that he would be there in 10 to 15 minutes, and told her she could administer the antipsychotic drug olanzapine if necessary.

108. RN Franke did not administer olanzapine to Michael, being of the view that '*he needed something stronger than olanzapine'* to calm him down more quickly. Besides, Michael had already told her that he didn't want to have medication.

109. After again asking when the doctor would arrive, Michael returned to his room and closed the door. Registered Nurse Franke then heard water running and loud thumping noises. At this point Registered Nurse Franke called police and asked them to attend. In her view Michael's behaviour had changed and she was concerned that there was no security.

110. Soon afterwards, Nursing Unit Manager Registered Nurse Anderson came into the triage area. She had been informed there was a patient who was behaving in a threatening manner. According to Registered Nurse Franke, Registered Nurse Anderson approached Michael and said to him words to the effect: '*What's the matter mate? Do you want to leave?*' Michael replied '*Yes'.*

111. At this, Registered Nurse Anderson led Michael to the door and he walked out of the hospital.

112. At the inquest Registered Nurse Franke told the court she had been surprised by Registered Nurse Anderson's handling of the situation. She thought Michael may have interpreted Registered Nurse Anderson's words as indicating he was free to go, when in her opinion he needed assessment.

113. For her part, Registered Nurse Anderson recalled that she had asked Michael *'What do you want?'* (in contrast with Registered Nurse Franke's recollection that she had said '*Do you want to leave?*'), and he had indicated that he wanted the door and to go outside. Registered Nurse Anderson said that she had then walked Michael to the door and he left. She had not tried to persuade him to remain, as she had felt intimidated and fearful for her safety.

114. When Michael departed, Registered Nurse Anderson asked Registered Nurse Franke to call the police and inform them that Michael was now outside the ED.

115. In fact, at that point three police officers had just arrived in response to Registered Nurse Franke's earlier call. They were Senior Constable Kate Gough, Constable Cameron Taylor, and Probationary Constable Lisa Smith. Registered Nurse Anderson spoke to them briefly, advising them that Michael had just left without seeing a doctor.

116. Dr Chandra also arrived within a very short space of time. He was told that the mental health patient had caused a scene and had gone. According to Dr

Chandra, he asked one of the nurses if he needed to do anything, to which she replied that he did not, as the police were aware that Michael had left voluntarily.

117. Dr Chandra did not take any further action. He had felt '*reassured'* that the police knew Michael had departed without a mental health assessment. He felt confident this meant they would bring Michael back to hospital, either on a voluntary basis or under schedule.

118. But this did not happen. The three attending police officers did speak to Michael, when they saw him leave the hospital. They decided they should check if he was alright. Michael appeared calm as he told them he had got tired of waiting and was walking home. None of the officers thought that his behaviour met the criteria for involuntary detention under the MHA 2007, and they took no further action.

119. I accept that there was no basis for the three police officers to take any further action that morning. Since Michael was not an involuntary patient, they could not compel him to return to hospital. Nor did they perceive it to be their role to persuade him to return. They told the court that they had simply thought they should *'make sure that he was okay'.* Since Michael did not appear to be particularly unwell, they let him go on his way.

120. It is not disputed that once Michael left, the hospital took no follow up action other than to make a call to his mobile phone number later that day, which went unanswered.

Was the care which Michael received at Gunnedah Hospital appropriate?

121. Consultant psychiatrists Dr Andrew Ellis and Dr Tanya Ahmed were asked their opinion as to whether the care which Michael received at Gunnedah Hospital that morning had been reasonable and appropriate. Dr Andrew Ellis is a consultant forensic psychiatrist. Dr Tanya Ahmed is a psychiatrist with a strong background in public mental health services.

122. In their reports and their oral evidence, both psychiatrists were of the view that within the limitations of a small rural hospital, it was. In his report Dr Ellis commented:

> *'In a small emergency department, with no on-site medical staff and no on-site security staff, it is difficult to manage patients who display aggressive behaviour'*.

123. In Dr Ellis' opinion, Registered Nurse Franke had responded appropriately to Michael's growing agitation by calling Dr Chandra and the police. Registered

Nurse Franke had in addition made efforts to encourage Michael to wait for the doctor, but he did not want to.

124. Neither psychiatrist was of the view that using the MHA 2007 to involuntarily detain Michael would have been productive. Nor would it have been prudent to challenge his decision to leave.

125. I accept their evidence that in circumstances where Michael clearly did not want to wait for the doctor, there was no proper basis for the hospital staff to detain him. And furthermore, that it was a reasonable decision on their part not to challenge his desire to leave.

126. I also accept the submission of Counsel Assisting, that there cannot be criticism of the hospital staff for the fact that Michael did not see a doctor within the period assigned to his triage category. This was due to circumstances outside their control, namely the limited resources available at the hospital that morning.

127. However, the question remains whether it was appropriate to allow Michael to leave without any follow up plan, other than the unanswered phone call mentioned above.

128. In Dr Ellis' opinion, it was not. What was needed was *' … a discussion with medical staff and the local mental health service about follow-up'.*

129. This was because:

> *'[Michael] had presented with a symptom of psychosis (hearing voices) and extremely unusual and risky behaviour (driving a car onto railway tracks). He did not stay for assessment and he was not under any form of treatment. Ongoing cannabis use would only make symptoms of psychosis worse.'*

130. Dr Ellis gave this further evidence:

> *' … leaving the hospital with no plan of follow-up, other than to notify police that [Michael] had left would not be considered a satisfactory standard of care for someone with a psychotic condition'.*

131. At the inquest Dr Chandra was asked why he had not taken any follow up action. Why had he not, for example, considered contacting the local community mental health team, reviewing Michael's triage notes, or contacting members of Michael's family?

132. Dr Chandra replied that he had an expectation that the nursing staff would make any calls to the community mental health centre. This, he said, was '*standard protocol'* in all other places where he had worked.

133. But there is no evidence of any such protocol in place at Gunnedah Hospital. As noted by Counsel Assisting in her reply submissions, Dr Chandra's misunderstanding about the existence of such a protocol provides support for the proposed recommendation that the Hunter New England Local Health District [HNELHD] consider the introduction of such a protocol. This proposal will be examined later in these findings.

134. As for reviewing Michael's triage notes, Dr Chandra said that he could potentially have *'done many things',* but he had worked throughout the night, had had little sleep, and still '*had the whole day to look after'.* He repeated that he had felt sure that the police would have brought Michael back to the hospital.

135. In similar vein Registered Nurse Franke responded that in their hospital ED '*you don't have time to be doing follow ups for people that have left without waiting to be seen'.* She added that as Michael had not been assessed, she had not been in a position to know if he needed referral to community health services.

136. Was it reasonable for Dr Chandra to assume that the police would bring Michael back that morning? After all, no hospital staff member had asked them to do this. Registered Nurse Anderson told the court she had not done so, because like Dr Chandra, she had assumed that the police would do this anyway.

137. It was not clear why Dr Chandra and Registered Nurse Anderson made this assumption. Since Michael was not an involuntary patient, the police officers could not compel him to return to hospital.

138. When asked to comment on Dr Chandra's assumption that the police would bring Michael back, Dr Ellis said that '*relying on police to make clinical decisions about returning a patient to hospital'* was not appropriate. In his view, although Dr Chandra's workload was excessive, he continued to have a general professional responsibility to try to ensure there was appropriate follow up of Michael after he had left.

139. It was Dr Ellis' further opinion, with which Dr Ahmed concurred, that as part of a follow up plan it would have been beneficial for hospital staff to have contacted members of Michael's family. Dr Ahmed said that although this contact would have been without Michael's express consent, if his family *'were made aware of the situation that they could have played a role'* in getting him assessed.

140. Michael's family members were in fact profoundly worried about him. It cannot be known if contact with them would have actually ensured a mental health assessment for Michael that day. But as noted by Dr Ahmed, obtaining family information would likely at least have given hospital staff '*a clear picture of an emergent psychotic illness'.*

141. I accept the submission of Counsel Assisting, that a more extensive follow up plan should have been in place given Michael's disturbing symptoms. It was not enough for Dr Chandra to have assumed that the police would bring Michael back to hospital for assessment, or to have assumed that nursing staff would make contact with his family and/or a community mental health centre.

142. In their evidence both Dr Ellis and Dr Ahmed highlighted the importance of having a plan which contained such elements. Dr Ellis thought this would provide hospital staff with better guidance, in situations where a patient presented with psychiatric symptoms but left before being mentally assessed. Dr Ahmed concurred, stating in her report that:

> ' … *if such a process had been in place at Gunnedah Hospital, there would have been an expectation of staff to have a follow up plan. This may involve discussion with a mental health specialist or emergency doctor for risk stratification of the incident, and based on this assessment various outcomes may have occurred, including contacting the next of kin, contacting the GP, … or referral to the local mental health team for attempted follow up/assessment'.*

143. It is clear that Gunnedah Hospital did not have a clear process in place for follow up of patients who leave without receiving a medical assessment. For this reason it would not be appropriate to criticise Dr Chandra or other hospital staff for the absence of follow up action after Michael left.

144. But in my view the facts in Michael's case, and the expert evidence of Dr Ellis and Dr Ahmed, provide strong support for a recommendation proposed by Counsel Assisting, that such a process be developed. This is addressed later in these findings.

145. Before leaving this issue, I note that Gunnedah Hospital staff are able to access a video-based mental health service, called the Northern Mental Health Emergency Care Rural Access Program [NMHEC-RAP]. This service assists rural and remote health clinicians to care for patients who present at the Emergency Department with symptoms of mental illness. The program is staffed by mental health professionals who can provide an assessment remotely, together with clinical recommendations.

146. The court heard evidence that since Michael's tragic death, the HNELHD has worked to encourage emergency departments to increases their use of this service.

**The afternoon of 19 May 2021**

147. Later that afternoon Michael had another encounter with police officers, his third for that day. At about 5.00pm he was seen riding a bicycle in south Gunnedah. Michael was not wearing a helmet, and his arms were raised to each side as he rode.

148. Sergeant Roden and Senior Constable Ashley Gough were driving in the area. It will be remembered that Sergeant Roden was one of the two police officers who had spoken with Michael that morning, after Michael had left his father's car on the railway tracks.

149. The two officers stopped their police car and told Michael they were pulling him over for not wearing a bike helmet. The ensuing conversation was recorded on police issue Body Worn Video camera [BWV]. The recording was played in court.

150. Michael told the officers he'd had '*a cone'* before he went for a ride, which was why he was '*riding around real happy and that'*. His interchange with the officers was brief, but was notable for the following:

- Michael told Sergeant Roden that the hospital had '*let [him] go'* that morning;
- when asked his address, Michael gave it and added '*It's right next door to hell … Oh Bell her name is, sorry'*;
- when Sergeant Roden advised Michael that it was riding negligently to not have both hands on the handlebars, Michael responded '*What if I have eight arms?*', then gestured with arms out the side saying '*like this, one, two, three, four'*.

151. Michael then got back on his bicycle and rode off.

152. At the inquest Sergeant Roden agreed that Michael's behaviour was *'odd'* and unusual. However even when combined with his knowledge of Michael's earlier behaviour (namely that he had driven his father's car onto the railway tracks), he did not think the situation warranted taking steps to have Michael mentally assessed. Michael's conduct was not '*serious behaviour',* and none of it had caused him to think that he was mentally ill.

153. Sergeant Roden added that since the police had not been asked to bring Michael back to hospital that morning, he had assumed that hospital staff had assessed him and had not been concerned about his mental health.

154. Senior Constable Gough too thought that Michael's comments and behaviour were unusual, but were not necessarily those of a person who was mentally ill. At that time he was not aware of the events of the morning.

155. Dr Ellis expressed the view that during this encounter it was likely Michael was continuing to experience delusions and hallucinations. Dr Ellis did not expect the police officers to have appreciated this. But he thought that given the morning's bizarre events, and the fact that Michael had left the hospital without being assessed, the two officers could have reasonably concluded that he required involuntary treatment.

156. However as I have noted, there is no evidence that Sergeant Roden was aware Michael had not seen a doctor at hospital that morning; nor that Senior Constable Gough was aware of the railway track incident.

157. This being so, I accept the submission of Counsel Assisting that it was not unreasonable for the two police officers to have concluded that Michael was not suffering a mental illness or disturbance that evening.

**Michael's family express concerns on 20 May 2021**

158. Michael's tragic death occurred the following night, which was 20 May 2021. During that day his behaviour steadily deteriorated, and the fears and concerns of his family mounted. They had numerous communications with police, seeking help for his mental health. Thus:

- at about 10.00am Michael's sister Rebecca and her partner Marlee went to Gunnedah Police Station to ask for help
- in response, three police officers attended the home of Michael's father Stephen and spoke (briefly) with Michael's grandmother and aunt, and then with Michael, Stephen, and Michael's cousin Jtaya
- soon afterwards Michael's grandmother and aunt also attended Gunnedah Police Station to voice their concerns
- about an hour later Jtaya Davis rang Gunnedah Police Station to say that Michael's behaviour was scaring her.

159. I now describe these events in more detail.

Rebecca and Marlee at Gunnedah Police Station

160. Just after 10.00am Michael's sister Rebecca and her partner Marlee went to Gunnedah Police Station to seek help for Michael.

161. Rebecca had been deeply unnerved that morning to find Michael standing on the verandah with his arms stretched out. He '*started to laugh uncontrollably',* and told her he was *'getting power from the sun and using the energy to burn holes through people'.*

162. At the police station Rebecca recounted Michael's behaviour to Senior Constable Sally Wenborn, telling her they were all worried for his safety and the safety of the people around him.

163. According to Senior Constable Wenborn, Rebecca and Marlee also told her that Michael had made threats of self-harm and had said that he was '*going to take the family out with him'*. He had been talking about getting superpowers from the sun; he was using cannabis daily and ice occasionally; and he had left hospital the day before without seeing a doctor.

164. Senior Constable Wenborn called Sergeant Roden and Senior Constable Gough to the police station, and asked them to go to Michael's house to assess the situation. She, or another police officer, also contacted NSW Ambulance to request that a paramedic team attend and perform a mental health assessment.

165. Sergeant Roden, Senior Constable Gough and another officer, Senior Constable Trowbridge, then drove to Michael's home to speak with him. Their interaction with Michael and his family is described at paragraphs [172]-[183] below.

Kylie Craig and Frances Stevens at Gunnedah Police Station

166. After Sergeant Roden had made his visit to Michael's home and returned to the police station, Michael's aunt Kylie Craig and his grandmother Frances Stevens attended Gunnedah Police Station. There they spoke with Sergeant Roden.

167. Ms Craig wanted to know what action was being taken with Michael after the police visit that morning. Sergeant Roden told her that Michael had been aware of his name and what day it was, and that Michael's father Stephen Peachey had said he would take Michael to hospital himself.

168. Ms Craig was not reassured to hear that Stephen had said he would take his son to hospital, telling Sergeant Roden that Stephen was afraid of Michael. She left the police station with the words:

*'I hope I don't have to come here when there is a crime scene. He will either hurt himself or someone else'.*

169. Outside the police station Ms Craig met Rebecca and Marlee, and they discussed the possibility of driving Michael to the Banksia Mental Health Unit in Tamworth. They felt sure however that Michael would not agree to this. Worried about their safety and that of the children in their care, Ms Stevens and Ms Craig decided not to stay in their home, but to spend the night at a motel with the children.

170. Rebecca in the meantime went back into the police station to ask why nothing was being done about her brother. In her statement she said:

'*I didn't know why they couldn't detain him and take him to be assessed. It was obvious to me that Michael needed help and they didn't do anything at all'.*

171. But she was told that there was nothing police could do, since Michael was not a threat to himself or anyone else.

The police officers' visit to 15 Herbert Street

172. As noted at paragraph [165] above, Sergeant Roden and two fellow officers were dispatched to speak with Michael after Rebecca Peachey's earlier visit to the police station. Michael was not at his home, but the officers found him at 15 Herbert St, which was the home of his grandmother Ms Frances Stevens. On arrival, Sergeant Roden activated his Body Worn Video [BWV] camera.

173. Outside the house Ms Stevens and Ms Craig were in a car, preparing to leave. The two women had not yet made their visit to Gunnedah Police Station, which is described above. Ms Stevens told the visiting police officers that Michael was '*everywhere'*, and she asked them to *'commit him please'.* Senior Constable Gough asked for permission to enter their house, to which Ms Stevens replied '*Yes, go. Go hard'*.

174. At the inquest Sergeant Roden agreed that what Ms Stevens told them was a strong indication that Michael may have needed to be committed for mental health reasons. Senior Constable Gough however said that he did not know what Ms Stevens had meant by the words *'commit him please'*. He accepted that information from family members is potentially important, but said that at the time he had not known who Ms Stevens was.

175. Michael then came out of his grandmother's house, telling the police officers that he thought he'd say hello to them. Senior Constable Gough decided he would

leave to Sergeant Roden the task of assessing whether Michael met the criteria for transportation under the MHA 2007. This was because in 2010 Sergeant Roden had completed the four day intensive program on Mental Health Intervention which was then offered to NSW police officers.

176. Sergeant Roden told Michael that people were worried about *'where your head's at'*, to which Michael replied that his head was '*where it needs to be, perfect'.* He denied having made any threats to hurt himself or anyone else, and correctly named the day of the week when he was asked this. He said he didn't mind if an ambulance came to chat to him.

177. Michael seemed tense from the way he was standing, Sergeant Roden thought. But when he commented on this, Michael told him he was '*standing tall and proud'*. Michael can in fact be seen on the BWV footage, standing with his body slightly bent forwards and holding his arms out in front, making the symbol described as '*the Illuminati symbol'.*

178. Sergeant Roden suggested to Michael that he wait outside with them until the ambulance arrived, and asked him if he wanted to have a smoke. In response Michael picked up a homemade bong.

179. Sergeant Roden then had a brief conversation with Michael's cousin Jtaya Davis, who was standing at the back door of the house. Sergeant Roden told her that Michael appeared *'fine'.* But Jtaya strongly disagreed, saying '*He's fucking not man, he thinks he's an entity, the creator of all beings'.* Sergeant Roden did not explore this any further with Jtaya. He told her that an ambulance would be coming to assess Michael, and that '*he's aware of time, date location. He's not, he's not having a psychotic break in front of us, alright'*.

180. In the meantime, Senior Constable Gough had rung Gunnedah Hospital and ascertained from Registered Nurse Franke that Michael had not been scheduled by anyone the previous day. This, he said, gave him confidence that Michael had not been considered mentally unwell. He agreed however that he did not know whether Michael had actually been seen by a doctor while at the hospital (Registered Nurse Franke said that she did advise Senior Constable Gough of this fact).

181. Further conversation with Michael reinforced Sergeant Roden's impression that he was not mentally unwell. Michael agreed with Sergeant Roden that it was '*not normal'* to have parked his father's car on the railway tracks the previous day, saying *'I didn't know what I was doing'*. He also agreed that he was not really a deity, saying '*I'm no god, I'm just a man. Look at me, do I look like a god …'*

182. All in all, Sergeant Roden considered that Michael was calm and grounded. He concluded that his unusual behaviour could be attributed to his drug use, rather than to mental unwellness. In his statement Sergeant Roden commented that:

> *'… the longer I spent with Michael the less I thought he actually needed a mental health assessment'.*

183. But although Sergeant Roden felt confident that Michael did not meet the criteria for police detention under the MHA 2007, he thought he would benefit from an assessment by ambulance paramedics.

The police officers' conversation with Stephen Peachey

184. While the police officers were talking with Michael, his father Stephen returned to his home next door at 17 Herbert St.

185. Stephen had been worried the previous day when he realised that Michael had not seen a doctor at the hospital. He told the court that when Michael got back *'… he was happy, but he wasn't there, it wasn't him'.* Stephen was particularly concerned that in this unstable mood Michael might drive to Inverell and *'try to keep his boy'*, meaning his little son.

186. Sergeant Roden asked to have a conversation with Stephen, a little distance away from Michael. He told Stephen that he didn't think they could take Michael to hospital, as he didn't appear to be mentally unwell. He mentioned that Jtaya Davis had told them that Michael '*keeps saying he's filled with the power of god and he's the monkey god or something, but he hasn't, we've asked'.*

187. In response, Stephen told Sergeant Roden to '*leave it with me and I'll see if I can take, get him to go to the hospital'.* Stephen went on to say that he would drive Michael to Inverell to see his son, and then try to get him into a drug rehabilitation centre at Brewarrina '*and he can stay out there for a couple of months'.*

188. Sergeant Roden therefore returned to Michael, telling him that if his father had any concerns ' … *he's going to ask you to go up to the hospital with him'*. Michael appeared to be amenable to this. Notably however, a few seconds later he said: '*No, no one's taking me anywhere man, I'm telling you right now, no one will take me anywhere'.*

189. Stephen Peachey reacted to Michael's words with mild alarm, telling his son to '*calm down'* and assuring the police: '*OK boys, he's with me now'*. The police officers left soon afterwards.

190. At the inquest Sergeant Roden said that he had felt reassured when Stephen told him he would try to get Michael to hospital. He disagreed with the suggestion that Stephen may not have been able to identify any deterioration in Michael's mental state, saying:

> *'Stephen would know what Michael is generally like, and should be able to judge if there's issues with Michael'.*

191. Stephen too was asked about this conversation. He told the court that he knew his son was not right and he very much wanted to get help for him. However he was clear that he did not want the police to take Michael to hospital, as ' … *if they took him it would have turned into a nightmare'.*

192. Stephen's approach that morning is instructive, when considered in the light of subsequent events. It indicates a strong desire on his part to minimise Michael's exposure to police. This was evident in his assurance to Sergeant Roden that he himself would try to get mental help for Michael, rather than rely on police for this task. It is entirely feasible, and understandable, that Stephen feared that Michael's unstable behaviour would spark a confrontation with police. As will be seen, this concern was even more evident that evening.

193. Most unfortunately, despite the police call to NSW Ambulance for a paramedic assessment that morning, this assessment did not take place. Senior Constable Gough and his colleagues were advised that the ambulance had responded to another job, and there would not be another crew available until after midday. According to NSW Ambulance records, at 11.47am a message was received from police to disregard the call for an ambulance, and that the police were no longer on the scene. It is unclear which police officer made this call, and whether it was prompted by Stephen's advice that he himself would take Michael to hospital.

194. Thus there was no attendance by an ambulance crew that morning or afternoon, and Michael did not receive a paramedic assessment of his mental health.

Jtaya Davis' call to Gunnedah Police Station

195. Michael's cousin Jtaya Davis also reached out to Gunnedah Police Station on 20 May 2021.

196. At the inquest Jtaya was asked if Michael's behaviour had been worrying her, to which she replied:

> *'Of course it was. Especially with the mental health issues in my family, and the drug induced psychosis, and the suicides and shit. Like, his mother killed*

*herself, my uncle, like two of my uncles, … it's just terrible. So yeah, of course I was worried about him'.*

197. She told the inquest:

> *' .. we just needed help, we just needed help. We couldn't do it ourselves, we needed, like, the police to make him go ...'*

198. Soon after the police left Ms Stevens' home that morning, Jtaya rang Gunnedah Police Station to report that Michael was scaring her. She knew that Michael needed help, and she felt sure that the morning's visit from the police officers had not changed anything.

199. Jtaya was advised by a female police officer that she could perhaps get Michael charged with an offence as a way of getting him into mental health treatment. But Jtaya did not want to get her cousin into trouble. The police officer then suggested that Jtaya make a recording of what Michael was saying, which she could then play to ambulance officers.

200. This suggestion made sense to Jtaya. She had noticed over the previous days that Michael's behaviour could suddenly swing from highly irrational to almost normal again. She believed this behaviour masked the extent of his mental unwellness. She described by way of example an encounter two days previously:

> *'I drove down to Rebecca's and when I got there [Michael] was on his bed bawling, sobbing. I started hugging Michael. He didn't tell me what was wrong. I sat next to him on the bed. Michael sat up and said 'I'm free!' Looking at his skin, saying 'I'm free'. He was looking at himself like he was someone or something else. He was staring into my eyes. He went from crying to screaming very quickly, like he just snapped out of being crazy to normal again'.*

201. And when the police officers came to 15 Herbert St on the morning of 20 May 2021 Jtaya observed that Michael was:

> *' …acting normal to them … Like, he wasn't saying to them that he was going to eat them with no mouth and no teeth. Like, he was still doing weird shit, but it wasn't major, it wasn't dramatic'.*

202. After the police left, Jtaya decided to make a phone recording which she could play to police or ambulance officers ' ... *so he can't act normal, you know. So he can't lie to them'.* They could then ' ... *take him away and get him help'*.

Jtaya Davis' audio recording

203. That afternoon Jtaya stayed with Michael until about 4.00pm, when she had to leave for work. Sometime after 1.00pm she used her mobile phone to make an audio recording of herself and Michael talking. Jtaya's recording was approximately 25 minutes long and was played in court.

204. Almost nothing said by Michael in the recording makes sense. In disconnected fashion he refers to himself as *'the perfect being',* and to *'demons'* which '*were already in me'* and were '*eating me when I was a baby'*, but '*you eat them and they can't come back'*. At one point he says to Jtaya:

> *'Imagine, if I didn't get that demon the other night in the room … imagine if I didn't get him, I wouldn't be here now'.*

205. Jtaya's sense of helplessness about her cousin's condition can plainly be heard in the recording:

> '*Don't say that man it breaks my heart, it breaks all of our hearts. I just want my fucking cousin back, she just wants her brother back, your boy, he just wants his dad'*.

206. Jtaya makes repeated and poignant appeals to Michael to '*give me back my cousin'*. She asks him to go out into the sun and '*build me a garden'*. At the inquest she explained that she was trying to divert him from his bizarre and fearful delusions:

> *'I was trying to … to do something else, like, instead of just sitting there wigging me out, because he used to be a builder … I was trying to get him to go outside and build me a garden bed or something'*.

207. But Michael was unable to respond to her suggestions. Nor was he able to engage when she offered to go with him to the Banksia Mental Health Unit or to Orana, an addiction treatment centre.

208. Later that night when Jtaya was driving home from work, she saw an ambulance in the street where Stephen lived. Her aunt told her that Michael had died, but Jtaya said she '*knew that he was gone, she didn't have to tell me'.* She took her audio recording into the Gunnedah Police Station on 24 May 2021.

209. I do not have the benefit of expert psychiatric comment upon what Jtaya's recording indicates about Michael's mental state. However, in his report Dr Ellis observed that:

*'By the evening of 20 May 2021 it is clear that Mr Peachey is in a state of acute psychosis with active delusions and hallucinations driving unusual, agitated, fearful and aggressive behaviour'.*

210. In my view, these features are evident in Jtaya's recording. Its content therefore provides valuable evidence as to Michael's state of mind in the hours before he died. Jtaya told the court that Michael 'd*idn't go back to being normal at all'* that afternoon. It is reasonable to assume that his mental state steadily worsened, culminating in the traumatic events of the evening.

211. At the inquest it was distressing to hear from Jtaya that she believed she was responsible for Michael's death. Jtaya told the court:

> ' … *I get sad and mad at the system .. but most importantly at myself for not trying harder. For not helping him when he was begging for it for days. It's like a knife inside my brain, I can't escape those thoughts.'*

212. Counsel for Michael's family asked Jtaya if this was because she was *'the only one left that day'.* She replied:

> *'Yeah, because I'm the only one, yeah. And I didn't do a good enough job, like, I didn't try hard enough. Like, there was so much more I could have done and that I should have done but I didn't … and that's just something I have to live with for the rest of my life … I felt so bad for him'.*

213. Jtaya was only nineteen years old when her cousin died, and it is clear that she cared very deeply for him. It was immensely sad to hear that she blamed herself for his tragic death.

214. I sincerely hope that Jtaya now understands, as would everyone involved in this inquest, that she is in no way to blame for what happened. I believe that she did everything that a loving cousin could have done for Michael.

<u>Did the police respond appropriately to the concerns of Michael's family on 20 May 2021?</u>

215. I now consider whether it was appropriate for the police officers to have concluded on the morning of 20 May 2021 that they did not have a basis to use their powers under section 22 of the MHA 2007.

216. A related question is whether in reaching this conclusion, the police officers adequately responded to family concerns about Michael's mental health and behaviour.

217. At the inquest Sergeant Roden adhered firmly to the position that Michael had not met the criteria of section 22. Although he acknowledged that some of Michael's behaviour was odd, he had found him to be '*clear, coherent'*, with rational thought patterns and speech.

218. Sergeant Roden also said that since he himself had not observed the more bizarre conduct reported by the family, he was not willing '*to detain someone against their will based on something that's not seen in front of me'.* Nor did he agree with the suggestion that he had placed too much reliance on his own assessment of Michael's presentation, and not enough on what the family had told police. He had '*already spoken to Michael and made my assessment, so I wasn't going to detain someone based on the word of someone else'.* He had '*dealt with what was in front of me'.*

219. But according to the submissions of Counsel Assisting, it would be open for the court to find that there was a sufficient basis for the police officers to have exercised their section 22 powers that morning. This submission was based on the evidence of Michael's unusual behaviour, on the serious concerns which his family had communicated to police, and on Sergeant Roden's own awareness of Michael's bizarre behaviour the previous day.

220. Counsel Assisting also relied on the opinion of Dr Ellis. This was that given all the above, it would have been *'reasonable'* for the officers to have concluded that he was suffering a mental disturbance or mental illness.

221. However it is important to note that Dr Ellis' opinion was tempered by his acknowledgements that:

- it would have been difficult for the officers to assess Michael's risk of serious harm that morning
- it would have been reasonable for them to use a less restrictive intervention than activating section 22 of the MHA 2007, if the same effect could be achieved.

222. Regarding Dr Ellis' first point, in her expert report Dr Ahmed pointed out the difficulty of assessing a person's mental health in circumstances where their behaviour tended to fluctuate. She wrote that:

> *'… lack of longitudinal mental state information is a frequent issue in emergency assessments of mental health patients. On a cross sectional assessment, a person can appear well, symptoms may fluctuate, and diagnostic formulations can shift significantly with collateral information and awareness of patterns over time …'*

223. In my opinion, Jtaya's observations of Michael's behaviour provide an example of this. Jtaya noticed that when Michael was interacting with the police that morning he appeared to be moderating his behaviour, and was not '*saying crazy things to them'*.

224. The above submission of Counsel Assisting was rejected by Ms Burke on behalf of the NSW Commissioner of Police. Ms Burke urged the court to consider:

- that police officers are not trained mental health professionals
- that in the BWV footage, Michael's demeanour throughout the interaction was relatively calm
- that Michael had expressed willingness when Sergeant Roden asked him if he minded '*if we get the ambos to come and have a chat'*
- that Sergeant Roden had discussed Michael's condition with his father, who had asked them to leave Michael with him and he would try to get him to hospital.

225. In my view the attending police officers were entitled to take account of all the above features, when deciding whether to use their powers under section 22.

226. Considerable weight ought to be given to the reality that although police officers do receive a limited amount of training in how to respond to mental health-related incidents, when it comes to assessing a person it is neither realistic nor fair to expect that they will apply the expertise of a mental health clinician. Thus while it was evident to Dr Ellis that Michael was suffering a mental disturbance or mental illness, it cannot be assumed that the features which Dr Ellis was able to identify on the basis of his qualifications and experience were identifiable to a general duties police officer, regardless of his or her experience in responding to mental health-related incidents.

227. Indeed this inevitable disparity in expertise is one of the reasons why, as I have noted at paragraphs [8]-[9] above, there is current debate about whether a health-led rather than a police-led response to such incidents would better serve the community. Potentially, such a response that morning would have identified that Michael was in fact becoming mentally very unwell, if he was not already so.

228. In assessing the police response that morning, I also take into account the evidence given by Chief Inspector Hanlon, summarised below at paragraphs [238]-[239], that police officers need to place *'significant weight'* on their own impression of a person's presentation when called to such situations.

229. Having regard to all the above, I have concluded that it was not unreasonable for the police officers to have decided that Michael's behaviour did not meet the threshold required under section 22 of the MHA 2007.

230. It is also important to have regard to Dr Ellis' second point, concerning the principle of *'least restrictive intervention'.* The NSW Police Handbook instructs police officers to consider alternative means of intervention when they hold concerns about a person's mental health, but are not of the view that the criteria for a section 22 intervention are met. Alternative interventions include *'engaging with members of the person's family … to take responsibility for the welfare of the person'*. At the inquest Dr Ellis agreed that Stephen Peachey's proposal to take responsibility for getting Michael assessed was an example of a *'less restrictive intervention'.*

231. It is also fair to note that Stephen expressly told Sergeant Roden that he (Stephen) wanted to take on the task of getting his son to hospital, rather than leaving this to the police.

232. Given the above, it would not be appropriate to criticise the police officers' unwillingness to use their coercive powers, when an alternative appeared to be available to them – namely, Stephen's intention to take his son to hospital himself.

233. Having said this, I accept the submission of Counsel Assisting that the morning's events were a missed opportunity for a health-led intervention that was desperately needed. In this regard, I note that Senior Constable Wenborn correctly identified the need that morning for a paramedic team to assess Michael. As I have noted, it remains unclear why the ambulance was cancelled that morning, although it may have been due to the police officers' decision to accept Stephen's proposal that he take Michael to hospital for assessment.

234. Related to this issue, is whether the attending police officers ought to have paid more attention to the information given by Michael's family. This is now considered.

Was sufficient weight given to family information about Michael?

235. I have noted above that Sergeant Roden did not agree with the suggestion that he had placed too much reliance on his own assessment of Michael's presentation, and not enough on what he knew the family had told police. He had '*dealt with what was in front of me'.*

236. Ought he to have given more weight to these concerns, when deciding if it would be appropriate to exercise his section 22 powers?

237. In his oral evidence Sergeant Roden agreed that the family's multiple reports about Michael were important because this was information over time, from people who knew Michael well, and who had observed recent changes in his behaviour. He conceded, with the benefit of hindsight, that he ought to have asked Jtaya more questions, given that her information about Michael strongly suggested that he was mentally ill.

238. At the inquest Chief Inspector Hanlon provided nuanced evidence about the weight which police officers should give to information from a person's family. In his opinion, obtaining family information was *'a more rounded, broader approach'* to accumulating evidence, and was '*a more optimal way of forming a decision around section 22'*. Nevertheless, he said, police needed to consider a number of elements, and their own impression of the person's presentation would be given significant weight.

239. All the same, Chief Inspector Hanlon thought it would be beneficial for police officers to be reminded that they needed to supplement their own impression of the person with information from family members who knew their relative well. He said that training of this kind was to be included in the new Co-Delivered Model of police training in mental health-related situations, which is described later in these findings. In the opinion of Chief Inspector Hanlon, such information could also be included in the NSW Police Force Handbook which was accessible to all police.

240. As noted above, Dr Ahmed too emphasised the importance of obtaining *'collateral information'* from people close to the person, in particular where the person's behaviour fluctuated.

241. Reflecting on the evidence, I have concluded that there was a basis for Sergeant Roden to have paid more attention to Jtaya Davis' concerns about her cousin. Further questioning would have established that she had a close relationship with Michael and held well-grounded fears for his mental stability. To his credit, Sergeant Roden acknowledged this in his evidence at the inquest.

242. There can be no criticism of Senior Constable Wenborn's response when Rebecca and Marley attended the police station earlier that day. It is clear that Senior Constable Wenborn took their expressed concerns seriously, and responded by requesting that a police team speak with Michael, and that an ambulance team provide a mental health assessment.

243. In closing submissions, Counsel Assisting stated that the evidence supported a recommendation that the NSW Commissioner of Police consider upgrading police training in the area of mental health-related incidents. This submission is addressed later in these findings.

## PART B: THE NIGHT OF 20 MAY 2021

244. I now move to the events which commenced at approximately 8.00pm that night, and culminated in Michael's tragic death two hours later. Within this two hour period, events unfolded rapidly and in an environment of intense pressure.

245. The events began with Michael's very disturbed behaviour in his home that evening, which prompted his sister Rebecca to again seek police help. There was then an altercation with two police officers outside Stephen Peachey's home, following which Michael ran down the road and into a house at 29 Herbert Street. A prolonged struggle with police then followed, during which a team of two NSW Ambulance officers arrived. It was there that Michael's fatal collapse took place, at some point before 9.13pm.

246. At the inquest these events were closely examined, as the background to the following broadly defined issues:

- whether the NSW police officers acted appropriately in restraining Michael, both outside his father's house, and inside the house at 29 Herbert St

- whether the NSW Ambulance paramedics acted appropriately in medicating Michael and in monitoring his clinical condition.

### Two important preliminary points

247. In these findings I have taken care to base my conclusions regarding the above issues on the totality of the evidence. Many eyewitnesses gave evidence about what they saw and heard on the night of 20 May 2021. They included Michael's family members, police officers, ambulance officers, and the occupants of the house where Michael died. Also included is video footage captured on a BWV camera worn by Probationary Constable Smith.

248. In examining this wealth of evidence I have kept in mind two important points.

249. First, although footage from the camera worn by Probationary Constable Smith is available it is not always of assistance. There were occasions when Probationary Constable Smith's camera was knocked to the ground and

captured nothing of significance. Furthermore, since Probationary Constable Smith was the only officer equipped with a camera, the visual perspective depends on her position, which for significant periods of time was lying across or on Michael's body as he lay on the floor. The consequence is that the BWV footage does not capture the actions of every person in the room, including those of Michael.

250. However, the many eyewitness accounts proved to be a rich source of information. Making factual findings on the basis of their evidence has not been an easy task, as the events which they endeavoured to describe were chaotic and fast-moving. Furthermore, their accounts are in some respects variable and incomplete. But this is not surprising. Events unfolded with great rapidity and unpredictability. There were episodes of violence and extreme emotion, which every person found to be distressing and deeply disturbing.

251. It is well understood that when witnesses are caught up in a traumatic event, especially one as prolonged as this, it is common for their memory to be affected by perceptual distortions. This phenomenon was described by Sergeant Watt in his statement:

> '*Police officers, like any other person, can be affected by a number of different, well documented perceptual and memory distortions when involved in a stressful incident. These distortions include time dilation or compression, auditory blunting or sharpening, memory gaps, looming and difficulty in perceiving details that may later seem incredibly obvious.'*

252. For this reason, I do not take these evidential discrepancies to indicate that any witness has been deliberately untruthful.

253. Secondly, in evaluating the decisions made that night by the police and ambulance officers, I have sought to keep firmly in mind the phenomenon of hindsight bias. Responders to an emergency make decisions in an environment which is volatile and extremely challenging. On this point, the evidence of Sergeant Watt was again instructive:

> *'It is important to point out that the timeframe for decision making during violent confrontations is generally extremely small, and must often be accomplished with limited information …. … An officer may have mere seconds to observe and identify a threat, consider the most appropriate tactical option and execute the appropriate actions …'*

254. This reality must be appreciated by those who are later tasked with judging the appropriateness of responders' actions. In particular, as highlighted by Counsel

Assisting, responders should not be criticised for matters that have only become apparent with the benefit of hindsight.

255. Equally however, hindsight has a unique and significant role to play in an inquest. As recognised in the submissions of the Hunter New England Local Health District and NSW Ambulance, *'hindsight is important as it can assist the Court and interested parties to learn lessons from events and to moderate future risk'.* This work lies at the heart of the coronial jurisdiction.

256. It cannot be forgotten that on the night of 20 May 2021, Michael lost his young life in a room where many people were present. Three police officers and two ambulance paramedics failed to notice that he had stopped breathing until it was too late to save him.

257. So hindsight analysis is indispensable to the Court's duty to understand, for the sake of Michael's family and other families, whether anything could have been done differently that night.

258. I now turn to the events of that evening.

At Michael's home

259. After the three police officers left Stephen's house on 20 May 2021, Michael played video games for a while, then told his father he was going home. Stephen asked Michael's brother Ben to go with him.

260. Back at 2 McDonagh Place that evening, Rebecca continued to feel anxious. She was *'worried about the kids saying something to set Michael off'.* She decided that her son Cooper and her little sister Breeanna would sleep in her bedroom that night.

261. At about 8.00pm, Michael's sister Chantelle saw Michael in the backyard of their home. He had taken off his clothes and was setting fire to them with petrol. The family then saw Michael run inside, collect more of his belongings, and throw them onto his backyard fire. He had put a towel around his waist and he seemed to be talking to the fire. A video recorded by Chantelle shows Michael in the backyard, throwing punches in the air and repeating: *'That's why they don't back down'.*

262. In fear, Rebecca rang her aunt and grandmother. According to Frances Stevens, Rebecca asked her '*very softly'* to ring the police as *'Michael is lighting fires everywhere and burning all his belongings'.*

263. The ‘000’ call was made at 8.09pm. Michael’s aunt Kylie Craig told the operator that Michael was ‘*threatening to kill everybody’*, and that she was scared for the young children in their care.

264. Still wearing only a towel, Michael made his way on foot to his father’s house in Herbert Street. He told Stephen he was alright, but Ben described his brother’s mood as ‘*a bit angry and aggravated’.* They sat down to watch a movie together.

265. At about 8.17pm, two police officers arrived at Stephen’s house, in response to Ms Craig’s call. They were Senior Constable Gough and Probationary Constable Smith. They had first called in at Michael’s home, where Rebecca told them that Michael had left and that he needed help.

266. Minutes later, Rebecca heard shouts coming from the direction of her father’s house.

The police visit Stephen Peachey’s house

267. Senior Constable Gough did not expect that the incident to which he and Probationary Constable Smith had been called would present much risk. He was aware from the police radio message that Michael had been ‘*running around the backyard naked, burning things’.* To him this was obviously odd behaviour, given that it was a cold night. Most probably, Senior Constable Gough thought, they would call an ambulance so Michael could be taken to hospital again for a mental health assessment.

268. For her part, Probationary Constable Smith was aware that Michael had been at Gunnedah Hospital the day before, but she did not know what had led to him being taken there. At Senior Constable Gough’s direction she called an ambulance as they drove to Herbert Street. Other than this, she did not think they had any discussion about what they would do when they arrived at their destination.

269. When the two police officers entered Stephen’s house, Ben Peachey could see that Michael was angry and didn’t want to speak with them. Ben didn’t know why this was the case, since Michael had not previously behaved like this with police. Stephen too thought that Michael was unusually agitated. He was talking loudly about being a Pharaoh, trying to fiddle with Probationary Constable Smith’s camera, and demanding that they use it to video the scene.

270. Senior Constable Gough spoke with Stephen, telling him that an ambulance had been called but since it was coming from Tamworth it would be forty to fifty minutes before it arrived. Acutely aware of Michael’s increasing agitation,

Stephen was anxious to keep his son away from the police officers. He asked them to take their police car around the corner and wait for the ambulance there.

271. This proposal made sense to Senior Constable Gough. He told the court that this would reduce the risk of Michael becoming more upset. To Stephen's relief, Senior Constable Gough and Probationary Constable Smith agreed, and they left the house. They returned to their police car which was parked out the front.

272. At the inquest Chief Inspector Hanlon stated that Senior Constable Gough's decision to remove himself and Probationary Constable Smith was sensible and commendable. It was consistent with NSW Police Force training to use de-escalation techniques in such situations whenever possible Dr Ellis agreed. In his opinion, the situation was by now high risk - Michael was in the grip of acute psychosis, making his behaviour very volatile and difficult to predict.

273. But after the two officers left the house, things went very wrong.

274. Unbeknownst to his father, Michael left the house by the back door and went around to the front, where the police officers had just got into their vehicle. From inside the house Ben and Stephen heard what they described as a bang, and Michael yelling: *'Help me Dad! Ben, help me!'*

275. Running outside, Stephen had ' .. *a bad feeling, that it wasn't going to end good'.*

<u>The attempt to restrain Michael outside Stephen Peachey's house</u>

276. The two police officers had been about to drive their vehicle around the corner, when Michael suddenly appeared out of the dark in front of them. He was naked and was holding a towel and his mobile phone. According to Probationary Constable Smith, he grabbed their bull bar and started shaking the vehicle. (After having viewed the BWV footage, both officers agreed that Michael had placed his hands on the vehicle's bull bar, but had then removed them).

277. Both officers got out, and Probationary Constable Smith activated her BWV camera. Senior Constable Gough told Michael that he was being recorded, and Probationary Constable Smith added: '*That's what you wanted, didn't you?'* Michael asked them to turn on their vehicle's light, apparently because he wanted to film them with his mobile phone.

278. At this point a neighbour, Ms Tracey Wortley, drove her car into an adjoining driveway, and Michael asked her to turn on her high beam headlights. Ms Wortley recalled that Michael '*wasn't yelling or anything'*, but Senior Constable Gough disputed this, saying that Michael was becoming agitated.

279. Senior Constable Gough accessed his handcuffs from his vest, and both officers walked towards Michael. On the BWV audio Senior Constable Gough can be heard telling Michael to get down on the ground. Senior Constable Gough then reached out to take hold of Michael's right arm, while looking at Probationary Constable Smith with a gesture to come in and assist him. Michael meanwhile started to pull away from Senior Constable Gough's grasp.

280. Probationary Constable Smith did not know what her colleague's purpose was in attempting to restrain Michael. She said in her evidence that at this point Michael was not physically threatening herself, Senior Constable Gough, or anyone else. Nevertheless, she was in no doubt that it was her duty to assist him:

> '*The reason I grabbed Michael is because Senior Constable Gough had gone in to restrain Michael at that point and obviously, I'm not going to stand back and not help, and he gave me a nod and looked at me. So, that's the reason I've gone in to help my partner'.*

281. Probationary Constable Smith therefore moved forward and took hold of Michael's other wrist and, as she put in in her evidence at court, they '*had a wrestle'*. Probationary Constable Smith's camera was knocked to the ground during this encounter, so there is no BWV footage about what happened next.

282. However there is no doubt that from this point the situation rapidly deteriorated.

283. As the two police officers wrestled with Michael, he can be heard shouting to his father and brother to help him. Stephen and Ben ran outside. Stephen is heard repeatedly telling Michael to *'calm down',* while attempting to help the officers to hold Michael. He '*just wanted it to stop'*.

284. Without warning, Senior Constable Gough deployed his oleoresin capsicum spray. This, he said, was because he was concerned that Michael would *'continue to violently resist'* them.

285. The deployment of oleoresin capsicum spray did not subdue Michael. He broke free of the police officers' hold and clambered up the side of a ute that was parked nearby. He then jumped off it and ran down the street towards the home of Peter and Louise Gort, at 29 Herbert Street.

286. Probationary Constable Smith retrieved her camera. She saw that Senior Constable Gough was running down the road after Michael, and she followed.

The police response outside Stephen's house: the officers' evidence

287. I pause here to consider whether the police officers' response of attempting to restrain Michael outside his father's house was appropriate.

288. It would be neither fair, nor open on the evidence, to assert that had the police officers responded in a different manner, or not responded at all, the situation would *not* have deteriorated in some manner. Dr Ellis' evidence was clear that by the evening of 20 May 2021, Michael was in a state of acute psychosis. There was no hope of paramedic assistance for up to an hour. The truth is that we cannot know what would have happened.

289. Nevertheless there can be no doubt that the attempt by the two police officers to restrain Michael was a pivotal event. As noted in the submissions of Counsel Assisting:

> *'It precipitated the struggle and lengthy restraint which followed. Had a different approach been taken, there is a real prospect there may have been a different outcome'.*

290. I accept this submission. Without doubt, when Senior Constable Gough and Probationary Constable Smith attempted to restrain Michael outside his father's house the situation deteriorated into violence and chaos. Given this, it is appropriate to examine whether this response was appropriate and if it was not, whether it reveals any deficiency in police training in this area.

291. At the inquest Senior Constable Gough attempted to explain his reaction to Michael's sudden appearance in front of their vehicle. But it is fair to say that his explanations were unclear, evidently reflecting his own uncertainty as to what he had intended in attempting to restrain Michael. Certainly there was no prior discussion between himself and Probationary Constable Smith as to how they ought to respond to this unexpected event.

292. With candour, Senior Constable Gough acknowledged that when Michael appeared out of the dark and placed his hands on their vehicle, he had not believed there was any risk that Michael would physically harm anyone. Given this, he was asked why he and Probationary Constable Smith had not simply stayed in their car and awaited the ambulance. Senior Constable Gough initially replied:

> *'I didn't think it was appropriate that he [Michael] was standing in the street naked'.*

293. There was a risk, he said, that Michael's appearance would offend people.

294. However it does appear that Senior Constable Gough had formed, or perhaps half-formed, an ancillary plan in attempting to restrain Michael. This emerged from the following exchange:

> Q. *Are you saying that in your view, at that point in time, namely when you moved to physically restrain Michael when he was standing naked in front of the car, at that point in time you had formed the view that the criteria –*
> A. *Yes*.
> Q. *- to schedule him was satisfied?*
> *A. Yes.*
>
> Q. *On what basis, can you explain that?*
> *A. There's a criteria to schedule someone if they've committed a crime which can be dealt with under the Mental Health Act. It's the best course of action to do it. He's naked in the street so therefore, he's committed a crime, and the best possible option would have been to schedule or have a mental health assessment conducted formally.*

295. A little later in his evidence Senior Constable Gough said:

> *'I thought it was the best possible scenario or – I thought that was the best possible choice to detain him so he could then inevitably get mental health assistance'.*

296. It appears therefore that Senior Constable Gough had in mind a plan of sorts to detain Michael, in order to facilitate a mental health assessment.

297. Well intentioned as this plan was, there were practical problems with it. The first was that Probationary Constable Smith plainly had no idea what her colleague's purpose was in adopting this use of force. She agreed in her evidence that Michael was not posing a physical threat to anyone. When asked why she thought Senior Constable Gough had grasped Michael's arm and directed him to get on the ground, she frankly replied:

> *'I didn't even know what we were actually trying to do. I think we were just trying to restrain him…. I believe we were trying to restrain him and calm him down. I don't know what plan we obviously had in that moment'.*

298. Secondly, when he approached Michael in this manner Senior Constable Gough did not appear to have considered whether this action might in fact worsen the situation. When Counsel Assisting asked him if it might have been better to physically move away, Senior Constable Gough replied that he had not been '*overtly thinking about'* that.

299. This is surprising, given that minutes earlier Senior Constable Gough had observed Michael's agitation inside his father's house, and had sensibly decided that they should remove themselves in order to avoid aggravating him.

300. There was a similar lack of clarity in Senior Constable Gough's explanation for why he deployed his oleoresin capsicum spray during the wrestle with Michael. Counsel Assisting asked Senior Constable Gough about this:

> *Q. But what risk do you think Michael posed at this point in time? So we're still in the vicinity of the car. A few moments ago you said you didn't think, prior to approaching Michael, that he posed a risk to anyone. What risk were you seeking to avoid by spraying the capsicum spray?*
> *A. The confrontation with him, to - if you call it assist with incapacitating him so we could detain him, and stop the incident from continuing.*
> *Q. But at this point in time, what risk did you think he posed if not detained?*
> *A. That he continue violently resisting us.*
> *Q. Would you consider that if you stopped trying to detain him, he would pose any risk at this point in time?*
> *A. No*.

301. In other words, the physical threat to himself or others which Michael posed, arose only from the actions he was taking to resist the officers' restraint of him.

<u>The police response outside Stephen's house: the expert evidence</u>

302. Expert opinion about this episode was given by policing experts Sergeant William Watt and Chief Inspector Matthew Hanlon.

303. Establishing context, in his report Sergeant Watt explained that in situations of confrontation there is usually little time for officers to make decisions. The gist of his evidence about this appears above at paragraphs [251] and [253] above.

304. Sergeant Watt explained that use of force by NSW police officers is guided by the principles set out in the Australia and New Zealand Use of Force Principles. These provide that officers should only use force that is reasonable, necessary, proportionate and appropriate to the circumstances.

305. NSW police officers are also guided by the Tactical Options Model. This model provides officers with a range of options. They are trained to select the appropriate one based on an assessment of the level of resistance they face, weighed against the amount of force required to control the situation.

306. Police are taught to make this evaluation on a continual basis as the situation they face evolves. The dynamic nature of this process is reinforced in police training with what is known as the STOPAR model. This is intended to emphasise to police officers the necessity of refocusing their mind on the situation as it changes.

307. In his report, Sergeant Watt said that the decision of the two officers to detain Michael and to use force was within the ambit of police training. At the inquest however, and noting the evidence of both officers that they did not consider themselves or others at physical risk, he considered that it would have been preferable for them to avoid a use of force option.

308. This opinion emerged from the following exchange at the inquest:

> *Q. And in a situation where as you know Senior Constable Gough's evidence was that at that point in time he did not consider that Mr Peachey put either him or Probationary Constable Smith at risk, or that he was at risk of harming other people. Do you not agree that the tactical option that avoided the use of force would have been preferable, given that both were available?*
> *A. On those assumptions, yes.*

And then:

> *Q . But to the extent that the question is whether or not the use of force was objective, that it was appropriate, the mere fact that an officer considered it was appropriate of itself doesn't answer the question does it –*
> *A. No, it doesn't.*
> *Q. And similarly, the mere fact that an officer considered they were at risk, doesn't mean objectively that the officer was at risk?*
> *A. That's accurate, yes.*

309. In his evidence, Chief Inspector Hanlon acknowledged that he could not know what Senior Constable Gough was thinking when he made the decision to restrain Michael. However from his review, he surmised that the two officers had interpreted Michael's agitation and distress as '*pre aggression behaviour*' calling for use of force action.

310. Chief Inspector Hanlon went on to state however that since Senior Constable Gough had not believed that Michael was at risk of harming someone, other ways of dealing with the situation may have led to a different outcome. He gave this evidence:

*'I do accept that if police stood further away and utilised that the reactionary gap or greater distance they can often create a safer environment, and I see this in the training with police often, is that they do get closer to a person than they necessarily need to …'*

311. Chief Inspector Hanlon then went on to explain:

*'… we do indicate that there's benefit in standing further away, even distances of up to five metres, just to calm the person. Allow them to accept the police presence and maybe utilise some effective communication to further calm the situation rather than being close, because we do know that the generalised experience of a person experiencing acute psychotic behaviour is one of fear'.*

312. Dr Ellis was also asked to review the evidence of this confrontation. While acknowledging that he was not an expert on policing, he observed that Michael did not seem to be behaving in a manner which physically threatened the officers. Since Michael was highly agitated, Dr Ellis agreed with Chief Inspector Hanlon that potentially a more effective approach would have been to maintain a physical distance and attempt to speak calmly with him. This also may have allowed the police officers time to form a plan. Dr Ellis acknowledged however that there could be no certainty that in his psychotic state Michael would have been able to respond to verbal attempts at de-escalation.

313. Both Sergeant Watt and Chief Inspector Hanlon highlighted the challenge of training police officers for real life situations of conflict, and in particular how to distinguish vulnerable situations from those where a risk of harm was actually present. As expressed by Chief Inspector Hanlon:

*'.. it's obviously a very significant challenge for us to train police officers not only [what] to do in the area of mental health in terms of vulnerability but then also apply their law enforcement skills and obligations under the Police Act to detain a person or reduce … the risk to public safety. … So it's two competing I guess values and that's very difficult to train around especially where there's only two police available.'*

314. Chief Inspector Hanlon said that Michael's case '*would encourage me to continue to reinforce that in future training'.* He was describing in particular, the challenge of training police officers to '*continually review their approach under STOPAR and … emphasising the benefits of standing further away'.*

Conclusion regarding the police response outside Stephen's house

315. I fully acknowledge the challenges which face police officers when they are called to situations of extreme behavioural disturbance. This is without doubt a very difficult area of police work, and one which is equally difficult to train for. I commend Chief Inspector Hanlon for his recognition of the need to increase police officers' understanding of these situations, by reference to the circumstances of Michael's tragic case.

316. By the time of the inquest, Senior Constable Gough had reflected on the way he and Probationary Constable Smith had responded outside Stephen Peachey's house. He was asked if he thought that Michael had reacted as he did, because of the police attempts to restrain him. Senior Constable Gough replied:

> *'Yeah. The violence when we initially tried to apprehend him out the front of the house'.*

317. When he was asked if he might have tried to de-escalate the situation before moving to a use of force, Senior Constable Gough initially replied that using force was *'the decision I made … In that moment, I thought that was the best decision.'*

318. However, a little later in his evidence he acknowledged that:

> ' … *more communication is always – could always alter the outcome of something. I don't know'.*

319. He further said:

> *'We tried to leave. Obviously, that didn't work. In hindsight, there's a lot of different things that – or further communication that we could have tried'.*

320. Senior Constable Gough is to be commended for his willingness to reflect on the events of that traumatic night, and to consider whether he might have taken a different approach at that earlier stage.

321. But in response to the same question, Probationary Constable Smith did not think there was anything she could have done differently:

> *' …the ultimate goal was control, and we couldn't get that control'.*

322. Acknowledging that police training required officers to use physical force only as a last resort, Probationary Constable Smith claimed that: *' …we tried to disengage, but then we were fronted to take action'*.

323. What attempts at disengagement Probationary Constable Smith was referring to is not clear - perhaps the initial decision to wait for the ambulance around the corner. Certainly while Michael was at the front of their vehicle, there is no evidence that the officers attempted to de-escalate the situation.

324. At the inquest Probationary Constable Smith was asked if she had received any training on dealing with a person with a mental illness. Specifically, she was asked if she had been taught that to approach such a person and attempt to touch them, might escalate a potentially violent situation. Probationary Constable Smith replied that she could not recall any such training. Nor had it occurred to her that evening that this might be the case.

325. In assessing the appropriateness of the police response to this episode, I do take into account this apparent gap in Probationary Constable Smith's training. I also take into account the evidence suggesting that Senior Constable Gough had hoped that their use of force would provide a pathway to obtaining a mental health assessment for Michael. I additionally accept that attempting to verbally engage with Michael may well have been fruitless, given Dr Ellis' opinion that Michael was by now in a state of acute mental distress and likely unable to engage with such attempts.

326. Nevertheless, the police officers' attempt to restrain Michael outside his father's house does not sit well with police training that officers should only use force that is reasonable, necessary, proportionate and appropriate to the circumstances. A decision to stand back and attempt to understand Michael's state of mind and intentions would have been a more appropriate response, given that neither officer perceived a threat to themselves or others.

327. I now return to the events.

<u>Outside the Gort family's house: 29 Herbert Street</u>

328. Stephen Peachey said that when he saw his son running down the street, he told Senior Constable Gough to let him go – he had no clothes on and Stephen thought he wouldn't go far. But then he heard screams coming from number 29, and *'I knew police had to go after him'.*

329. Looking back on that night Stephen became distressed, saying: *'I knew it wasn't going to end well, but I didn't think it was going to end that bad'.*

330. Stephen recalled that 29 Herbert Street was the only house in the street that night which had lights on. 29 Herbert Street was the home of Peter and Louise Gort. Also living there was Ms Gort's adult daughter Tanya Waugh. Peter and

Louise's seventeen year old granddaughter Chloe Waugh was staying at their home that night, although she ordinarily lived nearby with her parents Adam Waugh and Melanie Fulton.

331. Just before 8.30pm, Louise Gort was standing on the front porch of her home with Tanya and Chloe. It was dark, but their attention was drawn to a police vehicle further up the road and the sounds of yelling and screaming. Then they saw a man with no clothes on run down the street in their direction, followed by two police officers.

332. Seconds later the naked man appeared in the Gort's driveway. To the women's astonishment he ran towards them, calling out '*help me, help me'*. According to Chloe, he *'didn't seem normal, he was talking quickly'.* Tanya Waugh said that he appeared to be distressed and needing help, and was *'mumbling words that I couldn't understand amongst asking for help'.* She described Michael's eyes as looking as though they were *'all pupil … they're no colour at all, like the pupil was blown out'.*

333. The women told Michael to leave, but he ran up the front steps of their house. Louise Gort was standing at the front door. Grabbing her by the wrist, Michael pulled her downwards in a head lock while she screamed to her husband for help. Michael continued to repeat *'Help me, help me'*. Tanya Waugh pushed Michael's face and he let go of her mother, then he *'barged'* past them into the house.

334. Hearing the commotion outside, Peter Gort ran to the front door and was taken aback to see a man whom he did not know already inside. Peter Gort attempted to block Michael's path, but Michael pushed into him with his head and shoulders. Peter managed to get his right arm over Michael's shoulder and around his neck, then use his left arm to take hold of his own right hand to secure Michael. In his statement, Peter Gort said:

> *'I remember as I was doing it, I was worried about holding the man too tightly and thought it would be better for him to get away from me than for me to cause any injury to him.'*

335. Peter Gort told the court that he '*did not put any pressure against his neck',* thinking that if he put too much tension on '*I could strangle him and I didn't want to do that'*. He did not believe that he had restricted Michael's breathing.

336. Michael managed to squirm free of Peter's grip, then he ran into the living room of the house, '*moving very vigorously'* according to Peter. The living room is to the right of the hallway after entry through the front door.

337. Seconds later Senior Constable Gough and Probationary Constable Smith arrived, and they followed Michael into the house. It was now about 8.29pm.

Inside the Gort family's house: the use of OC spray and Taser

338. Both police officers told the court they had no opportunity to discuss what they would do when they went inside the house. Probationary Constable Smith was asked if she had considered trying to de-escalate the situation. She replied:

> '*No, he's just assaulted – quite severely assault, a home invasion on an elderly lady, no, I didn't – I was not de-escalating and going out'.*

339. According to Senior Constable Gough, when he entered the house he was '*immediately engaged in a violent confrontation'*. Michael '*was straight on top of me as soon as I went through the door'.*

340. Probationary Constable Smith recalled that on entry she saw Peter Gort standing in the hallway, and Senior Constable Gough and Michael in or close to the adjoining living room. Michael, she said, was positioned in front of her colleague and she did not know what he was going to do. She could not recall if she had seen any physical contact between them.

341. Probationary Constable Smith told the court that she did not have any other option than to use force. Michael was moving towards her colleague, and her obligation was to '*control the situation'*. She called out *'spray'*, and deployed her oleoresin capsicum spray. Again it appeared to have no effect on Michael, but it caused Peter Gort and Probationary Constable Smith to cough and become breathless. Senior Constable Gough then discharged his Taser.

342. At the inquest Senior Constable Gough said that he did this to assist him in detaining Michael. He was concerned about the risk posed by the proximity of the kitchen, and the likely presence within it of sharp objects.

343. Footage obtained from the Taser indicates that Senior Constable Gough's device was discharged six or seven times. Of these, some at least occurred when Michael tried to remove the Taser from Senior Constable Gough's grip, inadvertently causing it to discharge.

344. As will be seen, at autopsy it was found that two metal Taser probes had entered Michael's upper abdomen; but further, that it most unlikely they had conducted any electricity into his body. The probes had however likely caused Michael pain and discomfort, adding to his degree of agitation.

345. The NSW Police Force's Standard Operating Procedures on Use of Conducted Electrical Weapons (the Taser Standard Operating Procedures) instructs that use of multiple cycles should be '*only considered in exceptional circumstances after the officer has reassessed the situation in accordance with the Tactical Operations Model'*.

346. Furthermore, after three cycles '*police must reconsider the effectiveness of taser as the most appropriate tactical option and must consider alternative tactical options'*.

347. At the inquest Senior Constable Gough gave contradictory evidence as to whether he had complied with the Taser Standard Operating Procedures' instruction to reassess the situation after discharging three cycles. At one point in his evidence, he said that he had realised the first discharge had not affected Michael and therefore he decided to discharge it again. A little later however he said that he '*didn't stop and think about it, it was a fluid situation where there wasn't a moment that you could just stop and think for a moment'.*

Threshold question: the extent of Michael's struggles, and the level of physical risk

348. I now move to the critical phase of the night's events – namely, the physical restraint which culminated in Michael's fatal collapse. The entire forty three minutes of this restraint took place inside the Gort family's living room.

349. The extent to which Michael continued to struggle throughout this period and might reasonably be said to have posed a physical risk to others, emerged as a critical issue in the inquest.

350. As will be seen, at the inquest the expert paramedical evidence established that even at the commencement of the period of restraint, Michael was at high clinical risk. This risk was heightened when he was positioned face down on the floor. The paramedic experts were unanimous that it was essential to his safety that he be moved from the prone position onto his side or back as soon as this was possible.

351. The expert evidence was further that due to his clinical risk, Michael required close monitoring by the attending paramedics.

352. However, it will be seen that according to the evidence of some witnesses, Michael's levels of aggression precluded them from either moving him from the prone position, or undertaking close monitoring of his clinical condition.

353. A number of people were present in the room during the restraint period, as follows:

- soon after 8.35pm, Tanya Waugh and her father Peter Gort began to assist police by holding Michael's legs onto the floor. Peter Gort's son Adam replaced his father at about 8.53pm
- from approximately 8.48pm onwards, Michael was positioned face down on the floor. He remained in this position until 9.12.57pm, when it was discovered that he was not breathing
- an ambulance with paramedics Kim Summers and Derek Baker arrived at approximately 8.55pm
- a first injection of the sedative droperidol was given just before 8.58pm;
- an injection of midazolam was given almost immediately afterwards
- at 9.07pm a third police officer, Senior Constable Scott Douglas arrived
- a third injection, being a repeat dose of droperidol, was given at 9.08pm
- just before 9.13pm it was identified that Michael was not breathing
- Michael was removed from the house and resuscitation commenced
- Michael was taken by ambulance to Gunnedah Hospital and pronounced deceased at 10.10pm.

354. Some at least of what was happening in the room was captured by Probationary Constable Smith's BWV camera. As noted, this evidence has its limitations.

355. But the BWV footage is by no means the only source of information as to what was happening. All of the above eyewitnesses gave evidence in the form of statements and oral evidence as to what they saw, heard and did during the restraint period. In particular the three police officers and two paramedics were extensively questioned.

356. There was another important source of information. Peter Gort and Tanya Waugh were present in the living room for much of this time. In addition, Peter's son Adam Waugh joined them at about 8.53pm. The inquest therefore had the benefit of their observations as to what Michael was doing throughout the restraint period.

357. I commence with the evidence of the Gort family members.

<u>The evidence of Peter Gort, Tanya Waugh and Adam Waugh</u>

358. Peter Gort told the court that when he saw Michael run into his house:

> *' … it seemed to me that he was not thinking of a goal but rather reacting sort of trying to get away. … That was just the impression that I got as he was coming in the door'.*

359. Peter Gort was still standing in the hallway seconds later when Senior Constable Gough and Probationary Constable Smith ran past him into the adjoining living room. Peter saw Michael struggling against the officers' attempts to get him onto the ground and to handcuff him:

> *' … the man was on his hands and knees, the male officer was at the front of the man controlling his hands and the female officer was across his back … … and at least twice actually, the male officer has said to [Michael], because he stopped struggling momentarily, and said, 'Okay. Can we let you up now?'... and [Michael] replied 'yes'. And immediately, they started to release pressure, he started fighting again. That happened at least two times'.*

360. By now Tanya Waugh had joined her father. Standing at the doorway to the living room, she too could see the police officers struggling to place handcuffs onto Michael and to get him onto the ground. But Michael:

> *' … didn't want to be restrained at all, he was kicking and moving his arms around. I heard [Michael] say words similar to: 'I've been trying to save the world all my life, I've been building up to it'. I heard the male police officer say 'We know Michael, just calm down and get on the ground, we are here to help you, we want to get you some help'.'*

361. Like her father, Tanya Waugh had the impression that rather than intending to hurt anyone Michael was trying to get away. Nevertheless, she was taken aback by his strength:

> *'The guy wasn't saying much at this point, but he was honestly like the Hulk. He was smaller than me, I think he may have been around the same height as me, but he was skinnier than I am. He was very strong … he started using our furniture to try and stand up'.*

362. She gave a similarly vivid description in her statement:

> *'I have never seen anything like it. When I looked into his eyes, it was all pupil. … He would not calm down. He was off in his own world.'*

363. Senior Constable Gough was similarly shocked by Michael's physical strength:

> *' … the strength he had, it was – it was unbelievable … we physically could not get him to a point where .. it stopped us from doing the things we usually do … it's what gave him the ability to thrash his legs out and push off a cupboard or a bookshelf, kick [Probationary Constable Smith] in the chest, almost stand up when the smallest little bit of pressure was released from*

*him … the strength that he had was - I can't even describe it. It – it just allowed him to do whatever he wanted'*.

364. He agreed with Tanya Waugh that Michael would periodically calm down, then kick out again in an attempt to get back up:

*' .. every time we relaxed, he would take an opportunity to throw his legs around, get himself up off the ground'.*

365. Probationary Constable Smith managed to get one end of a set of handcuffs onto Michael's right wrist, but she and Senior Constable Gough were unable to bring Michael's arms close enough to link the set together. Therefore Senior Constable Gough attached a second set of handcuffs to Michael's left wrist, which he then linked to the first set. Michael's arms were restrained in front of his body.

366. During this manoeuvre Michael bit Probationary Constable Smith. As she described it, he *'latched'* onto her right arm. She responded by *'whacking Michael to the side of the head to let him release [her] arm'.*

367. Peter Gort recounted that during the struggle, Michael:

*' … rolled onto his back and started kicking out repeatedly. He was wiggling around trying to get his footing so that he could stand up again. He was kicking everything he could to try and stand up again'.*

368. Although handcuffed, at one point Michael managed to haul himself up, at which point Tanya offered to help the police officers. It was now just after 8.47pm. Tanya took hold of Michael's left leg and pulled it backwards. This move:

' *… caused the man to come down onto the floor so that he was laying on his stomach'.*

369. Seconds later, as Tanya was attempting to step over Michael his leg came up sharply. This caused Tanya to trip and she hit her head on the stereo speakers. Tanya interpreted this as attempt by Michael to break free of her hold, rather than a targeted assault on herself. She momentarily lost her grip on his leg, and Michael rolled onto his back and tried to stand up again. Tanya said that he was ' … *kicking everything he could to try and stand up again'*, but that ' … *the police officers got him on his stomach again'.*

370. The timestamp on the BWV recording indicates that Tanya's fall happened just before 8.48pm. It can be inferred therefore that Michael's period of prone restraint commenced very soon afterwards. Audio evidence reinforces this

inference: at 8.49pm Probationary Constable Smith can be heard asking Michael to pull his arms out, suggesting that he was by then lying face down.

371. The BWV footage supports the evidence of Tanya Waugh and Peter Gort that during this period there were times when Michael was indeed moving his body with great vigour and force. Although for much of the time it is not possible to see Michael, that he was struggling can be inferred from the way in which, on a number of occasions, the camera view jumps about wildly, indicating that Probationary Constable Smith was moving her body in response to strong movements from Michael.

372. At one point Michael can be seen lying face up, with his legs kicking upwards and outwards, trying to lever himself off the ground. It is at this point (8.47.54pm) that Tanya Waugh made her offer to help.

373. The physicality of the struggle during this phase is also reflected in what can be heard. Michael and the police officers can be heard panting and breathing heavily. In addition both police officers repeatedly ask Michael to '*get down Michael', 'don't flex up mate, come on'*, and *'don't kick me, don't Michael'*.

374. Notably however during the periods when Michael is still, both police officers verbally encourage him to '*take some deep breaths Michael*', '*we're going to get you some help',* and *'come on mate, it's all good'.*

375. At around 8.43pm, Senior Constable Gough instructed Michael to remain still so he could remove the Taser prongs and make him more comfortable. It may be inferred that Michael continued to struggle however, as a minute later Senior Constable Gough can be heard saying '*No, no, no, I won't pull them out until you calm down'.* He abandoned the attempt at 8.49pm with the words: *' … I dare say he's not going to calm down to the extent we need to, to get them out'.*

376. Tanya Waugh recounted that once Michael was forced onto his stomach he calmed down for a brief period, but he then '*began kicking the lounge again, trying to roll over.*' She managed to get a firm grip on his feet by putting her weight onto them, recalling :

> '*I did that because nothing was working, he was still bucking around, he wasn't calming down*'.

377. At this point, Peter Gort came to their aid by holding Michael's other leg. In his statement he described Michael's actions as follows:

> '*While Tanya and I were assisting in holding the man, he was still attempting to periodically escape. I could feel when the man relaxed and I eased my*

*grip, when he tensed and tried to move, I tightened my grip again. This happened several times while I was helping to hold the man down. The police continued to talk to the man during this process … the talking was mainly done by the male officer however the female officer spoke periodically. The male officer was saying 'calm down, relax and draw deep breaths'.*

378. At the inquest, Peter confirmed the intermittent nature of Michael's exertions during this period:

*Q. You say that at this point Michael was still attempting to periodically escape, and then you could feel when he relaxed, at which point you eased your grip. How did you know when Michael relaxed?*
*A. He stopped squirming.*
*Q. It was the fact that he wasn't moving?*
*A. His legs relaxed. His body stopped moving. The sounds of exertion eased. It did sound like he was reacting to the voice of the police officer, urging him to calm down and to take deep breaths. It seemed like he was trying to do that. After he relaxed, he would then start to struggle again.*

379. Outside the house, Chloe Waugh decided to ring her father Adam for help. Adam arrived quickly from his home around the corner, entering his parents' house just before 8.54pm. He took up his father's position holding one of Michael's legs. This enabled Peter to go outside to support his wife, who remained very shaken. Peter Gort did not enter the house again until after Michael had been taken away.

380. Tanya Waugh noticed that around the time her brother arrived, Michael appeared to be tiring:

*'Adam took over from Dad, grabbing his leg. No one really said anything, we just stayed where we were. It felt as though the guy was finally calming down because he wasn't moving around as much, nor was he saying anything.'*

381. However, in her observation Michael was still active, albeit intermittently. He was *'breathing very heavily like he'd run a marathon',* and was:

' … *moving more and then he'd slow down, and then he'd start doing it again and then slow down'.*

382. According to Tanya, by the time the two paramedics arrived a couple of minutes later:

'*…the guy was still moving around slightly, trying to get everyone off but it wasn't as ferocious.'*

383. She said that Michael was not lashing out but rather was *'wiggling like a worm'*. He *'started to calm down a lot'*, had *'stopped being aggressive at that stage',* and was breathing heavily.

384. Peter Gort agreed. He recalled that towards the end of the time that he was holding Michael's leg there was *'less exertion and fewer movements'.* Michael, Peter said:

> *' .. didn't seem to struggle or fight as hard and I thought the adrenaline was maybe wearing off and he was becoming fatigued'.*

385. Peter Gort agreed that this made it easier to keep him restrained.

386. When asked if he thought Michael was being violent towards the police, Peter replied:

> *'He was trying to not be restrained and trying to run away as I perceived it … it seemed to me he was still trying to just run away and just trying to get away, and I don't think he was cogitating any more than that'.*

387. He added that by the time his son Adam arrived, that is, about a minute ahead of the paramedics, Michael seemed to be tiring. He was '*principally restrained'* and was moving '*nowhere near as much as he had been earlier'*. Peter was of the view that the four of them (the two police officers, Tanya and himself) had Michael under control. Nevertheless, he still felt concerned that Michael might be able to get up again.

388. Tanya, Adam and Peter all described hearing the two police officers speaking to Michael throughout the restraint, urging him to calm down and telling him that help was coming. Paramedic Summers also heard these attempts when she arrived with Paramedic Baker at about 8.55pm. She commented that the police officers' verbal efforts sometimes appeared to calm Michael '*but only for a few seconds'*.

389. About five minutes after Adam arrived, that is at about 8.58pm, Tanya became exhausted and her brother took hold of both of Michael's legs. Tanya remained in the room, observing that '*the guy had calmed down for maybe 30 seconds but started moving again'.*

390. However, Tanya went on to say that by the time the paramedics were injecting Michael with medication, he had *'calmed right down'* and had:

‘ … *stopped moving … his chest was still going up and down, calm breathing, he seemed normal. He was quite still from then on’*.

391. She recalled that the third police officer (Senior Constable Douglas) arrived just afterwards. The evidence establishes that this was at about 9.07pm.

392. When Adam Waugh took over from Peter Gort in holding down Michael’s leg, he described Michael as *‘fighting hard … I could just feel him trying to push away with his legs to break free and get away from the police’.*

393. But Tanya did not agree with her brother’s impression:

> *‘No, he had stopped being aggressive at that stage. He was trying to breathe and move I suppose, to get comfortable.’*

394. Notably, in his initial evidence Adam told the court that Michael’s physical resistance did not diminish at any stage, in contrast with the evidence of his father and his sister. According to Adam, this remained the case even after the paramedics administered their third injection at 9.08pm.

395. But later in his evidence, and after having been shown BWV footage which corresponded with these times, Adam revised his account. By 9.06pm *‘it felt like [Michael] was asleep, he fell asleep … his whole body was just totally relaxed’.* He added that Michael was so calm that he did not feel the need to hold onto his leg.

396. Adam commented further that around the time Michael was given the third injection at 9.08pm, it was not correct to say that he ‘*started fighting again’.* Michael’s movements were now more like ‘*just muscle movements, like just tensing at the time’.* Adam expanded on this in his evidence:

> *Q. As it was leading up to the third injection, how would you describe Michael’s behaviour?*
> *A. Me, personally, I think he was like half asleep, drugged up. … just before the third [injection], he was having a bit of a wiggle, like movements. But wasn’t very much. And then, they gave him the third one. And then he just absolutely calmed down.*

And a bit later:

> *Q. Is it your evidence then really that when you say Michael was resisting a bit at this point, it was just tensing of muscles and a little bit of movement?*
> *A. Yep.*

397. In summary, according to the evidence of Peter Gort, by the time he left the room at around 8.58pm Michael's activity levels were substantially diminished. And on the account of Tanya Waugh and the later evidence of Adam Waugh, Michael was lying relatively still at, or very soon after, he received the repeat dose of droperidol at 9.08pm.

398. While the distress which the Gort and Waugh family members felt that night cannot compare with that of Michael and his family, the experience was deeply disturbing for them. In her oral evidence Tanya said she '*didn't want to think about it anymore'*, and she became distressed when she recalled Michael looking at her while he was being held down. His eyes were *'all pupil'*, she said, and he ' … *just looked like he was just trying to get away from everybody'.*

399. Peter Gort also wished to say this about the behaviour of the police officers and of Michael:

> *'I was struck by how calm the police sounded throughout this period. They were both obviously struggling hard to control the man, but their voices remained calm. At no time did I see the police or the man do anything other than wrestle and struggle with each other. I did not see anyone intentionally punch or kick or use any other strikes'.*

400. Peter Gort and Tanya Waugh gave detailed evidence at the inquest. Both impressed as honest and thoughtful people who did their best to provide an accurate and fair account of what they had seen and heard on this very distressing night.

<u>The evidence of Senior Constable Gough and Probationary Constable Smith</u>

401. I now turn to the evidence of Senior Constable Gough and Probationary Constable Smith as to what they saw and heard, and their perception of the level of risk which Michael presented. In important respects their evidence on these matters diverged from that of Peter Gort, Tanya Waugh and Adam Waugh.

402. For Senior Constable Gough, from the outset his interaction with Michael was a '*violent confrontation'*. Like Tanya Waugh and Peter Gort, he described a struggle in which, during the initial stages at least, Michael forcefully wrestled against their efforts to restrain him.

403. However Senior Constable Gough did not concur with Tanya's observation, and that of her father and brother, that Michael's physical efforts gradually abated as he became fatigued:

*'No, he was fighting until the ambulance person rolled up … there was constant fight or fighting happening.'*

404. Michael, he said, did not cease in his attempts to lever himself off the ground:

'*That's what he did throughout the entire process'.*

405. When he was asked if there were any periods when Michael appeared to be moving less, Senior Constable Gough gave this evidence:

*'There were definitely times when Michael appeared to move around less, because he's – he fluctuated with his resisting throughout the entire thing. So he'd – he'd fight and then he'd calm down for a little bit and then obviously it would kick off again'.*

406. Initially, Senior Constable Gough told the court that Michael was still resisting right up to the point when they noticed he wasn't breathing. He did not acknowledge there were any sustained periods of calm:

*' … every time he got his leg – one of his legs up off the ground, he would pull his arms up, he'd get leverage off the ground and then just continue the fight. So if – if we rolled hm onto his side, he would've straightaway either stood up, continued to resist us the entire time.'*

407. After viewing the BWV footage, Senior Constable Gough agreed that as time passed Michael did not seem to be thrashing around as much. However, he insisted that he was constantly forced to counter Michael's attempts to push himself off the ground.

408. Aware that there were dangers associated with prone restraint, Senior Constable Gough said that:

*' ... every time we tried to assist or deal with Michael, throughout the entire incident, every time we tried to help him, it delved into another physical altercation, resistance …*'.

409. It was because of this, he said, that they could not risk rolling Michael onto a safer position on his side.

410. Counsel Assisting asked further questions about this. As time went on, Counsel Assisting asked, were there periods when Michael was not being combative, and they could risk changing his position? Senior Constable Gough said there were none:

*'If we had the ability to change his position and we knew that nothing was going to happen, we would have taken that option. In the circumstances I don't think – obviously it didn't work out'.*

411. Senior Constable Gough's observations are therefore at odds with those of Tanya Waugh, Adam Waugh and Peter Gort that Michael's struggling gradually diminished to the point where he became relatively still. In light of this, Counsel Assisting asked Senior Constable Gough if, perhaps due to the very taxing nature of the restraint, his perception had been mistaken:

*Q. Is it possible, Senior Constable, that you were so focused on the struggle and what had happened before that you just didn't really notice that Michael had become still and stopped resisting?*

412. But Senior Constable Gough did not think so:

*'… because like I said, he would tense up and then it would continue to occur, the resistance, so it was always changing, I was always having to assess it.'*

413. Senior Constable Gough said that because of the risks associated with Michael's prone position, he and his colleague:

*' … kept checking his breathing, talking to him when he – when he resisted …That was always playing on our mind, that's why… we checked his breathing, we checked the rise and fall of his chest.'*

414. In addition, Senior Constable Gough had drawn reassurance from the fact that from 8.55pm onwards the ambulance officers were attending to Michael. He felt *' .. it would have been okay to just remain in that position'.*

415. Senior Constable Gough told the court that throughout the intensity of the restraint period he had desperately wished for help from additional officers. But he had little hope that this would happen soon. He knew that no additional police officers were at Gunnedah Police Station at that hour, and the nearest police station was at Boggabri, more than half an hour's drive away.

## The evidence of Probationary Constable Smith

416. Like her colleague, Probationary Constable Smith disagreed with the suggestion that as time passed Michael became less combative and resistant. She maintained that throughout the entire period of the restraint, there had not been any time at which Michael was not moving and resisting:

*A. I believe he was still resisting right to the end. He still resisted me and that's why I continued to do what I did.*
*Q. Did his resistance get less over time?*
*A. He still resisted us right to the end.*
*Q. But the question was, did his resistance get less over time? As in, less strong, less –*
*A. No, not less strong. No. He was still strong right to the end ……I believe he was as strong as he was the whole time … whether we all went down a level I'm not quite sure – but for me, he was as strong as we first went in. … His behaviour was pretty similar the whole time … I believe he didn't show a sign of fatigue.*

417. She too was asked if throughout the episode she had given any thought to altering Michael's position. She concurred with Senior Constable Gough that the risk of harm to others put this out of the question:

*A. I did, but he was still resisting at that point. So it did cross my mind a few times, but at that point we were tired and he was still resisting, so in my eyes, I felt that I possibly couldn't control him if he got up again.*
*Q. What did you think the risk would be if he did get up?*
*A. He proved that he could do anything. He's proved that he assaulted the female occupant of the house, so who knows what he could have done at that point? So that was my main goal, was to try and control, but we still obviously didn't get control because he resisted us right to the end … my thought processes at the time – 'If he got up, how do we control him again? We are all exhausted'.*

418. However, after viewing the BWV footage Probationary Constable Smith said that she '*could not remember'* if she had noticed there were in fact periods when Michael was not struggling as much as she had remembered. She explained that viewing the BWV footage again had been traumatic for her.

419. Her ultimate evidence was that although over time Michael may have become less violent, he was still resisting.

420. This prompted Counsel Assisting to ask Probationary Constable Smith the same question she had put to Senior Constable Gough:

*Q. Is it possible that your perception was altered and affected by what had occurred earlier such that you didn't notice changes in Michael's movement and conduct towards the later period of the restraint?*
*A. No.*

421. After Senior Constable Douglas arrived at about 9.07pm, Probationary Constable Smith was able to vacate her position restraining Michael. Thereafter she stood in the living room with a view of him. She did not take this opportunity to monitor his breathing, because '*I didn't want to get in the road of the ambos'.* Like Senior Constable Gough, she believed '… *they were taking over for that situation.'*

422. At the close of her evidence, Probationary Constable Smith was asked if there was anything she would have done differently to avoid the tragic outcome. She believed that: '*we did what we could in the difficult situation we were faced with'.*

The arrival of the paramedic team

423. Three other witnesses were present during the latter part of the restraint period. Two of these were Paramedic Kim Summers and Paramedic Derek Baker. Each gave evidence of what Michael was doing during the time they were present.

424. On 20 May 2022, this paramedic team was rostered to work from midday to 10pm at Gunnedah Ambulance Station. Both are qualified P1 Paramedics and have been employed for many years at NSW Ambulance.

425. That night they were driving back to Gunnedah after having transferred a patient to Tamworth. At about 8.30pm they received a radio request to attend at an address in Gunnedah. Their ambulance pulled up outside the Gort's home just before 8.55pm. By this time, Senior Constable Gough and Probationary Constable Smith had been inside for some twenty five minutes trying to restrain Michael.

426. On the information they had received, the two paramedics expected to be providing a mental health assessment of a man under police restraint, who was suffering a mental health episode and had been tasered and sprayed.

427. When they entered the Gort's living room, the paramedics saw Michael lying face down on the floor with his hands handcuffed and positioned in front of his head.

428. Paramedic Summers said that:

> *' …the entire time that I was on scene I was assessing the risk to [Paramedic Baker] and myself. I was also assessing the risk to the patient, the police, and the civilians in the room'.*

429. Paramedic Summers added that she had felt *'vulnerable'* from the moment she arrived. She thought the situation was '*very unpredictably volatile and unstable'* because Michael was '*clearly agitated and aggressive'*.

430. Paramedic Baker was likewise assessing the safety risks. He said that the most significant one was the risk of harm to himself, his colleague and the attending police. He was questioned about this:

> *Q. Did you also think that one of the big risks was the safety for Michael?*
> *A. Yeah, we always factor that in with our patients but the priority is – is the rescuers first.*
> *Q. …When you were assessing the risk on the scene … did you mean the risk to you or the risk to Michael or the –*
> *A. The risk to everyone on scene. Primarily we're taught, our scene safety first, safety for us, and then others, and then the patient.*

431. Paramedic Baker was here referring to NSW Ambulance's *Dynamic Risk Assessment,* which I will describe later in these findings when considering the appropriateness of the ambulance officers' response.

432. Michael was still moving when they arrived, said Paramedic Baker, but in a manner which was limited by the police officers' restraint. As they entered, both paramedics saw Michael move his head with the apparent intention of biting Senior Constable Gough's arm.

433. From their visual assessment of the scene, the paramedics determined that Michael was severely behaviourally disturbed, and was displaying aggression and severe agitation. In their opinion, the threshold to enact section 20 of the MHA 2007 had been met. They formed an intention to transport him to the Emergency Department of Tamworth Base Hospital for a mental health assessment.

434. The paramedics also decided to invoke NSW Ambulance's *MH6 Behavioural Disturbance Protocol*, another document which is described below. This would enable them to use medication to prevent Michael from harming himself or anyone else, and to help them assess his physical and mental condition. Paramedic Baker explained their reasons:

> *' ..the way he was wrestling and in the state he was in, given the information we were given … we had to lessen that risk'.*

435. I accept that it was reasonable for Paramedics Summers and Baker to find the section 20 threshold met, and to proceed to use chemical sedation. There is ample evidence that Michael was suffering severe behavioural disturbance. The

paramedics appropriately determined that he required a mental health assessment at hosptial, and that they would need to chemically sedate him in order for this to happen.

The evidence of Paramedic Kim Summers

436. While Paramedic Baker was preparing a dose of the sedative drug droperidol, Paramedic Summers carried out a partial survey of Michael's vital signs. She decided to restrict her survey to visual observations of his respiratory rate, a check of his rate of capillary refill, and a check to determine that he had a pulse. There would be no use of mechanical monitoring equipment, and no sustained close visual observation.

437. Paramedic Summers explained her reasons for this decision in her supplementary statement. Her predominant reason was that she considered Michael's behaviour was too aggressive. It presented an unacceptable risk of harm to herself and her colleague, and precluded them from staying near him to perform close observations of his condition:

> *'I determined that there was a risk to myself if I attempted to start physical observations of Mr Peachey, such as by getting close to him or placing medical equipment on him … I felt vulnerable from the get-go …'*

438. Paramedic Summers did not consider it was safe to apply any monitoring equipment to Michael's body, including a pulse oximeter. A pulse oximeter is an electronic device which measures a patient's blood oxygenation levels over a period of eight to fifteen seconds. At the inquest the paramedic experts endorsed this device as the most effective and reliable method of identifying any deterioration in a patient's ability to breathe.

439. According to Paramedic Summers, she could not have safely used a pulse oximeter, because there was no point at which Michael was not moving:

> *Q. Is it your evidence that at no point prior to the point in time when it was identified that Michael was not breathing … which was around 21.12.57 … that at no point in that period could you have safely put on a pulse oximeter?*
> *A. No.*
> *Q. Sorry, are you saying you couldn't have put it on?*
> *A. No, we couldn't have safely applied the pulse oximeter.*

440. She offered the further reason that the cord which is attached to the pulse oximeter could be used to harm them. That is, a patient could, even while handcuffed, seize the cord and '*wrap it around the nearest person'.*

441. Obtaining a reading of Michael's blood pressure was likewise out of the question, according to Paramedic Summers:

> *'His violent and aggressive behaviour did not allow me to approach the patient to complete a blood pressure'.*

442. Paramedic Summers strongly disagreed with the suggestion that there were in fact '*substantial periods of time'* during the restraint period when Michael was calm:

> *'No. There were times when we were with him and he would calm, and then we'd attempt to manoeuvre him on – and implement some more treatment. And then his behaviour would escalate…. There were different parts of the 10 or 15 minutes that we were there that his behaviours were calm, and then he wouldn't let us anywhere near him'.*

443. Clarifying this evidence, Paramedic Summers stated that Michael had been '*moving with intent to harm the police'*. When they arrived, she had observed him attempting to bite Senior Constable Gough. She insisted that she had seen him trying to do this many more times, so many that: '*I lost count. I couldn't tell you'*.

444. In light of Senior Constable Gough's evidence that Michael had tried to bite him '*a couple of times'*, Counsel Assisting asked Paramedic Summers if it was '*possible you're simply wrong as to that'.* But she replied that she was not.

445. Paramedic Summers was further questioned about her assessment that Michael had been too agitated and aggressive for her to perform close visual monitoring of his condition:

> *Q. … I suggest having regard to the body worn video footage, that Michael was not displaying violent behaviour?*
> *A. His behaviour, as I interpreted it, was out of control.*
> *Q. And I also suggest that at the time when you arrived, there was nothing about Michael's behaviour that suggested that you yourself were at any risk of harm. Do you agree with that?*
> *A. I disagree*.

And later:

> *Q. Is it right that you confused some degree of resistance with violence?*
> *A. Resistance is violence. If a police officer asks you to remain still and you don't, it is resistance and it is violence.*
> *Q. And in your second statement, you said you felt vulnerable and in an unstable situation?*

*A. Extremely.*

446. Paramedic Summers did acknowledge that when she was administering the repeat dose of droperidol at 9.08pm, she had noticed a decrease in Michael's movement. Closer monitoring however was still out of the question:

> *Q. … do you accept that if it were the case, certainly from that point in time, you could have put in place the monitoring that I have already put to you? Do you accept that?*
> *A. No.*
> *Q. And from that point in time, you could have safely moved Michael Peachey onto his side?*
> *A. No.*

447. Counsel Assisting then referred Paramedic Summers to the evidence of Senior Constable Douglas and Tanya Waugh, that by this time (that is, at around 9.08pm) Michael was barely moving at all:

> *Q. Now do you accept even the possibility that your recollection that Michael was out of control at this point in time is not accurate?*
> *A. No.*

448. After the repeat dose of droperidol at 9.08pm, almost five minutes passed before it was discovered that Michael was no longer breathing. Paramedic Summers insisted that for the entirety of this period, Michael continued to move his upper body:

> *'He was attempting – he was resisting police restraint … Police were struggling to hold him …'*

This was why she had not advised the police officers that Michael be moved to a safer position onto his side or back. His continuing aggression, she said, would have made this unsafe for herself and others in the room.

449. In short, Paramedic Summers was adamant that right up to the point where Michael became unresponsive, he presented too much of a risk of harm for her to conduct close observations, to use mechanical monitoring equipment, or to advise the police officers that he should be moved out of the prone position.

<u>The evidence of Paramedic Derek Baker</u>

450. Paramedic Baker shared his colleague's view that it would not have been safe for them to perform any monitoring which put them in close proximity to Michael.

451. In contrast with his colleague however, Paramedic Baker thought that by about 9.07pm Michael *'had started to decrease in his consciousness'.* Michael's resistance was diminishing too: there was '*no pulling or pushing or moving'*, and no movement at all through his body.

452. Paramedic Baker told the court that by this stage Michael was calm enough for a pulse oximeter to have been applied. But he did not think this was necessary: in his opinion *'a visual observation of the patient is more important than just a machine*'. He clarified that by this he meant, looking at the patient's general colour and their capillary refill.

453. As for moving Michael into a safer position on his side or back, Paramedic Baker's reasons for not taking this step were somewhat different to those of his colleague. Although he considered that Michael's behaviour had calmed, he believed the clinical priority was to transfer him onto a stretcher. His evidence about this will be discussed later in these findings.

The evidence of Senior Constable Scott Douglas

454. At approximately 8.35pm, Senior Constable Scott Douglas acknowledged a police radio broadcast to assist police officers in Gunnedah. Senior Constable Douglas was based in Tamworth and at the time he had been attending an incident at Somerton, some half an hour's drive from Gunnedah.

455. Senior Constable Douglas arrived at the Gort's house at approximately 9.07pm. When he entered the living room, Senior Constable Gough and Probationary Constable Smith had been involved in the restraint of Michael for almost forty minutes.

456. On entering, Senior Constable Douglas saw Michael lying face down on the floor, with his head facing to his right. When Counsel Assisting asked him if Michael was moving at this point, Senior Constable Douglas replied:

> *' … his head went from side to side, but actual body movement, trying to get up, no'.*
>
> *' … only his head, that's the only part of his body I seen move … just going from side to side'.*

457. Senior Constable Douglas took Probationary Constable Smith's post around the area of Michael's torso. Notably, he described his position as kneeling down beside Michael, with his own hands by his side:

*‘ … just watching him, because if he tried to get up, I’d probably try and stop him from getting up’.*

458. Unlike his two colleagues, Senior Constable Douglas considered that by this time Michael did not present a risk of harm to anyone:

*Q. And what you saw when you arrived, did you consider that Michael at that point in time was in a condition where he created a risk of harming someone in the room?*
*A. Not when I arrived, he was restrained on the floor.*

459. His evidence on this point is therefore in marked contrast to that of Senior Constable Gough, Probationary Constable Smith and Paramedic Summers.

460. But despite his assessment that Michael did not present a risk to anyone, Senior Constable Douglas did not see it as any part of his role to suggest that he be moved onto his side. Counsel Assisting asked him about this:

*Q. Given your position as somebody who had not been present for the violent part of the restraint and turned up and saw that Probationary Constable Smith and Senior Constable Gough were in a position where they were physically holding Michael, why didn’t you think it was your role to try to assess the situation and see whether Michael could be rolled over so he was no longer in the prone position?*
*A. Because - probably because they’re the ones who had control of the situation, I turned up to assist them only. … I had every faith in what they done was correct, I didn’t see anything that was outstanding…*

461. In similar vein, Senior Constable Douglas later commented:

*‘ … as I said, I was only backing up, and my main focus was on providing assistance to them, they had the situation under control as far as I was concerned’.*

462. For this reason he had not turned his mind to whether Michael still needed to be lying face down, or whether this position might be putting him at risk. Furthermore, he said, there were ambulance officers present and he considered Michael’s welfare to be their role: *‘… if there was a problem, they’d say so’.*

<u>The Body Worn Video footage</u>

463. Footage from Probationary Constable Smith’s camera was played a number of times at the inquest.

464. This video confirms the prolonged and very volatile nature of Michael's interaction with the two police officers. Its footage confirms the eyewitness evidence that up until a certain point in time Michael was distraught and very severely agitated, and struggled frantically against the police officers' attempts to restrain him.

465. The BWV audio also confirms the police officers' consistent verbal encouragements to Michael to calm down and to stop struggling. In my view their efforts were commendable, and show the officers' compliance with the NSW Police Force Handbook's instruction to *'use effective communication skills'* where possible, to de-escalate confrontations with a person suffering mental disturbance.

466. As time passes, the footage depicts a gradual but unmistakeable reduction in the level of Michael's activity. By 9.06pm Michael can be seen lying face down, with only his head moving slightly under Senior Constable Gough's left hand.

467. The audio of the BWV footage is also instructive. I have noted that over the period 8.29pm to 9.00pm the two police officers can be heard repeatedly instructing Michael not to struggle. Equally frequent are their encouragements to him to breathe and relax.

468. But over time these interjections are heard less frequently. There is a period between 9.04.44pm and 9.08.20pm when there are no such instructions. And after Senior Constable Douglas' arrival at 9.07pm there were only four occasions when the police officers said words to the effect of '*don't Michael'*. The last of these occurs at 9.08.59pm, and there were none thereafter.

469. The clear inference is that after this time, Michael made no significant attempts to move.

Conclusion: did Michael continue to struggle throughout the restraint period?

470. I reach the conclusion that from approximately 9.07pm onwards, Michael had ceased active struggling and was relatively still. He remained so for the minutes of life that were left to him.

471. This conclusion is based on a careful review of the evidence in its totality.

472. There is a high degree of consistency in the eyewitness evidence of Tanya Waugh, Adam Waugh, Paramedic Baker and Senior Constable Douglas, that from this time Michael's levels of activity were significantly reduced. Indeed according to the testimony of Peter Gort, Tanya Waugh and Adam Waugh, the force of his movements had been abating for some minutes before this.

473. The evidence of these witnesses is corroborated by what can be seen and heard on the BWV footage. In particular the police officers' instructions to Michael to cease struggling become markedly less frequent, strongly suggesting that he was no longer offering any significant resistance.

474. Regarding the evidence of Senior Constable Douglas, I have referred to his observations that when he arrived at 9.07pm, Michael was barely moving at all. Counsel for the paramedics has submitted that the court *'should not place significant reliance on Senior Constable Douglas' account (to the detriment of other accounts) as to Michael's condition*' between the first and the repeat dose of droperidol.

475. To the extent that this submission implies that Senior Constable Douglas was alone in observing Michael to be relatively still by this time, it is rejected. A wealth of evidence from other sources corroborates his observation on this point.

476. Furthermore, and contrary to the submission of Counsel for the paramedics, in my view significant reliance may be placed on the evidence of Senior Constable Douglas. He arrived at the scene with '*fresh eyes'*. In contrast with his police colleagues, he had not undergone a prolonged and very physical struggle with Michael. His evidence of what he saw and heard was unequivocal: Michael was not struggling and he did not present a risk of harm to anyone present.

477. I therefore reject the claims of Paramedic Summers, Senior Constable Gough and Probationary Constable Smith that Michael continued to be aggressive and to actively resist the police restraint. The weight of the evidence supports the submission of Counsel Assisting that:

> *'It could not reasonably be accepted ... that Michael's degree of resistance when he first entered 29 Herbert Street had not lessened by the time Senior Constable Douglas arrived and the second dose of droperidol was administered. While there were plainly periods of alternating calm and struggle, the Court may find that Michael's degree of resistance diminished significantly over the course of the restraint. By the time Senior Constable Douglas arrived, Michael was hardly moving'.*

Did the police officers apply 'weighted restraint'?

478. A related issue was whether during the restraint period, the police officers applied the pressure of their body weight onto Michael's torso.

479. In her evidence, Probationary Constable Smith denied that at any point she had applied her full body weight across Michael's body. Counsel for the NSW

Commissioner of Police referred to this evidence in her submissions, stating that there was not sufficient evidence to make a finding that Probationary Constable Smith '*applied her full weight or some of her body weight for any particular time of the prone restraint or for the whole period of the prone restraint'.*

480. It might be expected that footage from the BWV footage would assist the court to reach a finding on this point. Unfortunately, it does not. As submitted by Ms Burke, at times the footage captures images of Probationary Constable Smith in positions where it is unlikely that she was applying her body weight to Michael's upper or lower torso. But for the most part it cannot be determined if she was lying on Michael throughout the period of restraint, or merely leaning over him.

481. Nevertheless, there is eyewitness evidence that at various times, Probationary Constable Smith did apply her body weight to Michael's torso.

482. According to Tanya Waugh, in the initial period of prone restraint Probationary Constable Smith did not do so. However, Tanya asserted that at later stages Probationary Constable Smith had '*full body contact'* across Michael's upper back.

483. Peter Gort was also of the impression that at certain times Probationary Constable Smith was using her body weight to stop Michael moving, as indicated in the following exchange:

> *Q. Did it appear to you she was using her full body weight at this time to try to keep Michael restrained?*
> *A. I believe so.*

484. At the point when Paramedic Baker arrived, Peter's impression was that:

> *' …. the police had applied their full weight to the patient and were bracing with their feet to assist.'*

485. He clarified that Senior Constable Gough appeared to be using his body weight across Michael's upper torso, and that at times Probationary Constable Smith appeared to be applying some of her body weight to Michael's lower back.

486. In contrast however, Paramedic Summers did not think that either police officer had imposed their weight on Michael. According to Paramedic Summers, Probationary Constable Smith:

> *' … was not holding the patient in any way. [Michael] was moving her around quite considerably'.*

487. And twelve minutes later, when Senior Constable Douglas arrived, he did not think that any physical weight was being applied to Michael's body other than to his hands.

488. The above evidence supports the conclusion that Probationary Constable Smith applied her weight to Michael's upper back for some at least of the period of prone restraint. However, I accept the submission of Counsel Assisting that it cannot be precisely identified:

> *' … the exact position of Probationary Constable Smith, the duration of time she placed weight on Michael's torso and the degree of body weight that was applied at any given time'.*

489. Beyond the finding that weight was applied to Michael's upper back for some at least of the restraint period, the extent or duration of that weight cannot be determined.

## PART C: THE ISSUES AT THE INQUEST

490. The finding that by approximately 9.07pm Michael was relatively immobile is at the centre of the issues which were identified at paragraph [19]. With greater particularity, those issues are:

- whether it was consistent with NSW Police Force policy and training for the police officers to maintain Michael in the prone position instead of moving him into a safer position on his side or back

- whether it was appropriate for the ambulance officers to administer a repeat dose of droperidol at 9.08pm

- whether it was appropriate for the ambulance officers to decide not to undertake close observations of Michael for signs of clinical deterioration

- whether it was appropriate for the ambulance officers not to use monitoring equipment, in particular a pulse oximeter

- whether the ambulance officers ought to have communicated to the police officers the risks of maintaining Michael in the prone position.

**Did the police officers comply with policy and training, by not moving Michael out of the prone position?**

NSW Police Force training on prone restraint

491. I have outlined at paragraphs [302]-[314] above the evidence of Sergeant William Watt and Chief Inspector Chris Hanlon, concerning the training which NSW police officers receive on the use of force.

492. In brief, police are taught that in deciding whether to use force against a person, officers must assess the level of resistance met and weigh this against the amount of force required to control the situation. As Sergeant Watt explained, this requires officers to make ongoing evaluations of the risk of causing injury, against the need to maintain control.

493. Sergeant Watt had reviewed the BWV footage in preparation for this inquest. In his statement he said that the restraint methods used by the two police officers were consistent with NSW Police Force training and policy.

494. However at the inquest, he accepted that if it were found that the officers did not move Michael out of the prone position as soon as this was safely possible, this would be a non-compliance with their training.

495. Counsel Assisting questioned Sergeant Watt further about this:

> *Q. Would you agree that it would not be consistent with the training of an officer not to have rolled Michael onto his side as soon as possible?*
> *A. As I said, it's conditional on being able to maintain control … As a general principle throughout other training, they are trained that wherever possible they should remove them from the prone position as soon as practicable or possible, depending on the wording.*
> *Q. And equally, you therefore agree that if it were not what was done, and that will be subject to Her Honour's factual analysis, then that would be non-compliant with the training?*
> *A. It – arguably it can be, yes.*

And shortly afterwards:

> *Q. But on the assumption that Her Honour finds that it would have been possible to roll Michael onto his side on the basis of the evidence earlier, then would you agree that that would be non-compliant –*
> *A. Should –*
> *Q. - with the training?*
> *A. Should that finding be made, then yes, it could be considered to be.*

496. The training to which Sergeant Watt referred contains some guidance regarding the risks of prone restraint. The guidance is dispersed over various documents, and can be summarised as follows.

497. The NSW Police Force's *Handcuffing Manual* instructs that if a person is handcuffed in the prone position, officers '*will need to roll the subject onto their side (recovery position) as soon as possible and make constant observations of their welfare'.* The Manual does not provide any guidance on the type of observations that are required.

498. The *Taser Standard Operating Procedures* [the Taser SOPS] contain a brief section on positional asphyxia at Section 10.1 and following. Within this section it is stated that positional asphyxia is most likely to occur '*when the position of the body interferes with the person's ability to breathe*'.

499. Within the Taser SOPs, a risk factor for positional asphyxia is identified as *'restraint of the individual in a prone, face down position when handcuffed'*. Other risk factors include when the person *'is highly stressed'* and is offering among other things, violent resistance. The Taser SOPs instruct police officers to '*closely monitor the subject's breathing',* and to immediately roll the person to their side once they are secure and handcuffed.

500. Finally, the *Oleoresin Capsicum Defensive Spray Manual* directs police officers to adhere to a number of guidelines, which include the following:
    - if you subdue and restrain a subject who is violent, free the subject when operationally safe allowing them to breathe freely;
    - where practicable, roll the subject onto their side as soon as possible;
    - do not leave a restrained person lying on their stomach or in any position where pressure is exerted onto the stomach or diaphragm; and
    - always monitor the subject closely until restraint devices are removed.

501. At the inquest, Senior Constable Gough displayed a general awareness of these principles. However, he could not recall if he had received any training about the risks of restraining a person who has mental health issues. Nor could he recall any training on the need to watch out for altered sounds of the restrained person's breathing.

502. Probationary Constable Smith expressed only a general awareness that '*control is the first point and then putting them in a recovery position once you've got control'*. She described her training on the risks of prone restraint as '*very limited'*.

Conclusion: police officers' compliance with policies on prone restraint

503. I find that a risk assessment properly performed, which evaluated the degree of resistance Michael was offering, would by 9.07pm reasonably have led to the conclusion that it was no longer necessary to maintain him in the prone position. From that point onwards, consistency with NSW Police Force training required that he be moved into a safer position onto his side or his back. The three police officers' failure to do this amounted to non-compliance with the abovementioned training materials and operating procedures. I base this conclusion on the following factual findings:

    - that NSW Police training is that persons who have been placed in the prone restraint are to be moved onto their side as soon as it is safe to do so

    - that by 9.07pm, Michael had ceased struggling, was barely moving, and was not presenting a risk of harm to anyone else.

504. In my view, the risk assessment performed by Senior Constable Gough and Probationary Constable Smith was flawed. It is apparent that they continued to hold the subjective impression that Michael's level of resistance required prone restraint, well past the point where this was objectively not the case. By 9.07pm it was apparent to all others in the room (save for Paramedic Summers), that Michael had ceased to struggle and was lying relatively still.

505. As to why the police officers' subjective perception did not align with the objective reality, this is beyond my capacity to say.

506. However, I fully accept that by 9.07pm Senior Constable Gough and Probationary Constable Smith were physically and emotionally depleted. They had been involved in a volatile struggle for almost forty minutes. Until Senior Constable Douglas arrived (by which time Michael was largely immobile) they were forced to manage this extremely challenging situation without any police back up. This practical reality must be acknowledged.

507. The likely impact upon the two officers was described in the evidence of Chief Inspector Hanlon and Sergeant Watt, which provided valuable context to the two officers' subjective risk perception. Chief Inspector Hanlon explained that for first responders, and indeed for any person, a physical altercation typically creates a state of hyperarousal which can distort their perception of what is actually occurring. Chief Inspector Hanlon speculated that Senior Constable Gough and Probationary Constable Smith had maintained a '*use of force'* approach because:

‘ … *they didn’t believe that circumstances had changed; even if they had, they hadn’t been I guess cognisant of those changes.’*

508. He gave this further evidence:

> *‘ … once you go into that hyperarousal state .. it’s very hard for police to then break out of that if the threat to them is still persisting … that’s a normal human response to managing a situation or a crisis …’*

509. As I have noted, Sergeant Watt gave similar evidence that perceptual distortions created by stressful incidents can cause an officer to perceive that they are at risk, in circumstances where objectively they are not.

510. It is very feasible that the two officers’ subjective perception of the risk which Michael presented was distorted by the prolonged period of physical and emotional stress to which they had been subject.

511. Perhaps exemplifying this phenomenon, Senior Constable Douglas had a very different risk perception to that of his two colleagues. He had been spared the physical and emotional toll of an extended physical struggle with Michael. Unburdened by this, he was in a position to recognise that in fact Michael was lying still and was effectively restrained.

512. On this point, Sergeant Watt gave the following evidence:

> *Q. And you agree also, don’t you, with the evidence that Chief Inspector Hanlon gave that someone coming into the situation in circumstances where he hasn’t been involved in the previous physical altercation, is likely to be in a good position to identify the true level of risk, because he has not been subject to those matters that may lead to perceptual distortions?*
> *A. Yes I would agree with the precept generally, but again it comes down to the individual.*

513. It is disappointing that given this comparative advantage, Senior Constable Douglas did not take the opportunity to assist his police colleagues, by encouraging them to assess whether Michael might now be moved from the prone position.

514. Regarding this, Chief Inspector Hanlon said the following:

> *‘ … there was an opportunity for [Senior Constable Douglas] to take some alternative steps and it would be based on [Senior Constable Douglas’] perception about how real and the threat was. … certainly if in his evidence*

*he says that he saw him, Mr Peachey, not moving then certainly he could've re-evaluated, there was an opportunity for that at that stage'.*

515. And Sergeant Watt gave this evidence:

> *Q. …. Do you not agree that even though [Senior Constable Douglas] was coming in a support role – if I can put it that way, the way he appeared to understand it – he was still obliged to apply STOPAR decision-making, was he not?*
> *A. To any decisions that he's making, yes he should be.*

516. In summary, I accept that Senior Constable Gough and Probationary Constable Smith held a belief that prone restraint of Michael continued to be necessary, and further that this flawed assessment was likely associated with their state of physical and emotional exhaustion. But while this may help to explain their failure to move Michael into a safer position, it cannot alter the fact that their omission to do so represented a non compliance with NSW Police Force training and procedures.

517. And to the extent that Senior Constable Douglas was in a position to provide a better assessment of the actual risk, his failure to initiate this necessary discussion with his colleagues fell short of what might have been expected.

518. The evidence supports this further conclusion: that contributing to the three officers' failure to prioritise Michael's safety was their insufficient appreciation of the risks of prone restraint. The evidence strongly suggests that they underestimated, or in Senior Constable Douglas' case, did not consider at all, the risk to Michael of maintaining him in the prone position.

519. For this reason I have concluded that there is a need for policies and training to urgently address this specific knowledge gap. This is discussed later in these findings.

520. In closing, it was perhaps understandable for the three police officers to cite the clinical qualifications of the ambulance officers, when asked why they had not proactively discussed whether Michael should be moved out of the prone position.

521. But as highlighted by Sergeant Watt in his statement and evidence, police officers are trained that when using force they are obliged to continuously evaluate the risk of causing injury against the need to maintain control. I take this to mean that regardless of the presence of health professionals, police officers must continue to assess whether their use of force is appropriate and is within NSW Police Force guidelines.

522. Therefore, the presence of health professionals did not remove from the police officers their duty to carry out that continuous assessment.

**Was the care and treatment provided by the NSW Ambulance paramedics adequate and appropriate?**

523. I now examine the adequacy of the care and treatment which Paramedics Summers and Baker provided to Michael.

524. There is no dispute that appropriate paramedic care was given to Michael after it was realised that he had stopped breathing. The expert opinion, which I accept, is that despite the tragic outcome, the paramedics' response to this crisis was consistent with NSW Ambulance training and policy.

525. The inquest focused upon the earlier treatment provided by the paramedics, in particular whether it was appropriate for them to have:

a) administered a repeat dose of droperidol;

b) restricted their monitoring of Michael's clinical condition;

c) not communicated to the police team the desirability of moving Michael out of the prone position.

526. The two paramedics gave extensive evidence on these matters. I have considered their evidence carefully, against the background of relevant NSW Ambulance policies and protocols. I have also had regard to the expert evidence of the specialist witnesses Adjunct Associate Professor Tony Hucker, Associate Professor Jason Bendall, and Mr Sean Mutchmor. All three provided reports to the inquest. In addition, they gave oral evidence in a conclave.

527. Within their respective areas of expertise, pharmacologist Professor Alison Jones and psychiatrist Dr Andrew Ellis also contributed comment on the question of whether it was appropriate for the paramedics to have administered a repeat dose of droperidol.

<u>The relevant NSW Ambulance polices and protocols</u>

528. I will first outline certain policies and protocols of NSW Ambulance which are relevant to the paramedics' decisions that night. The primary ones are as follows.

529. **Protocol MH6: Behavioural Disturbance – Mental Health** which relevantly:

- authorises paramedics to administer chemical sedation to a behaviourally disturbed patient in order to '*reduce the risk of harm and to facilitate assessment, treatment and transport to hospital';* and
- at a number of points, reminds paramedics to '*remain vigilant and visually monitor the patient for signs of deterioration'* whilst they are under physical restraint.

530. **Pharmacology 241 Droperidol**. Droperidol is a sedative drug which is commonly used to manage behaviourally disturbed patients, because it induces tranquilisation and sedation. The Pharmacology 241 protocol cautions paramedics that droperidol may cause a fall in blood pressure and will increase the effects of other drugs which depress the central nervous system, including midazolam.

531. Pharmacology 241 also instructs paramedics that after an initial 10mg dose of droperidol, a repeat 10mg dose may be given after 15 minutes, if the patient continues to be behaviourally disturbed.

532. **Pharmacology 219 Midazolam.** Midazolam is a benzodiazepine used to reduce anxiety and to induce sedation. This instruction authorises paramedics to administer it in between initial and repeat doses of droperidol.

533. NSW Ambulance's *2021/2022* **Clinical Key Performance Indicators**. This document advises that: *'The best tool available for all clinicians for assessing and monitoring illness/injury, regardless of the setting, is repeated, accurate physiological observations'*. It permits paramedics to conduct visual observations without the use of monitoring equipment, where a patient is '*combative or non-compliant'*. In such cases, if the patient has acute severe behavioural disturbance, a minimum of two full sets of core vital observations must be recorded.

534. The '**Between the Flags'** system is a reference guide used in NSW public health systems. It is designed to identify clinical signs of deterioration over time, by measuring and recording the patient's vital signs. The 'Between the Flags' fundamentals are adopted by NSW Ambulance.

535. Of relevance, the Between the Flags system dictates that a patient whose respiratory rate exceeds 30 breaths per minute be classified as within the *'red zone'*, and must receive observations at five minute intervals.

536. **Protocol A4: Medication Administration** requires that a patient's response to each dose of medication be monitored by way of a full set of physiological observations, consisting at least of pulse rate, respiratory rate and blood pressure.

537. **Protocol P6: Incident in the Control of Another Agency.** This protocol applies where, as here, paramedics are called to assist a patient who is under the physical restraint of another agency. In such cases paramedics:

> *' .. must visually observe the patient for signs of clinical deterioration if safe and paramedics must communicate any clinical or patient safety concern to the agency responsible and document their concerns on the clinical record'.*

538. **Protocol MH1: Mental Health Emergency** provides that safety of the paramedics, patient and bystanders '*is the key priority'.* Similarly, NSW Ambulance's **Dynamic Risk Assessment** endorses *'the right of all paramedics to keep safe and make the decision not to enter a dangerous situation'.* It instructs paramedics to assess every scene for '*any possible risk or hazard that may cause harm to yourself, your colleagues or your patients'.*

539. Also of relevance, NSW Ambulance paramedics use an electronic Medical Record [eMR] to document details of the treatment they have provided. In Michael's case, the two paramedics were not able to enter contemporaneous details of their treatment into the eMR, because their computer terminal was located within their ambulance. The eMR records were entered by Paramedic Summers later that night, at Gunnedah Hospital.

540. As a final point, the timing of events recorded on the eMR does not align with that shown on Probationary Constable Smith's BWV camera. It is accepted by all parties that the timing on the BWV footage is accurate, and this is the timing which I have adopted.

<u>The treatment provided by the paramedics</u>

541. Paramedics Summers and Baker were involved in Michael's care from their arrival at 8.55pm until he was admitted to Gunnedah Hospital approximately an hour later. At all times when he was under their care inside the house, Michael was lying in the prone position.

542. Neither before entering the Gort's house, nor at any time inside, did the two paramedics discuss who would be responsible for assessing and monitoring Michael's clinical condition. Paramedic Baker told the court that on this occasion his colleague was the clinical lead, and thus had primary responsibility for this task. Therefore he did not turn his mind to what type and level of monitoring Michael required:

> *'No, there was no requirement to have a discussion. We both know our roles, and we know where that gets implemented'.*

543. Paramedic Summers did not disagree with this, but stated that she and Paramedic Baker were of equivalent rank and skill level, and therefore they would generally make a '*dual response'* as a team.

544. Again without prior discussion, Paramedic Baker appeared to have understood that his role would be to arrange for Michael's extrication from the house and into their ambulance. Therefore at times during their attendance, he was out of the living room getting various pieces of equipment ready.

545. The NSW Ambulance *Principles of Care* protocol requires that on arrival at a scene, paramedics conduct a '*primary survey'* of a patient, being an initial set of core physiological observations.

546. From the outset, Paramedic Summers had decided that she would '*stand off and visually observe Mr Peachey until the scene was under control'.* Her primary reason was her perception that due to Michael's levels of aggression, it was not safe for her to remain close to him or to apply monitoring equipment to him. Opting for visual observations only, she relied upon NSW Ambulance's *Clinical Key Performance Indicators* which as noted, permit this if a patient is '*combative or non-compliant'.*

547. Paramedic Summers' primary survey consisted of checking that Michael had a pulse, and measuring his capillary refill rate and his respiratory rate (his rate of breathing). To measure his rate of breathing she did not touch Micheal. Rather, she watched his back and counted its rise and fall as he breathed. The eMR reflects that she documented his respiratory effort as '*increased*', at 36 breaths per minute [bpm], and his respiratory status as '*normal'.* This observation was made at around 8.57pm.

548. It is accepted that the normal respiratory rate for an adult male is between 12 and 20 breaths per minute. At 36 bpm, Michael's respiratory rate put him within the '*red zone'* of the 'Between the Flags' system.

549. Why, in view of this elevated rate, did Paramedic Summers record Michael's respiratory status as *'normal'?* At the inquest she explained that Michael had been physically exerting himself, and therefore might be expected to have had an increased respiratory rate. Later in her evidence, she conceded that she ought to have recorded this as *'respiratory distress'* rather than '*normal respiratory status'*.

550. Meanwhile, at about 8.58pm Paramedic Baker injected a 10ml dose of droperidol into Michael's thigh muscle. He commented in his statement that Michael was *'still thrashing away'* while he administered this dose.

551. Less than 60 seconds later, Paramedic Summers drew up and administered a 5mg dose of midazolam. Paramedic Baker explained this was because they both considered that droperidol on its own would take too long to work.

552. According to the entry which Paramedic Summers later made in the eMR, the dose of midazolam was administered five minutes after the first dose of droperidol. But at the inquest Paramedic Summers acknowledged that this entry was incorrect, and that she had in fact administered the midazolam less than a minute after the initial dose of droperidol.

553. After this, Paramedic Baker went outside to start preparing the equipment needed to transfer Michael onto a stretcher. He collected a stretcher and mechanical restraints from their ambulance, and made a radio request to Tamworth for a second ambulance crew to assist them. These tasks took him outside the living room for a few minutes.

554. During this interval, Paramedic Summers performed a repeat set of partial observations. Again by observing the rise and fall of Michael's back, she measured his respiratory rate to be 52 bpm. This she recorded as *'mild respiratory distress'.* She said that she also felt Michael's pulse and found it to be '*fast'.* These observations were made at about 9.04pm.

555. Two minutes later Paramedic Baker can be heard on the audio of the BWV, asking if Michael's breathing was alright. Paramedic Summers replied: *'Yeah ... we've got good chest rise and fall'.*

556. On his return to the living room, Paramedic Baker heard his colleague advise that Michael's respiratory rate was 52 bpm. In his statement he commented that this rate is '*excessively high and can be used as an indicator for a deteriorating patient in conjunction with other vital signs'.* Nevertheless, he did not consider there was cause for immediate alarm, taking into account Michael's exertions in wrestling with police.

557. The paramedics performed no other class of observations. This was due, Paramedic Summers told the court, to '*the positioning of the patient and him acting aggressively'*. Michael's pulse and blood pressure were therefore recorded as 'u*nreadable*'.

558. Paramedic Baker did however resolve to get Michael into their ambulance as quickly as possible. He checked that Michael had a pulse, then began to attach soft cuff restraints to his ankles, readying him to be secured onto a stretcher. While doing this he observed that Michael *'had started to decrease in his*

*consciousness',* and that there was no movement at all through his body except for '*a little bit of resistance'* in his feet. It was now just after 9.07pm.

559. In her evidence Paramedic Summers agreed that by this time '*the patient's agitation was reducing … [he] had calmed to some extent and was no longer biting or grunting'*. This she attributed to the medication starting to take effect. As I have noted however, she insisted that at all times Michael was still moving his upper body.

560. Less than a minute later, Senior Constable Douglas arrived and took over Probationary Constable Smith's position alongside Michael's torso. In contrast with Paramedic Summers, he observed that the only part of Michael's body moving was his head '*going from side to side'*.

561. At 9.08pm, Paramedic Summers administered the repeat dose of droperidol. She commented in her statement that at this stage Michael was ' ... *still a bit combative. There were moments when he seemed calm, but also moments when he was agitated'*. In contrast however, Tanya Waugh told the court that although Michael had been moving prior to this repeat dose, '… *after that, is when he had stopped'*.

562. At 9.09.40pm, the BWV footage shows Paramedic Summers in a standing position and looking downwards, perhaps at Michael's body (which was not within the view of the camera). She then turned around and asked the other occupants of the room if they had any injuries. At 9.10.30pm she asked her colleague: *'How's his respiratory rate Derek? Is it still good chest rise and fall?'* Moments later, she said: '*Can I just have a look at his chest rise and fall, make sure he's breathing properly?'* She is seen bending over, presumably to get a closer look at Michael, and she then says: *'Yep'.*

563. After this, there is no evidence that any observations were made of Michael at all.

564. Instead, shortly after 9.11pm, Paramedic Summers can again be heard questioning others in the room if they had any injuries. The BWV footage shows that while asking this she moved away from Michael's vicinity. After this she is unseen but from the sounds that can be heard, she appears to be packing ambulance equipment into bags.

565. Notably, Paramedic Baker was not in the living room during this period, meaning that neither paramedic was positioned near Michael.

Michael is found to be unconscious

566. By 9.12.37pm Paramedic Baker was back in the living room and can be heard asking others if they have injuries. Twenty seconds later he can be seen looking downwards and calling Michael's name. A few seconds later he was joined by Paramedic Summers, who asked *'Is resus needed?',* to which her colleague replied: *'Yes I think so'.*

567. At 9.14.05pm, Paramedic Baker verbally confirmed that Michael was no longer breathing.

568. By this time a second crew of police officers had arrived. Still handcuffed and in the prone position, Michael was brought out of the house by four of the police officers.

569. As Michael was being brought outside, Paramedic Summers saw that he '*had suddenly become completely flaccid'.* The police officers put him face down onto the ambulance stretcher which was waiting at the front door. Paramedic Summers directed them to place him onto his back, which they did.

570. Michael had stopped breathing and was in cardiac arrest.

571. By this time, members of Michael's family had gathered outside and were waiting for him to come out. Stephen and Ben Peachey were there, as well as Jtaya Davis and Kylie Craig. Their feelings when they saw Michael being brought out limp and unconscious can only be imagined.

572. Both paramedics immediately commenced resuscitation efforts, with the assistance of police officers. Their efforts included cardiopulmonary resuscitation, use of a defibrillator, bag mask ventilation and insertion of an airway device. Michael was also given adrenaline, intravenous fluid and naloxone.

573. Michael was taken by ambulance to Gunnedah Hospital where further treatment was attempted, but it was to no avail. He never regained consciousness, and he was pronounced deceased at 10.10pm.

574. I turn now to an evaluation of the treatment which the two paramedics provided to Michael. Does the evidence support the claims of Paramedics Summers and Baker that their care of Michael was adequate? And was it in accordance with the policies and protocols of NSW Ambulance?

575. The court was assisted in this task by the evidence of the three paramedic experts referred to at paragraph [526] above.

The expert opinion: Michael's clinical condition

576. A very significant preliminary point made by the three paramedic experts was that by the time the two ambulance officers arrived, Michael was in fact critically ill. According to Associate Professor Bendall, a prolonged period of *'extreme activity, resistance wrestling [and] restraint'* had made him *'physiologically very abnormal',* and *'at risk of death right from the outset'.*

577. In his oral evidence Associate Professor Bendall graphically described Michael's likely condition at this stage:

> *' … I think Mr Peachey was on a serious downward spiral of critical illness … I'm not sure how reversible that was at that point'.*

578. Adjunct Associate Professor Hucker and Mr Mutchmor agreed, with the former stating Michael was '*very ill at the onset.'*

579. Michael's grave clinical condition was a very significant factor in the expert discussion which followed as to:

- whether it was appropriate for the paramedics to have administered the repeat dose of droperidol, and

- whether the paramedics undertook an appropriate level of monitoring of his clinical condition.

The expert opinion: the giving of medication

580. I have described above the administration to Michael of three doses of medication. These were droperidol at about 8.58pm; midazolam almost immediately afterwards, and a repeat dose of droperidol at 9.08pm.

581. It was not disputed that by administering a repeat dose of droperidol only ten minutes after the first dose, the paramedics contravened the NSW Ambulance *Pharmacology 241* protocol. This requires there be a 15 minute interval between an initial and a repeat dose of droperidol. The paramedics misstated on the eMR the interval between their administration of these two doses, as well as the interval between administering droperidol and midazolam. It can be accepted that in this respect, the standard of their record-keeping was inadequate.

582. However the main focus of expert discussion was on whether administering the repeat dose of droperidol was clinically appropriate.

583. Within the conclave there was firm agreement with Associate Professor Bendall's opinion that giving sedation to such a critically ill patient was '*very risky'.* He explained:

> *' .. there's a risk that anyone that's been restrained for a prolonged period of time is at much greater risk of being sedated, because I think … the metabolic acidosis means that your muscles are doing lots of work. What sedation then introduces is it changes your respiratory patterns and that introduces a thing caused acidosis …'*

584. Associate Professor Bendall explained that this is a condition in which acids build up in the blood, bringing about an accelerated heartbeat which can lead to shock and death.

585. But although there was full agreement as to this risk, the health experts were divided as to whether it was appropriate for Michael to have been given a repeat dose of droperidol.

586. In her evidence, pharmacologist Professor Jones said that she would probably not have done this, due to '*the risk of enhanced sedation and therefore the risk of enhanced respiratory depression'*. But her implied criticism was tempered by her recognition of the very challenging environment within which the paramedics were working: it was not a hospital setting and they had little control over their external circumstances.

587. Mr Mutchmor was not critical of the decision to give two doses of droperidol. Nor was Dr Ellis. But Dr Ellis expressed concern that there had been only limited observation of Michael's respiratory rate, pulse and peripheral perfusion. He commented:

> *' ... it may have been in hindsight more prudent to wait for a further period to observe additional response before proceeding to a second dose, and to have undertaken closer physical observations after the first dose'.*

588. The adequacy of the paramedics' observations and monitoring is addressed later in these findings.

589. Associate Professor Bendall considered that '*the clinical necessity for the second dose of droperidol is less clear'*. He himself '*may have done something different'*. He hypothesised that the paramedics had continued to perceive a behavioural disturbance, which caused them to consider that the additional dose was justified.

590. After viewing the BWV footage however, Associate Professor Bendall opined that the repeat dose was not required, since by the time it was given Michael appeared to have reached a reasonable degree of sedation. However he did not wish to be unfair to the paramedics, noting that they did not have access to a Sedation Assessment Tool. This is a scale which assesses and scores the patient's level of agitation and sedation after medication has been given.

591. Adjunct Associate Professor Hucker was firmly of the opinion that the repeat dose was not clinically justified. In his view, by that stage it ought to have been evident that Michael was sufficiently sedated.

Conclusion: the repeat dose of droperidol

592. The observations of Associate Professor Bendall and Adjunct Associate Professor Hucker that Michael was relatively still at the time of the repeat dose of droperidol accord with my finding of the facts. It is open to conclude that the medication previously administered had served its purpose, and the paramedics were now in a reasonable position to assess Michael's clinical condition without the need for further medication.

593. In light of this, and the unanimous acceptance of the risk associated with sedating a physically exhausted patient, there must be some doubt as to whether the repeat dose of droperidol was clinically appropriate.

594. However, it is fair to note the expert discussion which then followed. Should a reasonably competent paramedic have recognised the seriousness of Michael's clinical condition, and the consequent risk of giving him additional sedation?

595. Associate Professor Bendall provided nuanced comment on this question. He queried whether the average paramedic would have appreciated the dangers of administering additional sedative medication, in the '*highly unusual'* circumstances of a patient in Michael's situation. He explained that by this he meant, a patient who was exhausted due to a prolonged period of restraint.

596. Mr Mutchmor agreed that it would be difficult for most paramedics to identify '*from a metabolic standpoint'* how very ill Michael was.

597. However, Adjunct Associate Professor Hucker thought that a reasonably competent paramedic ought to have suspected that Michael was very unwell and hence at heightened risk from sedation, although the paramedic might not necessarily understand the complexities of the physiology.

598. Given the divergence of expert opinion, I do not believe it is open to find that in administering the repeat dose of droperidol, the conduct of the two paramedics was outside responsible clinical practice.

599. Nevertheless, it was very clear that Associate Professor Bendall recognised a need for improvement in the paramedic care of sedated patients. He told the court that there were *'elements of Mr Peachey's case that have already informed NSW Ambulance'.*

600. Later in these findings I address the work which has been undertaken in this area by NSW Ambulance. It is clear that the tragic circumstances of Michael's case have driven significant changes in NSW paramedic procedures.

601. I now consider the second question, as to whether the observations and monitoring which Michael received were adequate.

The adequacy of observations and monitoring

602. This part of the findings examines whether, given the information they held about Michael's condition, Paramedics Summers and Baker adequately monitored him for signs of deterioration.

603. A related question is whether they ought to have advised the police officers that Michael needed to be placed in a safer position.

604. I have summarised above at paragraphs [541]-[565] the steps which the paramedics took to monitor Michael's clinical condition.

605. Taking Paramedic Summers' evidence at its highest, it may be accepted that she checked that Michael had a pulse on a few occasions (although the results were not recorded in the eMR), and checked him for capillary refill on a few occasions (the results of which were likewise not recorded in the eMR). At around 9.08pm Paramedic Baker also checked that Michael had a pulse.

606. The paramedics also asserted that they had visually monitored Michael's respiratory rate in a vigilant manner. At the inquest Paramedic Summers gave this evidence:

> '*I had visual observations of Michael throughout the duration of this time. Visual observations are recording his chest rise and fall and his respiratory rate and effort'.*

607. Paramedic Baker agreed:

*'I believe we vigilantly monitored with what was safe at the time.'*

608. But on only two occasions does the eMR record the result of these observations. And although the BWV footage indicates that on two further occasions Paramedic Summers looked at Michael's back for the rise and fall of his chest, there is no evidence that she did so after 9.10.49pm.

609. Busying themselves with other tasks, it appears that neither paramedic observed Michael again until 9.12.53pm, when Paramedic Baker realised that he was unconscious.

The adequacy of observations and monitoring: the expert evidence

610. I have noted the opinion of the paramedic experts that Michael was critically unwell by the time Paramedics Summers and Baker arrived. In circumstances where the paramedics had decided against mechanical monitoring of his condition, the experts fully concurred with Adjunct Associate Professor Hucker's comment that:

> *' … adding sedation to an exhausted and prone restrained (and maybe drug affected) patient is dangerous without constant and close clinical monitoring'.*

611. What would have constituted adequate monitoring of Michael's condition? In his supplementary report, Mr Mutchmor provided context to this question:

> *'In a situation where paramedics were able to have safe and unaffected access to a patient, it is in most cases beneficial to be able to utilise diagnostic and monitoring equipment …*
>
> *Equally, it is in some cases appropriate to limit the type of clinical assessment or use of equipment,* if paramedics on scene determine *that the risk of those limitations is outweighed by the real or potential risk of attempting to do so.'* (underscore added).

612. Associate Professor Bendall reinforced this safety message: the position of NSW Ambulance, he said, was '*that we don't expect the paramedics to undertake activities that they believe to be unsafe'*.

613. Turning to the specific actions of the paramedics, Adjunct Associate Professor Hucker opined that they had not provided adequate monitoring of Michael. Having reviewed the BWV footage and audio, he considered that from the moment the paramedics arrived, and despite ' ... *a potential risk there'*, Michael was well-controlled by the police and was not moving aggressively. Thenceforth, since monitoring equipment was not being used, Michael ought to have received

'*close and constant monitoring'* rather than the '*occasional'* observations that he did receive. This would have involved one of the paramedics stationing themselves at Michael's head, watching his colour and *'looking at the pattern of his breathing very, very closely'.*

614. Adjunct Associate Professor Hucker went on to express strong criticism that the paramedics had recorded Michael's respiratory rate of 52 bpm as '*mild respiratory distress'*. This was *'a critical underestimation'* of his condition. Nor was he impressed with their decision not to apply a pulse oximeter to measure Michael's oxygen levels. Merely counting the rate of Michael's breathing was just '*one component of a respiratory status assessment and tells you nothing about oxygenation'.*

615. By way of contrast, in his report Mr Mutchmor opined that the two paramedics, presented with a difficult and dangerous situation, did '*adequately monitor Mr Peachey's clinical condition through visual and limited physical assessments, and did so to the degree they felt safely able to do so'.* But he acknowledged that this opinion was based upon the premise that the paramedics had reason to be concerned about their safety, and had therefore decided to restrict the scope of their observations.

616. Mr Mutchmor told the court that he had accepted this premise because of what he could hear on the BWV footage, wherein the two police officers repeatedly instructed Michael to *'stop'* and to *'calm down'*. He had interpreted these instructions as indicating that Michael was about to act aggressively, and therefore presented an ongoing risk of harm. Hearing these words, the paramedics might reasonably have made certain judgements about '*what assessment implementation they could have managed at the time'.*

617. But when the BWV footage was played in court during the expert conclave, Mr Mutchmor agreed that at least from 9.06pm onwards Michael's levels of activity had significantly declined. So too had the frequency of the above instructions from police. And when Mr Mutchmor was asked to assume that by this time, eyewitnesses had noted minimal movement from Michael, he said that monitoring at least in the form of pulse oximetry could have been applied.

618. For his part, in his report Associate Professor Bendall had concluded as follows:

> '*I formed a view that the patient was being clinically observed consistently throughout the case albeit without the use of quantitative equipment.'*

619. Like Mr Mutchmor, Associate Professor Bendall had based his assessment on the assumption that due to his acute behavioural disturbance, Michael posed a significant and ongoing risk of harm.

620. But after viewing the BWV footage in court, Associate Professor Bendall agreed that from at least 9.07pm Michael had reached a reasonable degree of sedation and was barely moving. He considered that the associated risk to the paramedics had likewise diminished:

> *'I've heard the evidence that the paramedics formed a view that they were at ongoing personal risk and that has led them to the decisions not to do – but I agree that the risk at the time of … the subsequent dose of sedation and the time of needing resuscitation, that the risk was definitely lower than at the start when they walked in the door'*.

621. On this basis, Associate Professor Bendall concluded that by the time Michael had received the repeat dose of droperidol it would have been safe to conduct closer monitoring. Like Adjunct Professor Hucker, in his opinion the most important monitoring would have been of Michael's oxygen levels, which he suspected had become '*critically low'*. Pulse oximetry:

> *'… would have been a more helpful and higher priority activity than other aspects of care and preparation for extrication. The earlier application of a pulse oximeter would have provided richer information on Mr Peachey's respiratory status, his heart rate and to some extent his perfusion … This may have facilitated earlier detection of airway obstruction, respiratory failure, hypoxaemia and cardiac arrest.'*

622. When he was asked if the paramedics ought reasonably to have assessed that it was safe for pulse oximetry by this time, Associate Professor Bendall replied:

> *'It's a matter of the judgment of was it safe to do so. But I get increasing certainty the longer the time frame goes.'*

623. In summary, Associate Professor Bendall was clear in his evidence that the degree of risk diminished over time. Similarly, Mr Mutchmor conceded that from 9.06pm onwards Michael's activity levels had declined, such that a pulse oximeter could have been applied to measure his ability to breathe.

624. It is thus incorrect to submit, as did Counsel for the paramedics, that Adjunct Associate Professor Hucker was *'the only expert who disagreed with the paramedics' own assessment of risk'*.

Conclusion: the adequacy of observations and monitoring

625. The evidence supports the submission of Counsel Assisting that the paramedics did not adequately monitor Michael's condition. They had been aware since

9.03pm that Michael's respiratory rate had passed into the *'red zone*'. Despite this they did not undertake closer monitoring which should have included pulse oximetry. The expert evidence was unanimous that pulse oximetry is a vital tool in measuring a patient's respiratory deterioration, and that in Michael's case it could and should have been applied at least by the time of the repeat dose of droperidol. In this respect the paramedic care of Michael fell short.

626. As for the observations that were in fact undertaken, in his evidence Adjunct Associate Professor Hucker described these as '*occasional only'*. This description is apt. The observations they undertook could in no way have been characterised as the '*repeated, accurate physiological observations'* which paramedics are instructed to undertake in NSW Ambulance's *Clinical Key Performance Indicators*.

627. Nor is there evidence that the paramedics attempted to comply with *Protocol A4: Medication Administration* (which would have required a set of physiological observations after the repeat dose of droperidol), apart from Paramedic Summers' evidence that she looked at the rise and fall of Michael's back. Furthermore, during the critical minutes before it was realised that Michael was not breathing, it does not appear that any monitoring was occurring at all.

628. I do not accept the evidence of Paramedic Summers that the degree of risk precluded herself and Paramedic Baker from performing more extensive observations, in particular applying a pulse oximeter. It ought to have been apparent that from 9.07pm onwards Michael was almost immobile. There was no reasonable basis to believe thereafter that the risk of approaching him to monitor for signs of deterioration was unacceptable.

629. It was submitted on behalf of Paramedics Summers and Baker that the approach they took to monitoring was consistent with their training as to the paramount importance of safety. Consequently, it was argued, the monitoring which they did perform was adequate, having regard to their perception of the risk to themselves.

630. I do not accept this proposition. The primacy given to safety in paramedic training may explain why Paramedics Summers and Baker did not perform a higher level of monitoring. But it cannot ground an assessment that the monitoring which they did perform was adequate. I have identified at paragraphs [625]-[628] the respects in which it was not.

631. The paramedics' subjective but objectively flawed perception of risk does not provide a basis to conclude that their response was appropriate. As I have found, the police officers' subjective perception of risk was similarly flawed (see paragraphs [504] and [518] above). Yet it was not urged by Chief Inspector

Hanlon or Sergeant Watt that a response based on such a perception, if objectively flawed, would render that response appropriate.

632. In my view, similar reasoning should apply to the response of the ambulance officers. Their subjective risk assessment could not make their response one which was compliant with NSW Ambulance policy and training.

Communicating the need to move Michael out of prone restraint

633. At no stage while they were in the Gort family's living room did Paramedics Summers and Baker speak with the police team about the clinical risks of keeping Michael in the prone position.

634. At the inquest there was full concurrence with the opinion of Associate Professor Bendall that:

> ' … *prone restraint is undesirable under any circumstances and … should be for the shortest duration that is physically possible. I think that's well understood as a principle.'*

635. Associate Professor Bendall added that in situations of restraint, health professionals needed to communicate the clinical risk '*as a priority'* to those who were restraining the patient.

636. Adjunct Associate Professor Hucker agreed. From his review of the BWV footage he estimated that by 9.07pm Michael's respiratory rate had reached 60 bpm. At this point, he said, Michael ought to have been '*immediately repositioned to the lateral position or the supine to make it mechanically easier to breathe'*.

637. Mr Mutchmor concurred that it would have been very important to move Michael out of the prone position '*as soon as it was safe to do so'*. Accepting that by 9.07pm Michael was barely moving, he agreed that '*it could have been safe'* at that point; and further that the paramedics needed to be communicating to the police officers the clinical risks if Michael was not moved.

638. This obligation is reflected in NSW Ambulance Protocol P6, as follows:

> *'If the patient is physically restrained by the other agency, paramedics must visually observe the patient for signs of clinical deterioration if safe and paramedics must communicate any clinical or patient safety concern to the agency responsible and document their concerns on the clinical record'.*

639. I have not overlooked evidence from the BWV audio that at 9.12.18pm Paramedic Baker asked the police team: '*You guys think you're up to getting him onto the stretcher?*' The reply from Probationary Constable Smith was that another police crew was on its way, to which Paramedic Baker responded: *'Right, right yeah we'll wait until, yeah'*. It could not be submitted that this cursory exchange met the paramedics' obligation to '*communicate any clinical or patient safety concern to the agency responsible'.*

640. At the inquest the paramedics were asked why they had not done this.

641. Convinced that Michael's aggression was persisting, Paramedic Summers insisted that moving him from the prone position would have involved an unacceptable risk to those in the room. This was why she had not raised the subject with Paramedic Baker or with the police officers:

> *Q. Do you not agree that it was important to communicate to the police not just to check whether Michael was breathing but that because of his potential respiratory compromise he needed to be put on his side as quickly as possible?*
> *A. Yes.*
> *Q. And so you should have told the police that in order to comply with this protocol, shouldn't –*
> *A. If we got that assessment. We didn't get past Michael being in a controlled state.*

642. Paramedic Baker's reason for not raising this concern was somewhat different. Unlike his colleague, he was in general agreement that from 9.08pm onwards Michael's behaviour had calmed. He had also noticed Michael's decreasing consciousness and relative lack of movement.

643. Counsel Assisting therefore asked Paramedic Baker if there had not been an urgent need to place Michael into a safer position:

> *Q. … one of the things that Mr Hucker says is that once Mr Peachey's respiratory rate was identified as being 52, at that point Mr Peachey should have been positioned to the lateral position or in a supine position to make it mechanically easier to breathe. Do you agree with that or disagree?*
> *A. I agree with that and that's what was taking place by extricating him.*
> *Q. Did you consider whether he should be restrained in the lateral position rather than in the prone position at that point in time?*
> *A. Yes, by getting him on the stretcher, that was the whole idea to put him in the lateral position …*

644. I do not suggest that Paramedic Baker ought not to have been planning for Michael's transfer onto a stretcher. It is clear that he anticipated this would assist them to provide him with a higher level of monitoring. But in hindsight it appears that in focusing on this task, he failed to perceive the more urgent priority of placing their patient onto his side. Notably in the opinion of Associate Professor Bendall, taking immediate steps to address Michael's respiratory compromise:

> *' … would have been a more helpful and higher priority activity than other aspects of care and preparation for extrication ….'*

645. I conclude that Paramedic Summers and Paramedic Baker did not take appropriate steps to advocate that Michael be moved out of the prone position. In this they failed to comply with the above NSW Ambulance Protocol P6, which required them to:

> *' ..communicate any clinical or patient safety concern to the agency responsible [for restraint] and document their concerns on the clinical record'.*

**Conclusion: the adequacy of the paramedics' care**

646. It is fully accepted that paramedics must have regard to their own safety in making clinical decisions. And I have no reason to doubt that Paramedic Summers did believe that it was not safe for her to undertake closer monitoring of Michael's condition.

647. I also accept there is an element of hindsight thinking in the conclusion that Paramedic Baker ought to have placed a higher priority on moving Michael out of the prone position, rather than getting him onto the stretcher.

648. Nevertheless when the evidence is viewed in its totality, it is apparent, particularly in the case of Paramedic Summers, that the paramedics' subjective understanding of their risk exceeded the actual degree of that risk. This led to the result that their clinical care of Michael that night was inadequate.

649. In the context of the police officers' response I earlier raised the question why, as time went on, their assessment of the risk level exceeded its actuality. A similar question arises in relation to the paramedics' response.

650. The paramedic experts were asked if they could offer any insights on this question.

651. In their responses Associate Professor Bendall and Mr Mutchmor underlined the practical challenges which the paramedics faced. Two generalist paramedics

were working in *'an incredibly complicated situation'.* Associate Professor Bendall surmised that they would have faced a multitude of stressors, including:

> *' … a hostile environment, multiple police, bystanders, people injured, and … the recognition that Mr Peachey was highly agitated, unwell and needing to move, and all of those elements would continue to take away pieces of bandwidth, and you can't get any more of it is I think the point to make'.*

652. Similarly, Adjunct Associate Professor Hucker spoke about the difficulty first responders face in cognitively '*stepping back'* from the turmoil of the crisis to which they have been called. Describing the paramedics' response as '*a graphic illustration of the danger of perceptual distortions',* he went on to say:

> *' …Michael had been very agitated, everyone is heightened and there's a momentum of care that is maintained ... we've had this very agitated young person that we need to keep sedated for our safety and their safety. But there comes a point where that needs to be assessed and I think, I didn't see that here'.*

653. Adjunct Associate Professor Hucker acknowledged that close and near-constant monitoring of Michael that night would have been challenging with just two paramedics, but the risks for Michael were *'very significant'* and *'we have to make sure we apply that level of monitoring'.*

654. These insights are similar in nature to those offered by Chief Inspector Hanlon, when he was asked about the challenges which police first responders face when assessing risk. I accept that the practical challenges and the highly charged atmosphere likewise contributed to the two paramedics' flawed perception of risk that night.

655. In my view however, the paramedics' flawed risk assessment was equally the result of their inadequate understanding of the high clinical risks associated with sedation of a patient who is being restrained in the prone position.

656. Certainly this was a matter of concern for Associate Professor Bendall, who expressed the opinion that there was an under-appreciation among paramedics of the high need for vigilance in such circumstances. Associate Professor Bendall's extensive career as a paramedic, paramedic educator, and now as Clinical Director of Medical Services at NSW Ambulance, merit the significant weight which I attach to his opinion on this issue.

657. This evidence provides a firm basis for specific proposals made by Counsel Assisting, which are discussed below.

Could better paramedic care have made a difference?

658. This was naturally a question of great importance to Michael's family. Could his tragic death have been avoided if he had been more closely monitored, or had been placed into a safer position?

659. Adjunct Associate Professor Hucker responded that the answer to this question could not be known. Michael however should have been given '*the best chance for survival'*, by being closely monitored and moved out of prone restraint as soon as possible.

660. Associate Professor Bendall agreed that ideally ' *… deterioration would have been detected earlier and he would have been put on his side earlier'.* He thought that with monitoring:

> *' ... there would have … been a detection of a rapid deterioration which would have potentially led to interventions.'*

661. Nevertheless, he continued:

> *'I think it would have been very difficult to retrieve Michael from that spiral of demise.'*

662. Mr Mutchmor agreed that ' … *it would have been beneficial to do everything as early as practicably possible'*. Even so, he *'would not be able to suggest that there would have been a change if that had happened earlier'.*

663. I accept that it cannot be known if a more appropriate level of care would have prevented Michael's tragic death. But Michael was at the least entitled to be given the best chance of survival possible.

664. Later in these findings I address certain proposals that were made for recommendations to the NSW Commissioner of Police and to the Commissioner and Chief Executive of NSW Ambulance, arising out of these findings.

665. I now turn to the issue of the cause and manner of Michael's death.

## PART D: THE CAUSE AND MANNER OF MICHAEL'S DEATH

The reports of Dr Brouwer and Professor Cordner

666. Two days after Michael's death, forensic pathologist Dr Isabel Brouwer performed a comprehensive autopsy. She carried out a thorough external and

internal examination and reviewed test results, witness statements, and the footage obtained from Probationary Constable Smith's BWV camera.

667. Dr Brouwer produced an expert report in which she concluded that the cause of Michael's death could not be ascertained. She did however identify a number of factors which may have contributed to his death. These were:

- sustained restraint in the prone position with weight on the torso including the chest
- the administration of droperidol and midazolam
- Michael's sustained physical exertion
- the impact of oleoresin capsicum spray
- psychosis.

668. At the inquest Dr Brouwer added that the impact of having been Tasered could also be considered as a contributor to Michael's death.

669. Of these numerous factors, Dr Brouwer stated in her report that she could not determine which '*were the actual ones which had contributed to his death'*; nor '*which one has contributed less or more'.* Therefore she recommended that the cause of Michael's death be given as unascertained. She adhered to this opinion in her evidence at the inquest.

670. Anticipating that Michael's case would be medically complex and controversial, Dr Brouwer recommended that a second expert opinion be obtained as to the cause of his death.

671. A second opinion was in fact obtained. On behalf of Michael's family, Professor Stephen Cordner performed a review of Michael's autopsy. Professor Cordner is Emeritus Professor at the Department of Forensic Medicine at Monash University, Melbourne. He reviewed the BWV footage and witness statements, as well as Dr Brouwer's autopsy report and the photographs taken in the course of her post mortem examination.

672. Professor Cordner prepared an expert report which concluded that Michael had died as a result of multiple causes. He identified these as:

> *'Asystolic cardiac arrest or cardiac arrhythmia following administration of droperidol and midazolam during weighted prone restraint, following a period of physical exertion (including the effects of oleoresin capsicum spray and Taser discharges).'*

<u>The opinion of other medical experts</u>

673. Owing to the medical complexities of Michael's death, experts from other medical disciplines were asked to comment on the likely cause.

674. Notably, these experts concurred that it would be a complex process to find the cause of Michael's death, and that it was likely there would not be one predominant cause.

675. Forensic psychiatrist Dr Ellis opined that '*the cause of mortality in restraint is likely to be complex and involve interacting factors'*. He identified a number of risk factors present in Michael's case, including the medications used, the length and type of restraint, and the physiological effects of prolonged stress and exertion.

676. In his expert report, cardiologist Associate Professor Mark Adams stated that it was '*very likely that the ultimate mode of death was a sudden cardiac death due to arrhythmia'*. In his opinion, multiple factors would have been the trigger. A major contribution was most likely *'the high level of psychological and emotional stress as well as the high level of physical exertion involved throughout the whole episode'.*

677. At the inquest Associate Professor Adams added that in the presence of acidosis, restraint in the prone position may cause death. The build up of acids in the blood brings about an accelerated heartbeat. Associate Professor Adams explained that prone restraint of a person who is significantly acidotic, as Michael probably was, can be fatal because it reduces their ability to blow off carbon dioxide.

678. But Associate Professor Adams did not think this would have been the only cause of Michael's death. In his opinion there would have been multiple causes present that night, and it was impossible to identify a single predominant one:

> *' …I don't rule out there being … multiple causes here because sometimes, particularly with say arrhythmia, it's often a build up of a number of different things which are doing their role to … destabilise the heart muscle.'*

The position of the interested parties

679. In their closing submissions the interested parties took divergent positions as to whether the evidence could establish a cause for Michael's death. This divergence reflected the very significant medical complexities involved.

680. Counsel Assisting submitted that:

> *'In circumstances where the extent of the contribution of the various factors precipitating Michael's death cannot be identified with precision, it would be open to the Court to record its findings as to the factors which contributed to Michael's death under 'manner of death'.*

681. Accordingly, Counsel Assisting concluded that the cause of Michael's death could be given as '*an asystolic arrest or cardiac arrhythmia'*. The manner could be recorded as:

> *' … an asystolic arrest or cardiac arrhythmia which was precipitated by prone restraint, some of which was weighted; the administration of droperidol and midazolam; and a period of exertion during which Michael suffered the effects of oleoresin capsicum spray, taser discharges and psychosis'.*

682. Counsel for Michael's family concurred with the above.

683. However Counsel for NSW Ambulance and the Hunter New England Local Health District submitted that '*this narrative for manner of death is not helpful'.* In addition, both he and Counsel for the paramedics strongly urged that the administration of droperidol and midazolam did not have a causal or even an associative connection with Michael's death. As will be seen, these submissions drew largely on the expert evidence of toxicologist Professor Jones.

684. Counsel for the NSW Commissioner of Police asserted that systolic cardiac arrest or cardiac arrhythmia *per se* was not a cause of death, and that the cause of Michael's death should be given as unascertained. As for the manner of death, this could be given as:

> *' … the circumstances of physical exertion, including possible contribution to a level of agitation from the taser and oleoresin capsicum spray, restraint, including a period of prone restraint, and possibly acute psychosis'*.

Why did the pathologists' conclusions diverge?

685. In her submissions Counsel Assisting acknowledged the difficulty faced by the court, given the medical complexities involved and the divergent conclusions reached by forensic pathologists Dr Brouwer and Professor Cordner.

686. Counsel Assisting rightly described both pathologists as *'highly experienced and respected forensic pathologists',* who '*expended significant effort in reviewing the evidence, preparing their reports, and giving oral evidence'*. At the inquest each gave considered and careful evidence, and it was evident that each respected the work of the other. In my opinion they sincerely strived to assist the court, and Michael's family, to understand what had caused his tragic death.

687. Properly understood however, the forensic pathologists' conclusions reflect differences in their individual approach to how a cause of death ought to be identified.

688. Professor Cordner acknowledged that his conclusion was *'quite a descriptive account of the cause of death which I believe encompasses how Mr Peachey and why Mr Peachey died'.* As he explained in his evidence:

> *' … the various factors there, taken in conjunction, … delineates a space within which death was caused in this case …[T]hose elements combined .. constitute in my view the reason Mr Peachey died'.*

689. By contrast, Dr Brouwer sought a factual anatomical cause of death, but found herself unable to identify one. As she explained to the court:

> *'I think the cause of death that Professor Cordner proposed is ... a descriptive cause of death describing the circumstances of the death. But this still doesn't give us a specific factual cause of death, it doesn't provide us with the exact reason why Mr Peachey died. So my recommendation would still be that the cause of death is undetermined ...'*

690. But although Dr Brouwer could not formally establish a direct cause of Michael's death, she isolated certain factors which in her opinion may have contributed to it. These were identified in paragraph [667] above.

691. It is significant that for the most part, these factors aligned with those identified by Professor Cordner.

692. It is true that in their reports each took a different position regarding whether the impact of being Tasered had contributed to Michael's death. But by the second day of their conclave evidence, both had modified their position on this question.

693. Dr Brouwer considered that of itself, the impact of being Tasered could not have directly contributed to Michael's death. The two probes found in Michael's body were physically proximate, and were thus most unlikely to have actually conducted any electricity into him. But as Dr Brouwer explained to the court, the probes had no doubt added to Michael's level of physiological stress because they had caused him pain.

694. On this basis of this evidence, it can be inferred that Dr Brouwer considered the effect of the Tasering to have potentially contributed to the fatal outcome.

695. After preparing his report Professor Cordner reviewed Dr Brouwer's findings on the Taser probes. On day two of their conclave evidence he told the court that he now accepted that Dr Brouwer's evidence *'reduces, to some extent, the impact of the Taser but by no means reduces it completely.'* Michael would not have suffered from '*the disabling consequences of widespread spasm of musculature',* but he '*would have had pain, which would have added to the stresses that he had'.*

696. Ultimately therefore there was consensus that the impact of being Tasered had potentially contributed to Michael's death.

697. In his oral evidence Professor Cordner also revised the phrase *'weighted prone restraint'* which he had offered as one of the factors contributing to Michael's death. He said that this phrase would more accurately have been worded as *'prone restraint, some of which was weighted'.* This reflected his acceptance that weight had not been imposed on Michael for the entire period of restraint.

698. Initially there was a further notable difference: unlike Dr Brouwer, Professor Cordner did not identify psychosis as a contributing factor.

699. However on reflection, Professor Cordner agreed with Dr Brouwer that psychosis was a condition which may have contributed to Michael's death. Psychosis had radically disordered Michael's sense of reality, making him *'more frantic and running around and energetic and unresponsive to calls to calm down'.* As a result:

> ' … *it increased his heart rate, it increases his metabolic rate, and that eventually increases his carbon dioxide and he can't blow it off …'*

700. Professor Cordner concluded that psychosis had likely contributed to an increase in Michael's physiological stress, as had the effects of being Tasered and sprayed with OC. All three factors could therefore be regarded as having contributed to his death.

701. Ultimately therefore, the factors identified by Professor Cordner as having caused Michael's death, and identified by Dr Brouwer as having potentially caused Michael's death, were substantially the same.

Did the administration of droperidol and midazolam contribute?

702. Significantly, both forensic pathologists included the administration of droperidol and midazolam as a factor which was present and had potentially contributed to Michael's death.

703. Dr Brouwer noted the temporal relationship between Michael's final collapse and the administration of the two medications. She acknowledged further, as did Professor Jones, that the time of Michael's cardiac arrest occurred at the estimated peak plasma concentration of the droperidol. It was for these reasons that Dr Brouwer considered the droperidol may have contributed to Michael's death, albeit ' *… it's one of multiple other things that happened at the same time that eventually contributed to his death'.*

704. This also was Professor Cordner's opinion.

705. Their opinions on this point did not align with that of toxicologist Professor Alison Jones.

706. Professor Jones accepted that she '*could never exclude a possibility that drugs are contributory'*. She too noted the temporal relationship between Michael's cardiac arrest and the administration of droperidol. But she did not think it was likely that the medication was causally related to Michael's collapse. Cardiac arrest, she noted, was extremely rare after administration of droperidol.

707. It was for this reason that Counsel for Paramedics Summers and Baker urged the court to find that droperidol and midazolam had not caused Michael's death or had even been associated with it.

708. Counsel for the paramedics rightly referenced the status of Professor Jones as a '*highly respected and experienced'* specialist toxicologist. Having regard to Professor Jones' '*unequivocal and compelling expert opinion on this issue'*, she submitted that the administration of the two drugs should not be accepted as a contributor to Michael's death.

709. But a closer examination of Professor Jones' evidence on this point is instructive. Her reasons for excluding the impact of the medications are in fact similar to those of Dr Brouwer in declining to find a definitive cause of death. That is, the administration of the medications was but one of a number of co-mingled features, whose relative contributions could not be disentangled.

710. At the inquest Professor Jones gave this evidence:

> *' …the only positive piece of evidence that suggests a role of [droperidol and midazolam] in the deceased's demise is the timing of the administration of the drug. But that timing also corresponds to the time that the deceased was in a prone position ... that [he] was highly agitated, I understand, and may have been under restraint, and their ability to breathe may have been compromised under the restraint scenario, so whilst I can't completely disregard any possibility of the drugs here, I don't believe it's likely'.*

711. In other words, Professor Jones could not conclude that the medications had contributed to Michael's collapse, because of the presence of many other factors which had potentially contributed.

712. I accept that the presence of those other factors must preclude the court from finding that the droperidol and midazolam of themselves caused Michael's death. But I do not accept that because other implicating factors were present and may have contributed, this must exclude the medications as a cause or contributor.

713. I therefore accept the evidence of Dr Brouwer and Professor Cordner, that the administration of droperidol and midazolam, and their interaction with other features which were present, was a potential contributor to Michael's death.

Can a cause of death be established?

714. There is a strong evidential basis for the submission that Michael's death was caused by a fatal arrhythmia. According to Associate Professor Adams, it is '*very likely that the ultimate mode of death was a sudden cardiac death due to arrhythmia'*, triggered by multiple causes which he identified as present that night.

715. Associate Professor Adams' opinion that the mode of Michael's death was a fatal arrhythmia was not challenged by any other evidence. His opinion is based on extensive qualifications and experience. I accept his opinion on this point.

716. As for the causes of Michael's fatal arrhythmia, Associate Professor Adams considered that multiple factors had contributed. Dr Brouwer and Professor Cordner were also of the view that a constellation of features was present that night which potentially combined to trigger his fatal cardiac arrhythmia. Furthermore, the features they identified were substantially the same.

717. Based on the evidence of Dr Brouwer, Professor Cordner and Associate Professor Adams, I am satisfied on the balance of probabilities that the above

features were present that night, and combined to precipitate the fatal cardiac arrhythmia which brought about Michael's death.

718. As noted by Counsel Assisting, it is not uncommon for the court to identify a range of factors or circumstances which have contributed to a person's death, without being in a position to identify with precision the extent of the contribution made by each. Ultimately, the features which I have identified constitute '*the space within which death was caused'*, as Professor Cordner aptly described it.

719. In light of Associate Professor Adams' opinion that Michael's fatal arrhythmia had a multifactorial trigger, I have determined that these features ought to be enumerated within the category of *'cause of death'* rather than *'manner of death'.*

720. I therefore find the cause of Michael's death to have been:

> *'Cardiac arrest due to cardiac arrhythmia triggered by prone restraint, some of which was weighted; the administration of droperidol and midazolam; and a period of exertion during which Michael suffered the effects of oleoresin capsicum spray, taser discharges and psychosis'.*

721. There are two other matters which the medical evidence established, and which I wish to highlight.

Factors which did not contribute to Michael's death

722. First, the evidence establishes that certain factors did **not** cause or contribute to Michael's death.

723. Dr Brouwer and Professor Cordner concurred with Associate Professor Adams that there was no evidence that Michael suffered a pre-existing heart disease which might have triggered his fatal cardiac event that night.

724. Nor was there any evidence that illicit drugs played any direct role in his death. There was thorough toxicological analysis of Michael's blood samples. This did not detect any alcohol, amphetamines or other stimulants. Although metabolites of cannabis were present, according to toxicologist Professor Jones these had not caused Michael's death.

725. Professor Jones thought it possible however that Michael's cannabis use had impacted his mental health in the days leading up to his death. It may have caused the abnormal behaviour which so disturbed his family members, and brought him to the attention of the police.

726. Professor Cordner and Dr Brouwer were further agreed that the concept of '*excited delirium'* is not a useful one. This term describes a supposed syndrome of extreme agitation and struggle followed by sudden respiratory arrest and death. '*Excited delirium'*, they stated, had no scientific basis as an entity which caused death, and it could not legitimately be given as a cause of death.

727. Nor were any of Michael's injuries considered to have contributed to his death. At autopsy Dr Brouwer identified a fracture to his thyroid cartilage, which was possibly the result of Mr Gort's grasp of Michael's neck when he first ran into their house. There was no evidence that this injury caused or contributed to his death.

728. Michael had also suffered a rib fracture and lacerations to his liver, which were identified at the autopsy together with an amount of blood in his stomach. Although Dr Brouwer and Professor Cordner did not reach consensus as to what had caused these injuries, they agreed that it was unlikely they had contributed to his death.

<u>The association between prone restraint and death</u>

729. Secondly, in the interests of public health and safety I believe it is important to highlight the expert evidence of an association between prone restraint and death.

730. Dr Brouwer and Professor Cordner were agreed that this association exists, although the extent of the association was not clear. One of the reasons for this lack of clarity is the difficulty of replicating in a scientific study what has taken place in a real-world restraint situation.

731. The court heard evidence as to whether there is an agreed scientific theory on what causes death during prone restraint. Professor Cordner referred to research indicating that cardiac arrest occurs due to the impaired ability of a person who is positioned on their stomach to reduce metabolic acidosis by breathing deeply and expelling carbon dioxide. But Dr Brouwer was less confident of this, and referred to other research which, she said, cast doubt upon this theory.

732. It may be accepted that the causal connection between prone restraint and sudden death is as yet not well understood. There is however widespread recognition of an association between the two. This was acknowledged by Associate Professor Adams, who concurred that:

> *' …the association of physical restraint and sudden death is well recognised but poorly understood ..*'

733. He commented that where such deaths occurred, they seemed to be '*more common in situations where prone restraint is used'*.

734. The well-recognised status of this association was acknowledged by Sergeant Watt in his evidence, which is further described below.

735. The concurrence of opinion as to the serious risks associated with prone restraint has important public health implications, and provides the basis for the first recommendation which I make below.

## PART E: THE QUESTION OF RECOMMENDATIONS

736. Counsel Assisting proposed a number of recommendations arising out of the inquest evidence.

**Proposed recommendation to the NSW Commissioner of Police: prone restraint**

737. Expert evidence at the inquest established that restraint in the prone position can present very serious risks for the person being restrained.

738. In Michael's case, none of the three involved police officers could recall being taught that there are particular risks in restraining a person who has mental health issues, or that it was necessary to continuously assess whether the person should be moved out of the prone position, or that there was a need to watch for an altered sound of breathing. Senior Constable Douglas could not even recall being taught that there are risks associated with placing weight on a person who was lying in the prone position.

739. It is clear that in Michael's case, the risks of prone restraint and the need to continuously reassess whether it is required were not at the forefront of the three police officers' minds. Had they been, it may be surmised that their risk assessment, at least during the latter stages of the restraint, would have strongly factored in the physical risk for Michael in maintaining him in that position.

740. In his evidence Sergeant Watt agreed that police officers need to receive mandatory training on this subject on a regular basis. Acknowledging that there was no specific training dedicated to this, Sergeant Watt explained that it was currently provided to police officers in a manner which integrated it into their training on tactical options. But he '*would certainly agree'* that there should be specific training on the risks of prone restraint. He wanted '*to effect a significant*

*change'.* He said he would see value in a recommendation that such training be both specific and mandatory.

741. In addition to the absence of specific training, it is also the case that there is not a separate NSW Police Force policy document or Operating Procedure addressing these risks. Instead, written guidance is provided on this topic across various manuals and Standard Operating Procedures. I have summarised these at paragraphs [496]-[500] above**.**

742. Counsel for the Commissioner submitted that Sergeant Watt had rejected the utility of an independent policy on the risks associated with prone restraint. But as noted by Counsel Assisting, this is not correct.

743. Sergeant Watt's initial evidence was that a specific policy document dedicated to restraint risk would not be useful. This topic, he said, was '*a difficult one to write policy around'* due to the wide range of circumstances in which restraint might be a feature.

744. Counsel Assisting asked further questions about this. Despite there being a range of circumstances in which police might have to consider use of restraint, did Sergeant Watt accept that '*there are certain unequivocal matters that could be identified?'*

745. Sergeant Watt agreed that there were, and that they included:

- the risks that are known to arise during prone restraint
- that weight applied to the person may increase the risk
- that there was a need for frequent re-assessment of the need for prone restraint
- that police needed to be mindful of the length of time that the prone restraint had been maintained.

746. Ultimately, Sergeant Watt agreed that a document reinforcing the above matters would be useful, provided it was '*coupled with appropriate amounts of technique training'*.

747. Sergeant Watt's opinion on this issue merits significant weight. He has very extensive experience in police training. This gives him a sound appreciation of the challenges in teaching police officers how to respond to crisis situations, with the myriad complexities and unpredictabilities that can be involved.

748. The evidence at inquest strongly indicated that an independent policy regarding prone restraint, with associated training, is necessary and desirable.

749. I do however wish to highlight Sergeant Watt's point that an independent policy about the risks of prone restraint would be '*a meaningless paper document',* unless it was accompanied by technique training. Therefore, I have condensed the two recommendations proposed by Counsel Assisting into a single one, as follows:

*That the NSW Commissioner of Police consider:*

*a) formulating an independent policy on restraint which provides clear guidance to NSW Police Force officers about the risks of prone restraint, the ways in which to mitigate those risks, and the importance of moving a person from the prone position as soon as possible, particularly in cases where there has been acute behavioural disturbance and emergency sedation; and*

*b) providing specific mandatory training to NSW Police Force officers on the above.*

**Proposed recommendation to the NSW Commissioner of Police: mental health-related incidents**

750. Counsel Assisting submitted that the evidence supported a need for increased guidance material in the NSW Police Force Handbook about section 22 of the MHA 2007. The proposed areas included the criteria for using section 22, the signs and symptoms of mental illness and disturbance, and the importance of having regard to information and concerns of family members and others close to the person.

751. Counsel Assisting further proposed that the NSW Police Force Handbook be updated to include additional information and guidance about least restrictive options when attending upon a person suffering from a mental illness or disturbance. Options included standing at a distance and engaging with the person empathetically. Counsel Assisting proposed that NSW Police Force officers be provided with additional training on this issue.

752. The court heard that mental health training for NSW police officers has undergone review in recent years. At the inquest Chief Inspector Hanlon told the court that a new program was in development, which was intended to replace the existing training which is provided to assist police in their management of mental health-related incidents.

753. In light of this evidence, the inquest sought additional statements regarding the nature and progress of the new mental health training. In response, a statement was provided by Superintendent Kellie Langley on 24 May 2024**.** In summary, the training to be delivered to police officers consists of the following:

- a mandatory face to face three hour session on mental health, as part of officers' initial training at the Goulburn Police Academy
- a mandatory online examination on de-escalation techniques in mental health-related incidents, also part of officers' initial training
- mandatory refresher training to be conducted on a biennial basis, consisting of both face to face and online components
- optional online 'micro' sessions on section 22 of the MHA 2007
- a two-yearly forum for police area command/district inspectors.

754. The refresher training will vary with each biennial cycle. The 2023-2024 program is titled: *'Mental Health – Signs, Symptoms and De-Escalation'*. It includes identifying behaviours associated with mental illness; de-escalating situations; and identifying support agencies which may be able to assist. The planned focus for 2024-2025 is face to face communication training.

755. I accept the submission of Counsel Assisting that police training in mental health-related incidents is limited in nature. This formed the basis for her recommendation that police receive additional training in the areas identified in paragraphs [750]-[751] above.

756. However on reflection, and taking into account the revised mental health training program, I have formed the view that with one exception, it is neither necessary nor desirable to recommend additional police training in this area. My reasons are as follows.

757. In my view the evidence at inquest indicated that the involved police officers held a reasonable understanding of some of the areas proposed by Counsel Assisting. These included the section 22 criteria, and the signs and symptoms of mental illness. Further, the police officers were clearly aware that although a person might not meet the criteria for action under section 22 of the MHA 2007, it may be appropriate to seek the assistance of agencies with a higher level of expertise in mental health assessment – namely, ambulance paramedics. In Michael's case, this assistance was sought by police officers in the period leading up to his death.

758. Regarding de-escalation techniques, it is certainly the case that on the night of 20 May 2021 the response of Senior Constable Gough and Probationary Constable Smith outside Stephen Peachey's house was flawed. On the one hand, their willingness to await the ambulance at a distance from Stephen Peachey's house demonstrated their understanding of the benefits of de-escalation in such incidents. Unfortunately their subsequent decision to attempt to restrain Michael when he appeared at their police vehicle was very much at odds with that understanding. This was in part acknowledged by Senior Constable Gough in his evidence at the inquest (see paragraphs [316]-[319] above).

759. However, it is apparent that the police training for 2023-2025 is centred upon building police officers' communication and de-escalation skills. With respect, this is a positive choice and reflects acceptance at a senior police level of the critical importance of these skills to the work of police officers.

760. I am also mindful of the need to avoid the problem of overload in police training; and equally, the challenge of providing mandatory training to a very large workforce.

761. I have therefore determined that with one exception, it is not necessary or desirable to recommend additional police guidance and training in the area of mental health-related incidents.

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762. The exception concerns the significance of family information to a mental health assessment under section 22 of the MHA 2007. Expert evidence confirmed the importance of such information when assessing whether a person is mentally ill or disturbed. I have found that insufficient regard was given to the information which Michael's family communicated to the involved police officers, in particular on the morning of 20 May 2021. Both Sergeant Roden and Senior Constable Gough said that in hindsight, they thought they could have paid closer attention to what Jtaya Davis and Frances Stevens had said to them about Michael's condition.

763. Counsel for the NSW Commissioner of Police has pointed to the inclusion of this guidance in the NSW Health – NSW Police Force Memorandum of Understanding 2018 [the MOU 2018]. But the function of this document is to guide and enable the development of local protocols. The MOU 2018 is not intended to operate as a resource for the general duties police officer.

764. Therefore I intend to recommend that the NSW Commissioner of Police consider:

a) *providing further guidance material in the NSW Police Force Handbook, on the importance of having regard to information provided, and concerns expressed by, family members or others close to the person about the person's behaviour, including changes in that behaviour, in determining whether a person appears to be mentally ill or disturbed for the purposes of section 22 of the MHA 2007; and*

b) *providing additional training to NSW Police Force officers in the above.*

**Proposed recommendations to NSW Ambulance**

765. In her closing submissions, Counsel Assisting proposed four recommendations to the Commissioner and Chief Executive of NSW Ambulance, connected with the evidence at the inquest.

766. These proposed recommendations arose from expert evidence which highlighted the need for health professionals to maintain a high degree of vigilance in monitoring a sedated and physically exhausted patient. In the opinion of Associate Professor Bendall, this need was *'often under-appreciated by non specialists'* including paramedics. He considered that Michael's tragic case had been *'an opportunity for us to look at what could have been improved,* adding that *'we need to do this work as rapidly as possible'.*

767. Mr Mutchmor and Adjunct Associate Professor Hucker agreed, with the latter giving this evidence:

> '*Being restrained prone when you're physiologically exhausted is potentially lethal and that needs to be understood by professional groups, police and paramedics'.*

768. All agreed that ambulance officers needed clearer guidance on the expectations for monitoring such patients. Associate Professor Bendall said that for this reason:

> ' … *improvement in the provision of sedation has been an area of focus within NSW Ambulance.'*

769. Since Michael's death, NSW Ambulance has undertaken significant work in this area. The court heard that in 2021 it performed an audit of the clinical management of acute behavioural disturbance, in particular following the administration of sedation.

770. The result has been a revision of NSW Ambulance's Clinical Procedures, Pharmacology Guidelines, and Guidelines which cover restraint, sedation, and

behavioural disturbance. A significant focus has been to improve monitoring of patients post sedation.

771. The effect of this review is that certain recommendations proposed by Counsel Assisting are no longer necessary.

772. Proposed Recommendation 1 was that NSW Ambulance consider amending Protocol MH6 to require that ambulance officers repeat physiological observations and physical examinations at regular, defined intervals.

773. Replacing Protocol MH6 is the new Behavioural Disturbance Clinical Procedure. This mandates continuous monitoring *'as the patient's condition allows'*. It also sets out minimum standards for frequency and documentation of observations.

774. I accept the submissions in reply of Counsel Assisting, that this new Guideline removes the necessity for proposed Recommendation 1.

775. Proposed Recommendation 2 was that NSW Ambulance formulate a policy to guide paramedics about administering emergency sedation, and how the patient is subsequently to be managed.

776. Proposed Recommendation 3 was that NSW Ambulance provide clearer guidance to paramedics about '*the greater risks involved in sedating a person who has been restrained for a prolonged period of time, particularly in the prone position'*.

777. Importantly, these proposed recommendations identified the need to allocate '*clear roles between attending paramedics, to ensure that there is an expectation that at least one paramedic will assume overall responsibility for the monitoring and management of the patient.*' Counsel Assisting identified three further areas of guidance:

- that an ambulance officer be positioned at the patient's head to continually observe their airway and condition following sedation
- that the prone position be avoided, as should pressure to the head, neck, chest or back
- that the patient be moved to the lateral position as soon as possible.

778. NSW Ambulance's new Clinical Procedure protocols now include a Sedation Safety Notice and a Sedation Clinical Procedure. These documents:

- identify that certain patients are at increased risk of deterioration with sedation, such as those who are affected by drugs or alcohol, and those who are physically or mechanically restrained

- instruct that monitoring be undertaken at least five minutely
- make pulse oximetry a priority '*as soon as it is safe to do so'*
- introduce a Sedation Assessment Tool
- instruct that where possible, a clinician undertake the role of *'sedation practitioner'* and that another practitioner be responsible for monitoring airway and cardiovascular system.

779. The new Guidelines also contain multiple reminders to paramedics about the risks associated with prone restraint, including:

    - that if face-down restraint is considered necessary, it must be time-limited;
    - that clinicians must *'closely monitor any person who is being restrained in the prone position and be alert for sudden clinical deterioration'*; and
    - that clinicians '*need to advocate for patients in the care of other agencies to avoid harm'.*

780. NSW Ambulance has advised that there will be associated training and education in the revised protocols.

781. NSW Ambulance has clearly undertaken very significant work for the guidance of ambulance officers who are faced with a patient in Michael's very vulnerable position. This work removes the need for proposed Recommendations 1, 2 and 3. It is apparent that Michael's tragic death has prompted substantial reforms to increase the safety of patients who are being restrained and are suffering acute behavioural disturbance.

782. Finally, it was proposed that NSW Ambulance consider having interagency training and/or development of guidance material with the NSW Police Force. This would focus on the respective roles of the two agencies and the need for communication, where both agencies attend a scene which involves acute behavioural disturbance, prone restraint and emergency sedation.

783. Submissions on behalf of NSW Ambulance were that this training would be '*mutually beneficial at mitigating risk',* but that its '*feasibility and scalability'* were less clear. That may be the case. But in their evidence both Associate Professor Bendall and Mr Mutchmor emphasised the importance of interagency communication in such cases. Moreover, the absence of any such communication in Michael's case was very evident.

784. For these reasons, I accept the submission of Counsel Assisting that this recommendation remains necessary and desirable.

## Recommendation to the CEO of the Hunter New England Local Health District

785. I accept Counsel Assisting's submission, based on the expert evidence at inquest, that Gunnedah Hospital needed to have had in place a follow up plan to deal with Michael's departure on the morning of 19 May 2021. In Dr Ellis' view the hospital's existing plan, which was to notify police that the patient had left:

> *' … would not be considered a satisfactory standard of care for someone with a psychotic condition'.*

786. Both he and Dr Ahmed thought there should have been a discussion with a mental health specialist or emergency doctor, to assist the staff with classifying Michael's risk and considering what other action might be appropriate.

787. This evidence led to the proposal that the Hunter New England Local Health District consider introducing follow up policies for voluntary patients with symptoms of mental illness, but who leave without having received a medical assessment.

788. This proposal was supported by Michael's family and by Registered Nurse Franke, and not opposed by Dr Chandra. The Hunter New England Local Health District did not indicate support or otherwise, but noted that it did not oppose strategies to better support its nursing staff.

789. In my view the evidence supports the making of this recommendation.

## Conclusion

790. This inquest will not bring Michael back to the family who love him. They will never forget the heartbreak of his passing, and their lives have been forever changed. On behalf of everyone at the Coroners Court, I offer them my deepest sympathy.

791. I hope there will be at least some comfort for Michael's family, in knowing that NSW Ambulance and senior members of the NSW Police Force acknowledge the profound tragedy of Michael's death, and the need for changes in their response to people who are in his situation.

792. I will close by expressing my gratitude for the outstanding assistance I have received in this tragic and very complex inquest by the Counsel Assisting team. I thank also the legal representatives of the interested parties, and the Officer in Charge Detective Inspector Richard Howe.

## Findings required by section 81(1)

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

**Identity**
The person who died is Michael Peachey.

**Date of death**
Michael Peachey died on 20 May 2021.

**Place of death**
Michael Peachey died at Gunnedah, NSW.

**Cause of death**
Michael Peachey died as a result of cardiac arrest due to cardiac arrhythmia. This was triggered by prone restraint, some of which was weighted; the administration of droperidol and midazolam; and a period of exertion during which Michael suffered the effects of oleoresin capsicum spray, taser discharges and psychosis.

**Manner of death**

Michael Peachey died as a result of a police operation.

## Recommendations pursuant to section 82

**To the NSW Commissioner of Police**

794. That the Commissioner consider:

a) formulating an independent policy on restraint which provides clear guidance to officers of the NSW Police Force about the risks of prone restraint, the ways in which to mitigate those risks, and the importance of moving a person from the prone position as soon as possible, particularly in cases where there has been acute behavioural disturbance and emergency sedation; and
b) providing specific mandatory training to NSW Police Force officers on the above.

795. That the Commissioner consider:

a) providing further guidance material in the NSW Police Force Handbook, on the importance of having regard to information provided, and concerns expressed by, family members or others close to the person about the person's behaviour, including changes in that behaviour, in determining whether a person appears to be mentally ill or disturbed for the purposes of section 22 of the Mental Health Act 2007; and
b) providing additional training to NSW Police Force officers in the above.

**To the NSW Commissioner of Police, and to the Commissioner and Chief Executive of NSW Ambulance**

796. That NSW Ambulance and NSW Police Force consider having interagency training and/or development of guidance material. This would focus on the respective roles of the two agencies and the need for communication, where both agencies attend a scene involving acute behavioural disturbance, prone restraint and emergency sedation.

**To the Chief Executive Officer of the Hunter New England Local Health District**

797. That the Hunter New England Local Health District consider the introduction of polices for following up voluntary patients who present to an emergency department with symptoms of mental illness or disturbance, but leave without having received a medical assessment.

I close this inquest.

**Magistrate E Ryan**
Deputy State Coroner, Lidcombe

**28 November 2024**