



CORONERS COURT OF NEW SOUTH WALES

Inquest: Inquest into the death of Jesse Mathew Riley

Hearing dates: 19-23 January 2026, Coroners Court, Coffs Harbour

Date of findings: 25 March 2026

Place of findings: Coroners Court, Coffs Harbour

Findings of: Deputy State Coroner, Magistrate Hosking

Catchwords: S 23 of the *Coroners Act* - death in police operation; cause and manner of death; police and paramedic use of physical restraints, risks of positional asphyxia, use of droperidol to sedate and epilepsy.

File number: 2021/178308

Representation: Counsel assisting the inquest: Timothy Hammond of Counsel instructed by Rosanna Muniz, NSW Crown Solicitor's Office (**Assisting team**)

Commissioner and Chief Executive of NSW Ambulance (**NSWA**): Ben Bradley of Counsel instructed by Nathan Guenette of Norton Rose Fulbright Lawyers

NSWA paramedics Warwick Mordue and Mitchell Cooper: Jacinta Smith of Counsel instructed by Claudine Watson-Kyme of Hicksons Hunt & Hunt

Commissioner of NSW Police (**NSWPF**), Sgt Grant Price and Insp. Richard Garrels: Ian Fraser of Counsel instructed by Ashleigh Constance of NSWPF Office of General Counsel

Findings: **Identity of deceased:** Jesse Mathew Riley

Date of death: 20 June 2021

Place of death: Coffs Harbour Base Hospital, Coffs Harbour NSW

Manner of death: Jesse died from natural causes being an undiagnosed epileptogenic brain lesion (cerebral cavernoma) which led to his status epilepticus and sudden unexplained death in epilepsy (**SUDEP**).

Cause of death:
Status epilepsy secondary to cerebral cavernoma.

Recommendations: No recommendations were made.

Publication orders: Copies of the non-publication orders made by Magistrate Hosking can be obtained from the Coroners Court Registry.

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Introduction

- 1 Jesse Mathew Riley was born on 14 January 1990 to Susan Dorizas and Darren Riley. He was much loved by his parents, his partner Abby and their daughter, as well as his siblings Chelsea, Zoe and Tanner.
- 2 These are the findings of an inquest into the circumstances of Jesse's death.
- 3 The inquest into Jesse's death was a mandatory inquest pursuant to sections 23 and 27 of the *Coroners Act 2009* (NSW) (**the Act**) because Jesse's death occurred 'as a result of' NSWPF operations.

The role of the coroner

- 4 The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death¹. A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future².

The issues examined at the inquest

- 5 The inquest was held at Coffs Harbour Court House between 19 and 23 January 2026.
- 6 The issues identified in the coronial investigation to be explored in the inquest follow.
 - (1) The date, place, manner and cause of Jesse's death.
 - (2) Whether appropriate care and treatment was provided to Jesse by NSWA including:

¹ S 81 of the Act

² S 82 of the Act.

- (a) whether adequate action was taken in response to Jesse's presentation
 - (b) the conduct of physical examinations
 - (c) the administration of medication
 - (d) the physical restraints used
 - (e) the communication of information, decisions and delegation of care of Jesse between NSWA paramedics, having regard to NSWA policies and protocols relating to the use of sedatives and use of physical restraint.
- (3) Whether the response by NSWPF officers was appropriate having regard to NSWPF policies and/or protocols.
- (4) Whether it is necessary or desirable to make any recommendations in relation to any matter connected with Jesse's death.

The evidence

7 Tendered to the court was a 4-volume brief of evidence³ compiled by the NSWFPF Officer in Charge of the coronial investigation, Det. Insp. Grant Erikson and supplemented by the Assisting team.

8 Oral evidence was also taken from the following witnesses at the inquest:

- (1) Warwick Mordue, attending paramedic, NSWA
- (2) Mitchell Cooper, attending paramedic, NSWA
- (3) Sgt. Grant Price, attending officer, NSWPF

³ Exhibits 1 and 2 and an additional 3 exhibits were tendered in the course of the inquest.

- (4) Sen. Sgt. William Watt, Instructor, Operational Safety Training and Governance, NSWPF
- (5) Martin Nichols, Associate Director Paramedicine & Clinical Practice, NSWA
- (6) Michael Richer, Director Paramedicine Education & Training, NSWA
- (7) Alan Morrison, Associate Director Professional Engagement & Partnerships, NSWA

Experts

- (8) Adjunct Assoc. Professor Anthony Hucker, critical care paramedic, Adjunct A/Professor at the University of the Sunshine Coast, Director of Clinical Operations with the Qld Ambulance Service, Senior Medical Educator with the Royal Australian College of General Practitioners
- (9) Sean Mutchore, National General Manager, Quality and Safety, Australian College of Rural and Remote Medicine
- (10) Dr Michael Robertson, pharmacologist and forensic toxicologist
- (11) Assoc. Professor Armin Nikpour, neurologist, Clinical Associate Professor at the University of Sydney, Senior Staff Specialist in Neurology, Epilepsy and Positron Emission Tomography at Royal Prince Alfred Hospital, director of the Comprehensive Epilepsy Service
- (12) Professor John Watson AM, neurologist, Emeritus Professor in the Faculty of Medicine and Health, the University of New South Wales and former Director of the Eccles Institute of Neuroscience at the Australian National University
- (13) Assoc. Professor Robert Sanders, anaesthetist, Nuffield Chair of Anaesthetics at the University of Sydney and Royal Prince Alfred,

Hospital and Academic Head of Department, Royal Prince Alfred Hospital.

Findings and recommendations

- 9 Having considered all of the evidence and submissions in this inquest, my findings follow.
- (1) Jesse died on 20 June 2021 at Coffs Harbour Base Hospital from status epilepsy secondary to cerebral cavernoma in the context of an undiagnosed epileptogenic brain lesion (cavernoma) which led to status epilepticus and SUDEP.
 - (2) The evidence adduced at the inquest did not support a finding on the balance of probabilities that Jesse's nicotine consumption was a causative factor in his death.
 - (3) I consider in all of the circumstances that the care and treatment provided by the attending NSW paramedics was appropriate.
 - (4) I find that the response by attending NSWPF officers was appropriate having regard to NSWPF policies and/or protocols. In particular, their communication, co-operation and engagement with each other and attending NSW paramedics and the restraint techniques they adopted. However, while it may not have been contrary to NSWPF training, policies and procedures, I consider Garrels use of his 'boot' to restrain Jesse was inappropriate and ill-advised.
- 10 Given the changes to NSW policies, procedures and training since Jesse's death to reduce the risks associated with sedation and restraint and the management of behavioural disturbance, it is not necessary or appropriate that any recommendations be made.

Background

- 11 A Statement of Facts was agreed as between the participants and provided to me as an *aid memoire*. I am grateful for the assistance and have relied on this Statement and the submissions from Counsel Assisting in relation to non-contentious facts.
- 12 I also had the benefit of hearing about Jesse in family statements prepared by his partner Abby and his mother Susan.
- 13 Jesse was born on 14 January 1990 at Manning Base Hospital, Taree. He was the oldest of four children. For the first ten years of his life, his family lived on a farm at Kolodong near Taree and he developed a love of horses. Jesse completed his schooling in Taree and his mother described him as a gifted student at school. He wanted to be a jockey, like his father Darren, and found an apprenticeship riding. Unfortunately, he became too big and moved into trackwork. He was talented with horses and in particular developed a real skill in quietening difficult horses. He had a strong work ethic from his teens to adulthood.
- 14 Abby described Jesse as charismatic with a contagious personality.
- 15 In his early twenties, Jesse moved away and lived in Sydney for a while. He became involved in drug-taking and used crystal methylamphetamine. Jesse failed a workplace drug test. Jesse confided in his mum. Through self-determination and a desire to continue trackwork, Jesse abstained from illicit drugs and repaid his debts. He moved back to Taree and started work with jockey Raymond Stokes who became a mentor and assisted Jesse in obtaining his riding licence again. Jesse re-established himself in trackwork.
- 16 Jesse met Abby in 2017 and they commenced a relationship. Abby described him as an intelligent, loving and compassionate person. Jesse and Abby's daughter was born in September 2018. Jesse was a very attentive, conscientious and caring father. His daughter was his pride and joy.

- 17 Jesse lived at 700A Bucca Road, Bucca, which is one of several houses close by on a larger property. The area is rural, about 20km north of Coffs Harbour and about 8km inland. It connects with the Pacific Highway via Bucca Road.
- 18 As at June 2021, Jesse worked as both a trackworker and as a painter.
- 19 The impact of Jesse's tragic death remains for his family, friends and the broader racing community.

Health and Sleep Issues

- 20 Jesse was a healthy child growing up. He had a number of injuries from falls when he worked as a jockey and horse trainer. This included some concussion, fractures and other less serious injuries.
- 21 Jesse's mum described him having night terrors as a child. These occurred if Jesse developed a temperature and manifested in Jesse becoming erratic, screaming, yelling and running around the house banging into things. Jesse's mum would sometimes have to restrain him to prevent injury to himself or his siblings. Panadol would usually reduce his temperature and the symptoms would subside. These episodes would usually last about half an hour. Jesse would not remember them the next day.
- 22 In a separate incident, as a teenager Jesse received serious burns to large parts of his body and spent several weeks in hospital where he received skin grafts.
- 23 Abby described Jesse having blood in his stools for about a year before his death. He did not seek medical attention for this despite her urging.
- 24 Jesse was not a heavy drinker, usually having a four pack of pre-mixed bourbon per week. For the three years prior to his death, Jesse did not consume illicit drugs except one or two occasions when he used cocaine. Jesse gave up smoking and replaced cigarettes with patches and a vape about a month before

his death. There was no information before the court about Jesse's level of patch use and no reliable evidence about the extent of his vape use.

- 25 Neither Jesse's mum nor Abby were aware of any earlier episodes of psychosis or mental illness in Jesse.

Events of 19 June 2021

- 26 On the morning of Saturday 19 June 2021, Jesse and Abby got up early to go to work at Coffs Harbour Racecourse before returning home at 8.30am. Jesse was not involved in any accidents and appeared fine at work. Later, he and Abby went shopping and returned home again in the afternoon. Jesse watched an NRL match on the TV and drank about three Wild Turkey bourbon cans.
- 27 Following the match, Jesse, Abby and their daughter attended a bonfire and barbecue at a neighbours.
- 28 Abby dropped off Jesse and their daughter at the barbecue at about 5.00pm. Abby returned a short time later. They socialised and spoke to other attendees. There were about 28 people there including about 10 children. Jesse drank a couple more Wild Turkey bourbons. Witnesses noted nothing unusual in Jesse's behaviour.
- 29 Abby and their daughter left at about 7.20pm and Jesse left about half an hour later. Jesse walked through the paddock that connected his property to the neighbour's property, using his phone as a torch. Jesse arrived home at about 8.10am and played with their daughter for a while. He was happy and laughing.
- 30 Jesse went to bed about 8.20pm because he had an early start for work the next day. Abby and their daughter slept in a separate bedroom. Jesse had told Abby that he was tired.

Events of 20 June 2021

- 31 At about 1.30am, on Sunday 20 June 2021, Abby was awoken by some banging and noises in the house. About 15 minutes later, she heard footsteps and thought Jesse might be attending to the cat.
- 32 The banging noises continued so Abby left her room and looked down the hallway. She saw Jesse staggering around, bent over with one hand on the wall. She asked what was wrong and despite trying to communicate with her, Jesse could not give a coherent answer. Jesse came towards Abby, leant on her and told her he needed the toilet.
- 33 Jesse walked down the hallway and into the lounge room. Abby assisted Jesse to the bathroom and he urinated in the toilet. When he finished he came back down the hallway and asked for water. Abby took Jesse into the kitchen and poured him a mug of water. She had to hold the cup for Jesse as he could not lift the cup to drink.
- 34 Jesse was incoherent and shrieked from time to time. Abby helped Jesse back into her bed where he lay shaking and quietly shrieking. Jesse got out of bed and checked that the bedroom door was shut and seemed concerned about the door. Jesse was saying 'mummy' and 'daddy' in an odd way amongst other words, possibly trying to speak to his daughter. Several times, Jesse got up to check the bedroom door was closed.
- 35 Abby tried to take Jesse to his own bedroom, but he seemed terrified of something. He then came back into Abby's room and held her tightly but was falling onto the floor. Jesse mentioned something about his hand and held it to his cheek and was shaking.
- 36 Jesse continued to yell and shake, and this frightened Abby. She had previously heard him talk or yell and jolt in his sleep occasionally but never seen Jesse like this. She was aware of his childhood night terrors and was concerned about what Jesse might do next. Their daughter was awake and screaming at this point. Abby asked if he needed a doctor.

37 Abby called 000 at 1.57am and described what she had just experienced. She asked for help. During the 000 call Abby said Jesse was not being aggressive but was acting 'really weird', crying and muttering, convulsing and shaking. He was not making threats but acting strangely. The call was recorded as a 'concern for welfare' priority 2 job.

38 The CAD⁴ record noted that Jesse:

has been found in the neighbour's backyard having an episode and acting strange, crying and muttering, convulsing and rambling. No intoxication. Ambos have been requested for a mental health assessment. There's no weapons sighted or previous police history, and a 3-year-old child at the location. There's no further information. Woolgoolga car or any car in the vicinity.

Attendance of Police and Ambulance

39 At 1.58am:

(1) Glenreagh 24 - Garrels and Price - (**GLR24**) acknowledged the job and stated they were finishing off another job in Coffs Harbour before attending⁵.

(2) NSWA was notified through the ICEMS1 system.

40 At 2.11am, GLR24 informed radio they had finished their earlier job and were on the way to Bucca with an ETA of 20 minutes. They were advised that the ambulance ETA was also 20 minutes.

41 At 2.25am, GLR24 arrived on scene and in the driveway spoke to Abby who told them what had unfolded. Price activated his BWV⁶.

42 The events described below have been largely extracted from the BWV and supplemented with the evidence of the witnesses.

⁴ Computer aided dispatch.

⁵ The other job involved two people having fallen from a roof resulting in a head injury.

⁶ Body worn video.

- 43 When police went into the house at 2.31am, Jesse can be seen lying on the bathroom floor in his underpants and he is heard snoring loudly. The police retreated to await the arrival of the NSWA. Price said he saw Jesse's hand move. At 2.34am Jesse started making a very loud howling or whooping sound repeatedly. Sounds from inside the house are consistent with a glass or cup rolling on the floorboards and someone moving around⁷.
- 44 At 2.37am, a NSWA arrived on the scene with paramedics Cooper and Mordue in attendance. They too spoke with Abby in the driveway.
- 45 At 2.38am, Jesse came out the door and rolled headfirst down several steps to ground level. He then laid on the ground and attempted to sit up or move on all fours. Price attempted to verbally engage Jesse calling his name.
- 46 At 2.39am Jesse's whole body convulsed with his legs and arms very stiff and above the ground. This lasted for less than a minute.
- 47 At approximately 2.40am, Mordue and Cooper arrived at the front door of the property where Jesse, Garrels and Price were located.
- 48 At 2.41am Price withdrew his Taser.
- 49 At 2.41am, Mordue checked Jesse's radial pulse and stated that Jesse had a good strong heart rate. Mordue recorded Jesse's vital signs as:
- (1) heart rate - 90bpm
 - (2) blood pressure - 170/PALP
 - (3) blood sugar - 5.3mmol/L
 - (4) pupils - dilated and reactive pupils.

⁷ At a later examination of the scene, a broken glass was found in the bathroom and Jesses' blood was found on several walls.

50 Price said, 'I've never come across anything like this'. He described Jesse's actions as 'aggressive screaming and mannerisms⁸.'

51 At 2.50am, Jesse started to make loud howling noises again and move around on the ground. Garrels used his boot to keep Jesse prone on the ground whilst keeping his torch shining on Jesse. Garrels repeatedly used his foot to restrain Jesse rather than his hands. Jesse was still incoherent and did not respond to verbal prompts and questions.

52 The following conversation took place at 2:51am:

Garrels: are we going to knock him out?

Cooper: We can give him some; we just don't know what's causing it.

53 Cooper drew up 10mg of droperidol but Mordue decided not to sedate Jesse immediately.

54 At 2.52am, Jesse rolled around and attempted to stand up. He got to his knees but fell forward striking his head on the concrete path. Price considered Jesse to be a danger to himself and needed to be restrained. Cooper decided Jesse needed sedation given his presentation.

55 At 2.54am, Jesse was restrained in a prone position to administer the sedative. Mordue injected 5mg of droperidol into Jesse's thigh muscle. Mordue said the usual dose for this drug is 10mg but because of Jesse's presentation and unknown cause, he decided at the last minute to halve the dose⁹. Jesse appeared to continue struggling against the attending officers.

56 At approximately 2.56am, Mordue observed that Jesse's body had relaxed and that he was snoring.

⁸ While that is Price's description, on review of the BWV, that appears somewhat overstated.

⁹ The needle was disposed of and there is no way of independently verifying the dose. Mordue's evidence was that he told Cooper later in the ambulance that he had halved the dose.

- 57 It is difficult to see from the BWV exactly where each of the officers applied pressure to Jesse's body. In his statement, Garrels said he pushed down on Jesse's right arm, Price was near Jesse's legs, Cooper was on the opposite side to Garrels leaning on Jesse's left shoulder, and Mordue applied the syringe to Jesse's leg. Garrels said that Jesse had another spasm while he was on his stomach.
- 58 A discussion followed about how to restrain Jesse on the stretcher with straps.
- 59 By 2.56am, Jesse can be heard to be snoring again, although he appeared to be taking fewer breaths. A minute later a comment was made about putting Jesse on his side and Price replied that they needed to be cautious about positional asphyxiation.
- 60 At 2.59am, Jesse was lifted to his feet and placed onto the stretcher. It is unclear on the BWV whether Jesse was able to bear any of his own weight, although Mordue stated that Jesse took his own weight until his legs gave way.
- 61 At 3.00am, Jesse was strapped into the stretcher and wheeled towards the ambulance. His breathing can be heard on the BWV but much less frequently than before. A loud audible breath was taken at 3.02am.
- 62 At 3.02am, Mordue felt Jesse's pulse but did not record the pulse rate. His evidence was that he must have felt a pulse or he would have immediately commenced CPR.
- 63 At 3.03am, Jesse was loaded into the rear of the ambulance and Cooper commented that he did not think Jesse was breathing. A life pack monitor was attached to Jesse and he was found to be asystole¹⁰. CPR¹¹ with chest compressions were commenced by Mordue and a life pack monitor device attached.

¹⁰ Jesse's heart's mechanical and electrical activity had stopped.

¹¹ Cardio-pulmonary resuscitation

- 64 At 3.04am, Price began loosening and detaching the mechanical restraints on Jesse, while CPR continued.
- 65 At 3.07am, Price took over giving CPR to Jesse.
- 66 At 3.08am, Cooper inserted a laryngeal mask airway.
- 67 At 3.10am, Garrels took over giving CPR to Jesse.
- 68 At 3.11am, Price contacted Police Radio, stating: 'For your information Radio, our patient here has taken a turn. We're currently doing CPR on him.'
- 69 At 3.14am, Garrels drove the ambulance, and Price drove the police vehicle from the property. CPR continued enroute to the hospital.
- 70 At around 3.39-3.42am, Jesse arrived at Coffs Harbour Hospital Emergency Department and resuscitation efforts were taken over by hospital staff.
- 71 At 4.00am, Dr Hywel James pronounced Jesse life extinct.

Post-mortem examinations

Dr Clifton, Staff Specialist in Forensic Pathology, report dated 30 November 2021

- 72 A post-mortem examination on Jesse was undertaken by Dr Clifton on 24 June 2021. Dr Clifton recorded Jesse's cause of death as 'unascertained.'
- 73 As to the circumstances of Jesse's death, Dr Clifton stated:

The circumstances of death are of an acutely confused young adult male who suffered a witnessed cardiorespiratory arrest whilst in the care of Emergency Services, after a witnessed tonic-clonic seizure, post-ictal agitation, prone restraint and the intramuscular administration of the antipsychotic agent droperidol.

- 74 Significantly, no illicit or prescription drugs were detected in Jesse's toxicology testing (save for droperidol which was administered by paramedics at the scene and amiodarone which was administered by ED staff during resuscitation).

75 Dr Clifton noted:

- (1) Jesse's heart was enlarged which could provide for a theoretical risk of a sudden arrhythmia in the right conditions
- (2) there was no pathology identified in any of the major organs of the body to explain the cardio-respiratory arrest
- (3) post-mortem bacteriology and virology testing on brain swabs was unremarkable excluding organic brain pathology that may have caused the agitated behaviour, altered sensorium, seizure or ultimate cause of death
- (4) post-mortem biochemistry testing was unremarkable and failed to identify any evidence of active systemic inflammation or bacterial infection that explains Jesse's agitated behaviour or altered sensorium or the death.

76 Dr Clifton noted that the role of restraint in deaths associated with law enforcement encounters is a controversial area in forensic pathology and not well understood. The literature is mixed in that the 'Vilke Review' in 2020 suggested that positional restraint does not cause ventilatory or cardiac compromise in healthy adult subjects. The 'Steinberg Review' in 2021 indicated that deaths due to restraint asphyxia are rare and postulated to occur in the context of metabolic acidosis, exacerbated by inadequate ventilation and decrease in carbon dioxide (potentially worsened by the administration of sedative agents).

Clinical A/Professor Michael Buckland,¹² report dated 10 September 2021

77 In his post-mortem examination of Jesse's brain, A/Prof Buckland found a lesion identified as a cavernous angioma (cavernoma) located in the right

¹² Clinical Associate Professor at the University of Sydney School of Medical Sciences, Head of the Department of Neuropathology at Royal Prince Alfred Hospital, founder and director of the Australian Sports Brain Bank amongst other things.

parietal lobe of the brain with some surrounding scarring. There was evidence of an older bleed from the cavernoma that could have been weeks or years old.

78 A/Prof Buckland stated:

The cavernous angioma shows evidence of a prior bleed, but the histological appearances indicate that this happened at least several weeks, and possibly many years, prior to death. The cortex overlying the lesion is gliotic and disorganised. This region of cortex may be epileptogenic, which may in part explain some of the deceased's behaviour immediately prior to death.

Expert evidence

Clinical A/Professor (Dr) Armin Nikpour,¹³ neurologist, report dated 11 February 2022

79 A/Prof Nikpour, opined that the direct cause of Jesse's death was:

Status epilepsy¹⁴ secondary to a cerebral cavernoma.

80 Having the benefit of the BWV, A/Prof Nikpour opined that:

- (1) the episodes witnessed would be consistent with focal epileptic seizures arising from the right parietal lobe of the brain at the site of Jesse's cavernous angioma
- (2) given he was having repeated seizures, Jesse was unable to communicate properly and he would have been confused and agitated in between attacks
- (3) when Jesse was outside the house, his seizure spread to involve both sides of the brain, manifesting as generalised tonic-clonic convulsions¹⁵.

81 Following Jesse's generalised seizure, the NSWA officers arrived and Jesse was administered 5mg of droperidol. After receiving the droperidol, Jesse had

¹³ See [8(11)].

¹⁴ Repeated seizures without recovery.

¹⁵ This is seen on the BWV at 2.39.30am.

a low respiratory rate and his airway was slightly compromised by him being in the recovery position.

82 A/Prof Nikpour stated:

I suspect this would have led to a severe reduction in blood oxygenation, leading to cardiac arrest and the lack of a heartbeat (asystole). Apnoea and bradycardia (reduce respiratory and heart rate) during and following epileptic seizures are a recognised cause of sudden death in epilepsy¹⁶...It is thought that the central brain mechanisms for regulating respiration and cardiac rhythm are disrupted by the storm of epileptic electrical activity in the brain, leading to sudden death. It is unclear whether intervention with cardiovascular resuscitation or artificial ventilation can always prevent death.

83 A/Prof Nikpour opined that the cause of Jesse's poor respiration would have been due to his epileptic seizures and *may* have been exacerbated by the use of droperidol.

84 Significantly, in his oral evidence, A/Prof Nikpour did not consider the administration of droperidol in the circumstances to have been inappropriate.

85 A/Prof Nikpour reported that:

Cavernous angiomas are benign vascular malformations present from birth and are occasionally genetically inherited. They rarely cause any major issues apart from epileptic seizures. Unfortunately, I think, in this case, the subject may have had occasional seizures leading up to this event-as described by his partner. These were not recognised or investigated. His behaviour during epileptic seizures was unusual and is often mistaken for psychiatric or intoxicated behaviour. ... Status epilepsy and repeated seizures may occur spontaneously, and there is no clear evidence of any precipitants in this case.

86 A/Prof Nikpour maintained his opinion in oral evidence that there was no clear precipitating event causing the seizure in Jesse's case.

87 In his evidence, A/Prof Nikpour said Jesse's reduced oxygenation could have been due to seizures shutting down the mechanisms regulating breathing combined with partially obstructed airway and low blood haemoglobin.

¹⁶ SUDEP.

88 A/Prof Nikpour thought that the night terrors reported by Jesse's mum may have been seizures.

Professor John Watson AM¹⁷, neurologist, report dated 25 November 2025

89 Prof Watson was engaged by the legal representatives for the paramedics.

90 Prof Watson agreed that the primary event was the epilepsy although he thought there was a chain of focal and generalised seizures occurring that evening. In A/Prof Nikpour's words, to which Prof Watson agreed, a spot fire, leading to a bushfire - or an epileptic storm that can play havoc with brain mechanisms for breathing and cardiorespiratory control.

91 In relation to the cause of Jesse's seizures, Prof Watson opined that:

...the heavy use of vaping plus the nicotine patches may well have been the precipitant for these seizure events.

92 That said, Prof Watson acknowledged that there was no evidence as to the amount of nicotine Jesse ingested the evening prior to his death, the strength of his vapes, when he last ingested nicotine, or his nicotine levels at the time of his death¹⁸.

93 Prof Watson referred to lay literature and anecdotal evidence, such as one of his patients having a seizure minutes after using a vape for the first time. Prof Watson stated:

There is evidence that seizures can be provoked by high levels of nicotine as delivered by vaping apparatus.

94 This is an emerging area of research and interest.

95 After Prof Watson had given his evidence, an article entitled 'Seizure Susceptibility in E-cigarette Users: Navigating the Clinical Management and

¹⁷ See [8(12)].

¹⁸ At the time of Jesse's death routine testing for nicotine or its metabolite cotinine were not conducted. The Assisting team were able to confirm with Dr Lorraine Du Toit-Prinsloo of NSW Health Pathology that nicotine and cotinine are now routinely tested.

Public Health Considerations' was proffered. The effect of the study revealed a range of neurological symptoms, including sudden tonic-clonic seizures, tongue biting, and urinary incontinence linked to e-cigarette use, highlighting the potential dangers of neurotoxic substances like propylene glycol and nicotine in e-liquids. These ingredients may disrupt neuronal function and increase seizure risk, pointing to the necessity of further research to understand their interactions with the brain.

96 A/Prof Nikpour considered nicotine as the precipitant for Jesse's seizures was possible but improbable. He noted the temporal disconnection between known nicotine ingestion and the seizures and the short half-life of nicotine in the blood. He made the comment that anecdotally, an epidemic of vape usage has not necessarily resulted in an epidemic of epileptic seizures.

97 A/Prof Nikpour acknowledged the unsatisfying nature of not having a precipitating cause and said that in a sizeable number of patients, a cause is often not identified.

Professor Robert Sanders¹⁹, Anaesthetist, report dated 15 October 2025.

98 Prof Sanders also considered the nicotine hypothesis was unlikely though it could not be ruled out. He also indicated that from a purely assumptive pharmacologist perspective, he would expect the impact to occur with peak consumption of nicotine, that is, contemporaneously.

Issues

99 I have had regard to all of the evidence and submissions in this inquest. I refer only to the salient aspects below.

¹⁹ See [8(13)].

The date, place, manner and cause of Jesse's death.

- 100 The expert evidence allows a finding that Jesse died on 20 June 2021 at Coffs Harbour Base Hospital.
- 101 Consistent with A/Prof Nikpour's opinion, I find Jesse's cause of death to be status epilepsy secondary to cerebral cavernoma.
- 102 While I discuss in detail above, the circumstances in which Jesse died informing Jesse's manner of death, as will be seen, I conclude that Jesse died from natural causes being an undiagnosed epileptogenic brain lesion (cavernoma) which led to status epilepticus and SUDEP.
- 103 The evidence adduced at the inquest did not support a finding on the balance of probabilities that Jesse's nicotine consumption was a causative factor in his death.

Was the care and treatment provided to Jesse by NSWA appropriate?

Actions in response to Jesse's presentation/the conduct of physical examinations

- 104 Mordue and Cooper were expecting a 'Mental Health and Concern for Welfare job'. On arrival, they spoke to Abby. When they approached the house, Price's taser was drawn. They were also told by attending officers that Jesse was aggressive and unpredictable causing them to proceed with caution. They did not have the benefit of seeing Jesse's seizure.
- 105 Mordue said officers told him Jesse had 'charged at them from the house.' Initially, he said this was said but not picked up by the BWV. However, he later agreed he could have been told that 'Jesse came flying out the door' (which was picked up on the BWV), but at the time he wrote his first statement, that is how he recalled it. Given the stressful situation in which he gave his statement and the sequence of events, I draw no adverse inference in respect of this likely error in his recollection of events.

106 Mordue confirmed he was familiar with NSW protocols for patients presenting with behavioural disturbance. However, given the nature of Jesse's presentation, it was difficult to determine which protocol was appropriate²⁰.

107 As to monitoring:

- (1) Mordue was taken to the EMR²¹ and said that he made a written record of Jesse's pulse at 2.44am as 90bpm but did not record his pulse again during the incident due to the sequence of events and the safety risks involved.
- (2) Mordue checked Jesse's pulse immediately prior to being loaded into the ambulance, however the rate was not documented²².
- (3) Mordue and Cooper maintained that they were individually monitoring Jesse's respiratory rate during the period between the administration of the droperidol and when Jesse was loaded onto the stretcher. Mordue said that he was aware of the risks of prone restraint and was consequently monitoring Jesse's body by standing at Jesse's head.
- (4) Mordue and Cooper disagreed that monitoring equipment could have been attached to Jesse prior to him being transferred into the ambulance.

108 Cooper told Mordue and the attending NSWPF officers that he had been to the residence before for Jesse and that he was in a drug induced episode. On further questioning and review of the relevant records, that was not the reason for his prior attendance. Though when he said that, he believed it to be true.

²⁰ At the time there were 3 potentially relevant protocols in place, M-28 - Behavioural Disturbance Medical, T-24 - Behavioural Disturbance Trauma and MH-6 - Behavioural Disturbance Mental Health.

²¹ NSW Electronic Medical Record.

²² The Vital Signs Survey and the main commentary was written after the job, not contemporaneously.

109 Cooper and Mordue were told by Price that Jesse had a seizure before they arrived, a description of the seizure was also provided.

A/Professor Tony Hucker²³, critical care paramedic, report dated 5 July 2024

110 A/Prof Hucker opined that:

- (1) overall, the paramedics who attended on Jesse performed below the standard expected of a reasonable paramedic crew. He described their approach as 'casual' and noted a failure in conducting a thorough and ongoing assessment of vital signs such that they did not recognise Jesse's deterioration and cardiac arrest.
- (2) a reasonable paramedic team would have thoroughly assessed Jesse on arrival and continued very close and regular monitoring. Jesse was unresponsive with obstructive breathing (snoring) and this could have been simply controlled with a positional movement.
- (3) there was a lack of clinical curiosity about Jesse's presentation and an apparent assumption that it was related to drugs or alcohol.
- (4) by not examining Jesse's conscious state, the paramedics had no way of knowing whether he was unconscious or asleep. He thought Jesse was more likely unconscious after the seizure and the snoring was an indicator of airway obstruction. A cardiac monitor along with oxygen saturation probe ought to have been attached to measure pulse and oxygenation.

111 In oral evidence, A/Prof Hucker reiterated that the critical failure was to apply monitoring equipment to Jesse during an available opportunity which would have allowed paramedics to tell the difference, during Jesse's calming phase, between sedation working and Jesse deteriorating. Without the correct

²³ See [8(8)].

monitoring equipment, it is very difficult to tell whether a person is simply responding to the sedative or clinically deteriorating.

112 Despite rigorous examination by counsel for NSW, A/Prof Hucker maintained his position that he thought the care provided by the paramedics was below the standard reasonably expected. He fairly recognised the very difficult situation in which the paramedics was working and was able to empathise with this, having a great deal of experience in similar situations as an operational paramedic and a reviewer of many videos of adverse outcomes following sedation. He also acknowledged that each of the paramedics and NSWPF officers were acting with the intention of helping Jesse as best as they were able.

113 A/Prof Hucker maintained that there was a period of time when Jesse was quieter, motionless on the ground when the paramedics could have reasonably attempted to apply monitoring equipment to Jesse, especially as there were two NSWPF officers available to assist. He did not consider Jesse to be overly agitated at that stage.

114 A/Prof Hucker thought Jesse posed no risk when he was on the stretcher. He considered that Jesse appeared to be flaccid, and his breathing was laboured. A/Prof Hucker considered that if someone had called 000 and reported those symptoms, they would have been told to commence CPR at that point. He was critical of the focus on applying restraint rather than monitoring Jesse.

Sean Mutchmor²⁴, critical care paramedic, report dated 5 November 2025

115 Mutchmor agreed that there were opportunities missed by the paramedics. He thought Jesse's pulse should have been taken more regularly. He also thought Jesse could reasonably have been moved sooner after he was sedated and he agreed that there should have been closer monitoring of Jesse. Mutchmor

²⁴ See [8(9)].

ultimately thought that, in the circumstances, the care given by the paramedics was reasonable given the difficult circumstances in which they were working.

116 Prof Watson's view was that, on balance, Jesse's death 'could not have been prevented with different treatment and management'. A/Prof Nikpour agreed that the only way things would have been better is if Jesse was in an emergency department with all available monitoring equipment around him and rapid response.

117 In relation to A/Prof Hucker's criticism of the paramedics for not applying monitoring equipment prior to transferring Jesse to the ambulance, Prof Watson said that the right place for Jesse was the back of the ambulance and it was appropriate to try and get him there before they could even start to apply monitoring equipment.

118 Prof Sanders stated:

While seizures can be fatal, it is my opinion, that the combination of [Jesse's] postictal²⁵ state and the droperidol contributed to respiratory depression. In my opinion, there was inadequate attention to the positioning of [Jesse's] airway to prevent airway obstruction, combined with lack of supplemental oxygen and adequate monitoring of oxygen saturations.

The administration of medication

119 In relation to the amount of droperidol administered, Cooper said he drew up 10mg. Mordue said he made a split-second decision to give only half a dose without discussing this with Cooper. Mordue was taken to the transcript of the BWV where he was heard to say, '*When you're ready, I'm just going to give some in his leg. I'll just go the whole 10.*' Mordue maintained this last second change of mind and there was no way of independently confirming what dose was given. His evidence was not challenged and I accept that 5mg of droperidol was administered.

²⁵ Post seizure.

- 120 Prof Sanders considered the plasma concentration of droperidol taken from Jesse at autopsy was within the normal range and not considered to be toxic.
- 121 Dr Robertson opined that cardiac arrest is not expected after a 5mg dose of droperidol. He indicated that given the dose and the time frame, he would not have expected any adverse effect.
- 122 Prof Sanders agreed with A/Prof Nikpour that it is 'often difficult to predict the reaction of the different individuals and their sensitivity to different sedatives'. He considered it plausible that the sedative effect of droperidol precipitated the cardiac arrest. However, he opined that it was the combination of the drug in the post-ictal state that is the critical event. That is, the effect of the drug could have been exaggerated in someone having an epileptic seizure. In Jesse's case, the combination leading to respiratory depression, hypoxia and cardiac arrest. Prof Sanders reiterated that the effect of droperidol on a patient could not be known.
- 123 The experts agreed, and I accept, that a 5mg dose of droperidol was reasonable in the circumstances.

Positioning and physical and mechanical restraints

- 124 In June 2021, there was little published guidance within the NSW regarding appropriate restraint. Contained within the 'Skill-Mechanical Restraint Device' document there is reference to never restraining a patient in the prone position. However, there was nothing in the three NSW protocols dealing with Behavioural Disturbance²⁶. That said, the paramedics involved in this matter acknowledged they were aware of the dangers of prone restraint. Mordue said after the droperidol was administered and during the prone restraint period, 'Can we get him on his side at all?'
- 125 As reflected in the BWV, the situation was a difficult and dynamic one. Jesse was making odd noises, and he was not engaging with or responding to

²⁶ See footnote [20].

anything said to him. This was not his fault and not intentional - it was as a result of his status epilepsy. He continued to move during the restraint period and it was understandably difficult for all those present to keep Jesse contained.

- 126 Physical restraints and mechanical restraints were used on Jesse by paramedics with assistance from the police officers. Mordue said that it was easier to administer the droperidol from the prone position due to Jesse's movements and the darkness outside, which limited the places he could stand while being able to see adequately. Cooper said a decision was made to physically restrain and chemically sedate Jesse from the prone position as it was the safest option at the time. Both denied that pressure had been applied to Jesse's upper back, although Cooper's statement makes reference to him putting weight on Jesse's lower back.
- 127 Prof Sanders reported that the impacts of a seizure on the person experiencing it are often profound and can include impaired understanding of language and expression of language, and decreased comprehension. It is common for this to continue into the post-ictal state where delirium and significant confusion is common.
- 128 Jesse would not have been able to understand verbal communication while in the post-ictal state and therefore likely he would not have been able to cooperate with police officers and paramedics through the inability to comprehend requests. This puts the apparent resistance to requests in a different context.
- 129 Prof Sanders could not exclude a contribution of prone restraint to any subsequent hypoxia. However, he suspected this to be a less significant contributor than, later, lying supine in a post-ictal state with droperidol sedation.
- 130 A/Prof Hucker said it would have been safer to restrain Jesse and sedate him in a lateral position. He considered prone restraint to be risky because it reduces the capacity to breathe and can cause respiratory acidosis²⁷ which can

²⁷ Development of large level of carbon dioxide in the blood due to inefficient respiratory function.

cause deterioration and/or 'tip' a person 'over the edge'. However, he accepted lateral positioning is not always possible. Mutchmor agreed but noted it is rarely possible to sedate from a non-prone position for those who are agitated or potentially agitated.

131 Jesse was restrained at about 2:53:00 and sedated immediately thereafter. He was moved onto his back and then stretcher at about 2:59:00, being about 6 minutes later.

132 Mordue and Cooper denied that it was possible to move Jesse into lateral position after administering the droperidol due to safety.

133 It was put to Mordue that he and Cooper had prioritised restraining Jesse over treating his clinical needs. Mordue said it was not always possible to get close to someone without restraints due to safety. Mordue said his priority was getting Jesse to the ambulance where it was a safer environment. He denied that there had been a significant change in Jesse's presentation by this time.

134 Prof Sanders opined that the placing of Jesse on the stretcher in a supine position²⁸ with restraints is likely to have contributed to him becoming hypoxic in the presence of reduced respiratory drive. Prof Sanders considered this as being evident on the BWV. He also reported that snoring is an indicator of an obstructed upper airway.

135 Prof Sanders stated that:

It is possible that the focus on placing the mechanical restraints distracted the team from the need to protect [Jesse's] airway and monitor [Jesse]...

[there was] inadequate attention to the positioning of [Jesse's] airway to prevent airway obstruction, combined with lack of supplemental oxygen and adequate monitoring of oxygen saturations.

136 A/Prof Hucker also thought during the restraint and sedation process Jesse should have been closely monitored. He acknowledged that whilst it is

²⁸ On his back.

sometimes challenging to maintain cardiac and oxygen saturation monitoring on an agitated patient, this level of monitoring should be applied immediately once the patient becomes less agitated. He said the safest position for restraint and sedation is to have the patient positioned on their side. In this position it is mechanically easier to breath.

137 A/Prof Hucker thought Jesse could be observed on the BWV deteriorating soon after the restraint and sedation process. He said during the phase of care where Jesse was wheeled on the stretcher to the back of the ambulance, normal breathing had ceased. At this point he was only taking occasional gasping type breaths, also known as agonal breaths. A/Prof Hucker suspects Jesse was in cardiac arrest at this time.

138 A/Prof Hucker observed that after Jesse had been taken to the back of the ambulance the two paramedics were concentrating on physical restraint at a time it looked like Jesse was not breathing. He said Jesse did not need physical restraint but rather needed his airway, breathing and circulation assessed.

139 Prof Hucker thought Jesse posed no risk when he was on the stretcher. He was flaccid and his breathing was laboured. He was critical of the focus on restraint rather than monitoring Jesse.

The communication of information, decisions and delegation of care

140 The communication and engagement as between Mordue and Cooper themselves, and in turn their engagement with police, was entirely appropriate.

141 Mordue explained that he was the treating officer during this shift and Cooper was the driver/assisting officer. They alternated roles each shift. Both paramedics referred to themselves as a team and referred to the working relationship with police on this night as cooperative.

142 Mordue said he understood that responsibility of police is scene safety. Price saw police's role as assisting the paramedics as well as scene safety. Price agreed that the police had a good working relationship with the paramedics.

- 143 In June 2021, there was an MOU between NSWPF and NSW Health in relation to care of patients with mental health problems who may fall under the *Mental Health Act 2007*. A new MOU is currently being developed. While it was discussed during the course of the inquest, its relevance is limited as it is directed to situations arising primarily in a hospital setting for patients with suspected or known mental health behavioural disturbances.
- 144 Watt²⁹ said he was not aware of any training given to police officers regarding relationship between themselves and paramedics where there is a behavioural disturbance job such as this. When asked about who makes decision about the scene, he said it is complex. He said paramedics decide the course of action they wish to take according to what they are taught about restraint, while the police focus on what tasks they are good at. Watt noted that police will be better at restraint than paramedics are. He added that while patient advocacy is a concern for paramedics, ‘no police officer would not listen to a paramedic.’
- 145 In relation to communication, A/Prof Hucker criticised the attending paramedics for having insufficient ‘clinical curiosity’ when ascertaining from police what had occurred. On a closer examination of the BWV transcript, appropriate questions were asked. We know now that the most significant issue was Jesse’s tonic-clonic seizure occurred prior to paramedics’ arrival. The seizure was referred to and Jesse’s physical actions were only described to paramedics. This information was provided in a broader context. With the benefit of hindsight, it is an issue that could have been further highlighted, however, at the time, paramedics were taking in the scene as a whole and all of the first responders were managing the unpredictability of Jesse’s presentation.
- 146 I consider in all of the circumstances that the communication between the first responders was entirely appropriate.

²⁹ Watt provided a statement that addressed the use of restraint generally by NSWPF officers, and in relation to the use of force used by Price and Garrels on 20 June 2021.

Conclusions - NSW

- 147 Paramedics Mordue and Cooper attended the residence for what they believed to be a 'welfare check'. On arrival, Jesse was described to them as being in an aggressive state - so much so that Price had drawn his taser. What was causing Jesse's state was unclear. Mordue indicated he did not know if it was a physical or mental episode or whether drugs were a contributing factor. It was dark and given the unpredictability of Jesse's presentation, transferring him into the ambulance, where they could properly examine and treat him, was going to be difficult.
- 148 In these difficult and unpredictable conditions, it is readily apparent on the evidence (and the experts concurred) that they did what they thought was necessary and appropriate to treat Jesse.
- 149 I consider in all of the circumstances that the care and treatment provided by the attending NSW officers was appropriate.
- 150 As detailed above, some of the experts did opine as to alternative courses which could have been undertaken, I consider these to be reflections on areas of potential learning in a complex area of out of hospital treatment rather than as criticisms of Mordue and Cooper's conduct in the lead up to Jesse's death.

Was the response by NSWPF officers appropriate?

- 151 Price, on shift with Garrels, arrived on scene expecting a cross between a mental health job and a concern for welfare job. He explained that a concern for welfare job is a broad term for 'someone needs help, don't know why'.
- 152 On arrival they entered the house. Price saw Jesse lying on his back, he could hear snoring and he could see Jesse's chest rise and fall. A couple of minutes later, when Jesse started screaming, Price thought it sounded aggressive and Jesse might attack so he drew his taser.

- 153 Price said he and Garrels spoke to Abby while still in the car on the driveway, though he could not recall most of this conversation. He could not recall any mention of Jesse having bad dreams that made him act strange in the past.
- 154 Price activated his BWV. This proved invaluable in relation to the investigation into the circumstances of Jesse's death, particularly as the medical experts were able to see what was happening to Jesse in the lead up to his death.
- 155 Price said he thought the howling noises were aggressive based on his experience, despite saying he had never heard that noise before. He acknowledged when questioned at the inquest that they could have been distress noises. He also said the smashing heard from inside the house could still be violent even if unintentional.
- 156 At 2.38am, Jesse came out the door and rolled headfirst down the several steps to ground level. He then laid on the ground and attempted to sit up or move on all fours. Price attempted to verbally engage Jesse calling his name. At 2.39am Jesse's whole body convulsed with his legs and arms very stiff and above the ground. This lasted for less than a minute. Price still had his Taser drawn at this stage. He later told investigators he had never seen anyone acting like this before.
- 157 When Jesse came out of the house, Price said he saw what he thought were seizure-type movements in that Jesse's body was contorting and toes were curling. He agreed the movements were involuntary. He agreed that at this time, Jesse was not aggressive, rather he was unpredictable.
- 158 When the ambulance arrived, Price advised the paramedics to be careful as he thought Jesse might lash out. He maintained that the noises being made by Jesse were interpreted by him as being aggressive.
- 159 After seeing Jesse repeatedly trying to stand up and falling over onto the concrete path, Price considered Jesse to be a danger to himself and determined he needed to be restrained for his own safety.

- 160 Price saw police's role as assisting the paramedics and making the scene safe for everyone. He gave repeated warnings to paramedics about Jesse becoming violent and that he might 'swing for them', despite Jesse not swinging for anyone prior to this and his actions appearing to be completely uncoordinated.
- 161 Garrels told investigators he was absolutely convinced Jesse was on drugs. Price couldn't recall whether Garrels said that to him at the scene. Price considered drugs as a possibility, but he was not sure what was causing Jesse's presentation. Jesse did not present like an ice-user, someone on heroin or a person taking marijuana. He thought, if it was drugs, it was as drug he had not come across before. The encounter with Jesse was not like one he had ever experienced before and no training in drug use, medical events or mental health addressed behaviour such as that displayed by Jesse.
- 162 The warnings given by Price to the paramedics had the effect of making the paramedics more cautious and reluctant to approach Jesse and to attach monitoring equipment. In retrospect, these warning may have been an overstatement. However, it is clear that none of the attending paramedics or police officers had experienced a presentation like Jesse's previously, they were unsure what was causing the presentation and they were acting cautiously as a result.
- 163 Garrels provided a statement but was excused from giving evidence at the inquest due to health reasons. In interview, he recalled attending the property where Jesse lived and hearing Jesse from 20 - 30 metres away. He then recalled seeing Jesse on the veranda floor thrashing around and making 'weird noises.' Garrels immediately thought Jesse was on some sort of drug (we now know he was not).
- 164 Garrels described Jesse falling out of the door and attempting to get up before starting to have a 'spasm' where his arms and legs were raised and locked. He had never seen such a thing before. He said they did not approach Jesse at that stage as a safety precaution. A short time later, Garrels put his boot under Jesse's head to stop it banging on the concrete. He said he then asked Mordue

to give Jesse something to calm him down. Garrels described putting his boot on Jesse's shoulder to keep him lying down in case he became violent. He told investigators that the shortage of police officers in the Coffs Harbour area also played a role in his decision making on this evening.

Use of restraint by NSWPF officers

165 At 2.50am, Jesse started to make loud howling noises again and he was moving around on the ground. Garrels repeatedly used his boot to keep Jesse prone on the ground whilst keeping his torch shining on Jesse. Jesse was uncoordinated, incoherent and did not respond to verbal prompts and questions.

166 In his statement, Watt discussed the philosophical policing approach regarding the use of force and the emphasis placed on 'reasonableness' being the underpinning feature of all force used by police, that is:

Police should only use force that is reasonable, necessary, proportionate and appropriate to the circumstances. Police should use no more force than is reasonably necessary for the safe and effective performance of their duties.

167 Training is delivered through the Tactical Operations Model which is a non-hierarchical model incorporating various types of force accessible depending on the circumstances. This model is taught along with the STOPAR³⁰ mandatory online training module.

168 Watt said control of a situation is paramount for police. He watched the BWV and said he had never seen anyone behave like Jesse. He would not categorise Jesse's behaviour as significantly violent but maintained it was not predictable.

Use of a boot

169 In relation to Garrels use of his boot, Watt said:

Police [are] expected to improvise and take advantage of what may be a fleeting opportunity to gain either an advantage or control during an incident.

³⁰ Stop, Think, Observe, Plan, Act, Review.

This may result in the employment of a technique not formally taught by the NSWPF.

- 170 Watt accepted that this technique might distress the person on the ground and he described that they might feel demeaned, disrespected and it might make them more hostile. Price had no concerns about seeing his colleague doing this and did not think it might have caused further distress to Jesse. Watt called it a 'terrible visual presentation.' Despite these things, Watt said whilst he would not endorse these actions by Garrels, he would not call them inappropriate either.
- 171 In terms of the techniques used to restrain Jesse, Watt said, 'there is no specific training that teaches utilising a foot to hold someone down. However, there is also no policy or training that prohibits it.' He further stated, 'the decision by Garrels to attempt to hold Jesse down with his foot is within the ambit of training and does not breach any policy from an operational safety perspective.'
- 172 While it may not have been contrary to NSWPF training, policies and procedures, I consider Garrels use of his boot to restrain Jesse was inappropriate and ill-advised.

Prone restraint

- 173 The BWV does not show clearly the exact positions of each of the NSWPF officers and paramedics involved in restraining Jesse. The evidence is consistent in terms of who was in what general position. Price was around Jesse's legs, Garrels was on Jesse's upper right side and Cooper was on Jesse's upper left side. Price reported that he could only see the backs of the two men on the front.
- 174 Dr Clifton observed on post-mortem 'contusions to the central and upper back, back of the neck, back of shoulders and lower back suggestive of pressure to these areas whilst lying prone'. Price could not see exactly where pressure was being applied to Jesse although he thought none was applied to Jesse's back. He speculated that the injuries found there could have been from when Jesse first fell down the stairs as he came out of the house.

- 175 After 5 minutes or so of Jesse being held in a prone position, Mordue mentioned moving Jesse to his side. In relation to awareness of positional asphyxiation, Price told investigators during interview that he ‘...hadn't thought it until the exact second that it came into my head the words came out of my mouth and I just said, "Guys, we need to be conscious of positional asphyxia.”
- 176 In evidence, Price could recall that he had been trained to move someone out of prone position once it was safe to do so but could not recall being instructed about a time limit for a safe period for restraint. Price also recalled being instructed to monitor breathing during restraint. Price said he has not received training on prone restraint or sedation since June 2021.
- 177 Watt said that prone restraint is still trained as an option in situations where it is most appropriate. Officers are not trained on the time limit for which a person should be restrained as it depends on the circumstances. Watt spoke about the unfortunate wording of a 2014 NSWPF manual about prone restraint that was inconsistent with the training that was being delivered.
- 178 Watt said:
- At the time of the incident now before the court, the primary focus of training was prone restraint to initially gain control followed by a move as soon as practicable to side or lateral position akin to the recovery position provided control could be maintained in that position. Because both the purpose of restraint and the actual situation it occur in are incredibly variable, police are given wide leeway in how they effect the restraint of the subject.
- 179 Watt did not consider that the period of Jesse’s restraint was excessive. Watt agreed that Jesse’s reduction in movements after sedation would be an opportunity to move him to a different (lateral) position, with the caveat that the information (e.g., touch, muscle tension) that was available to NSWPF officers on the scene is not available to him. Watt said he would quite possibly have moved Jesse to a safer positioning at an earlier stage. He also said he would have moved Jesse to the lawn area for Jesse’s safety.
- 180 Watt agreed that the Clinical Safety Alert from NSWA regarding physical restraint and Sedation in Behaviourally Disturbed Patients (which prohibits

prone restraint and emphasises patient advocacy) was inconsistent with the way in which NSWPF officers are currently trained. However, he foreshadowed training due to begin on 1 July 2026 (based on his own research) which is consistent with NSWA's position.

181 Watt thought that the decision to restrain Jesse for his own protection and to facilitate sedation by paramedics was in accordance with NSWPF policies and trainings.

182 I find that the restraint techniques used by the attending NSWPF officers were within the scope of their policies, procedures and training.

Conclusions - NSWPF

183 I find that the response by attending NSWPF officers was appropriate having regard to NSWPF policies and/or protocols. In particular, their communication, co-operation and engagement with each other and attending paramedics and the restraint techniques they adopted. However, while it may not have been contrary to NSWPF training, policies and procedures, I consider Garrels use of his 'boot' to restrain Jesse was inappropriate and ill-advised.

Is it necessary or desirable to make any recommendations?

184 At the inquest we heard from Martin Nichols and Michael Richer from NSWA about substantial changes to practice and procedure since 2021 including new Clinical Practice Guidelines (**CPG**) BD-1 and BD-2 released in late 2023³¹, updated procedures and associated training packages/modules.

185 Nichols indicated that the NSWA Director of Medical Services, Dr Bendall, wanted a clear statement to stand out to the paramedic workforce that sedation is a high-risk intervention, so they developed bold red warning in CPG BD-1.

³¹ These generally replaced MH-6, M-28 and T-24 (see footnote [20]), but NSWA still maintain separate guidelines for behavioural disturbance in mental health situations.

- 186 In 2021, the only procedure or protocol that guided paramedics on restraint was the Mechanical Restraint Device procedure which included a small section dealing with prone restraint. The Clinical Procedure on physical restraint was added in 2024. It is an addition to an existing skill sheet on how to attach mechanical restraint devices to stretchers. It was also designed to highlight the risks NSW and the paramedicine profession more broadly have been aware of in relation to sedation and restraint. It includes monitoring post-sedation as a professional reminder.
- 187 Clinical Procedure on sedation intentionally highlights to all staff that sedation is a high-risk procedure. Nichols indicated there was no direct policy or procedure regarding monitoring equipment post-sedation in 2021, and that this new standard provides greater guidance. This is particularly significant for a case such as this where there is a suggestion that post-sedation monitoring could have been better.
- 188 NSW issued a Clinical Safety Alert on 1 August 2025 named *Physical Restraint and Sedation in the Behaviourally Disturbed Patient*. The alert noted the ‘immediate clarification is provided below regarding sedation and physical restraint, and an immediate change of practice related to sedating patients who are prone.’ The current advice issued by NSW is that clinicians should continue to advocate for the safety of their patient throughout the duration of care.
- 189 A Clinical Safety Alert³² on physical restraint and sedation was produced in August 2025 following a high-profile case and awareness of other matters going through NSW’s clinical governance process. Nichols indicated a theme noticed in some identified cases was the opportunity for paramedics to advocate for the release of restraint at an earlier point in time.

³² A Clinical Safety Alert is the highest tier of safety information in NSW. Paramedics are required to acknowledge that they have read and understood the alert prior to attending their next job, or that they would like to speak to an educator or manager about its contents.

190 The *Peri-Sedation Checklist* was released in August 2025 as a quick reference for paramedics once they have decided to sedate a patient. Prof Hucker referred to this as an impressive document.

191 Richer confirmed the training on the sedation assessment tool is mandatory and was designed to coincide with the release of the new CPG.

192 In terms of training, Richer explained that existing paramedics are required to undertake mandatory CPD³³, being two days (two x 12-hour shifts) every six months, though sometimes that interval may be extended due to operational requirements. He said the learning objective 'patient ownership rests with paramedic' is highlighted based on recent concerns with sedation but has also been part of paramedic training for a long time.

193 Nichols also indicated that mandatory training that coincided with the release of the new guideline ensures alignment across a workforce of over 6,000 paramedics with different levels of experience.

194 Richer said in his statement that by September 2025, all available NSW clinicians had completed the MCPD 2401 which included modules on mental health, behavioural disturbance and sedation.

195 Given the changes to NSW policies, procedures and training since Jesse's death to reduce the risks associated with sedation and restraint and the management of behavioural disturbance, it is not necessary or appropriate that any recommendations are made.

Concluding remarks

196 I will close by conveying to Jesse's family my sympathy for the loss of Jesse.

197 I thank the Assisting team for their outstanding support in the conduct of this inquest.

³³ Continuing professional development.

198 I thank the officer in charge, Det. Insp. Grant Erikson, for his work in conducting the investigation and compiling the brief of evidence which was supplemented by the Assisting team.

Statutory findings required by s 81(1)

199 As a result of considering all the documentary and the oral evidence heard at the inquest, I make the following findings:

Identity

The person who has died is Jesse Mathew Riley

Place of death

Coffs Harbour Base Hospital, Coffs Harbour

Date of death

20 June 2021

Manner of death

Jesse died from natural causes being an undiagnosed epileptogenic brain lesion (cerebral cavernoma) which led to his status epilepticus and SUDEP

Cause of death

Status epilepsy secondary to cerebral cavernoma.

I close this inquest.



Magistrate Hosking
Deputy State Coroner
Lidcombe
