



**CORONER'S COURT
OF NEW SOUTH WALES**

Inquest:	Inquest into the death of Phillip Mark WALTON
Hearing dates:	20 October 2025 – 24 October 2025
Date of findings:	20 March 2026
Place of findings:	NSW Coroners Court, Lidcombe
Findings of:	Magistrate Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in police custody – prone restraint – whether the response of police and ambulance officers was appropriate and consistent with policy and training
File number:	2023/00090739
Representation:	Mr J Harris, Counsel Assisting the Coroner, instructed by P Smith of the Crown Solicitor's Office Mr B Bradley instructed by M Turner of Minter Ellison representing NSW Ambulance Service Mr S Kettle instructed by C Blair of Makinson D'Apice Lawyers representing paramedic, Tracey Wheeler Mr S Barnes instructed by R Li of McCabes Lawyers representing paramedic, Shannon-Lee Chapman Mr D Nagle instructed by S Robinson of the Office of General Counsel of the NSW Police Force representing the Commissioner of Police Mr J Watts instructed by T McQuade of Legal Aid NSW representing Mr Walton's Senior Next of Kin, Sharon Olive

<p>Non publication order:</p>	<p>A non-publication order has been made pursuant to section 74(1)(b) of the <i>Coroners Act 2009</i> (NSW).</p> <p>A further order was also made pursuant to section 65(4) of the <i>Coroners Act 2009</i> (NSW) in relation to applications for access to the Court's file.</p> <p>Copies of these orders are on the Registry file.</p>
<p>Findings:</p>	<p>Identity</p> <p>The person who died is Phillip Mark Walton.</p> <p>Date of death</p> <p>Phillip died on 19 March 2023.</p> <p>Place of death</p> <p>Phillip died at Casino police station, Casino, NSW.</p> <p>Cause of death</p> <p>The cause of Phillip's death was cardiac arrhythmia which occurred in the context of physical exertion and hypoxia caused by restraint.</p> <p>Manner of death</p> <p>Phillip died while in the lawful custody of police, following an episode of agitation and self-harm that caused police to remove him from the dock and restrain him on the floor of the charge room. During the restraint, which lasted less than two minutes, Phillip lost consciousness and could not be resuscitated.</p>



Phillip Walton's art
Provided by the Walton family.



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1 Introduction

- 1.1 Phillip Mark Walton (**Phillip**) died on 19 March 2023, in the charge room at Casino Police Station. He was 48 years old.
- 1.2 On the morning of his death, Phillip attended a circus at the Casino showground. Soon after arriving, he became agitated and aggressive towards others. Police were called, and ultimately Oleoresin Capsicum (**OC**) spray and then a Taser were used to subdue him. Phillip was then handcuffed and taken to Casino police station.
- 1.3 On arrival at the police station, Phillip was placed in the dock in the charge room. He was briefly assessed by paramedics but was not transported to hospital.
- 1.4 As the paramedics were leaving, Phillip became agitated, and he struck his head forcefully against the Perspex wall and frame of the dock. Police removed Phillip from the dock and restrained him, face down, on the ground. He initially struggled, but lost consciousness. Although cardiopulmonary resuscitation (**CPR**) was commenced, Phillip could not be revived. He was declared deceased at 12:17pm.
- 1.5 Phillip was a much-loved member of a large extended family. He was a talented artist and sportsperson. He loved live music. He was passionate about Rugby League and a tragic Parramatta Eels fan. He was a great darts player. His sister described him as *big and soft like a teddy bear, with a loving, caring and gentle nature*. Phillip's behaviour on 19 March 2023 was very much out of character, and his death was sudden and unexpected. His mother, Sharon, brother, Ian, sister, Loen, step-father, Phil, and his extended family continue to experience profound sorrow and grief at his loss.
- 1.6 On behalf of the Coroner's Court of NSW, I acknowledge the tragic circumstances of Phillip's death and extend my deepest sympathies to his friends and family.

2 Why was an inquest held?

- 2.1 Under the *Coroners Act 2009* (**the Act**) a coroner is responsible for investigating all reportable deaths. This investigation is conducted primarily so that a coroner can answer questions that are required to be answered by section 81 of the Act, namely, the identity of the person who died, when and where they died, and the cause and manner of that person's death. A secondary function of a coroner is to make recommendations, if

appropriate, that arise from the evidence, in relation to any matter connected with the death.

- 2.2 At the time of his death, Phillip was in the custody of police at Casino Police Station, meaning that responsibility for his care and safety had been assumed by the State. An independent examination of the circumstances of Phillip's death and the care that was provided to him is therefore important to ensure that the State has adequately and appropriately discharged its responsibility to a person in its care. Sections 23(1)(a) and (c) of the Act provide that a coroner has jurisdiction to hold an inquest if it appears to the coroner that the person has died (or there is reasonable cause to suspect that the person has died) *while in the custody of a police officer or in other lawful custody or as a result of police operations*. Section 27(1)(b) of the Act provides that an inquest concerning the death of a person is required to be held if the jurisdiction to hold the inquest arises under section 23. An inquest is also required because the cause of Phillip's death has not been sufficiently disclosed (s27(1)(d)).
- 2.3 After Phillip died, Detective Inspector Wayne Walpole of the NSW Police Force (**NSWPF**) undertook an investigation into the circumstances of his death. Further material was gathered during the coronial investigation. At the commencement of the inquest, relevant material was tendered in the form of a 17-volume brief of evidence which included electronic evidence. Further material was tendered during the inquest, and, with the consent of the parties, two further exhibits were tendered after the oral evidence had been completed. In addition, oral evidence was given by police officers and NSW Ambulance (**NSWA**) staff who interacted with Phillip on 19 March 2023.
- 2.4 Five experts were also engaged to assist the court in understanding the cause and manner of Phillip's death. These were:
- Associate Professor Anna Holdgate, emergency physician;
 - Professor Alison Jones, clinical toxicologist;
 - Associate Professor Mark Adams, cardiologist;
 - Associate Professor Danny Sullivan, forensic psychiatrist; and
 - Adjunct Professor, Tony Hucker, paramedic.

All these experts gave evidence during the inquest.

3 Phillip's life

- 3.1 While any inquest inevitably focuses on the circumstances of the death of a person, it is important to recognise and acknowledge the life of the person the subject of the inquest in a brief and hopefully meaningful way, to better appreciate what their life, and their loss, meant to those who knew and loved them.
- 3.2 Phillip was born in Kurri Kurri and grew up on a small farm in Abermain, near Cessnock, with his parents, Sharon and David, his older brother, Ian, and his younger sister Loeen. His parents separated in about 1988. Sharon re-partnered with Phillip Olive (**Phil**). Phillip's father died in 2010.
- 3.3 Phillip grew up as part of a large multi-generational extended family. Many members of his family lived nearby. He was an adventurer who lived life to the fullest.
- 3.4 Phillip attended the Seventh Day Adventist High School in Cooranbong, and then Kurri Kurri High School. He was sociable and had a big friendship group. He was very good at art, sport, and music. He played rugby at school and later for the Kurri Kurri Bulldogs.
- 3.5 After leaving school, Phillip worked at a supermarket. He then joined a circus and later toured with a travelling carnival show.

Phillip's mental health

- 3.6 In his early twenties, Phillip began experiencing a decline in his mental health. Because of this, the trajectory of his life was altered for many years. It is important to understand Phillip's difficulties with his mental health during these years to appreciate how stable he was for almost two decades prior to 19 March 2023 and how unexpected and out of character his behaviour was on the day of his death.
- 3.7 In about 1992, Phillip moved to Broken Hill, where his sister Loeen lived. In 1994 he was charged with two armed robberies, in relation to which he was ultimately sentenced to eighteen months in custody.
- 3.8 On his release from custody in January 1996, Phillip returned to the family home at Abermain. Within a very short period, his mental health deteriorated.
- 3.9 On 15 February 1996, three weeks after his release from custody, Phillip went for a bushwalk with his cousin. He went missing and was found later with serious injuries, having attempted to jump from a cliff into a tree. He was taken to Cessnock District

Hospital for treatment, although he later absconded and was located swimming in a dam at a nearby vineyard. He was returned to Cessnock Hospital but became psychotic. On 27 February 1996, Phillip was transferred to James Fletcher Hospital in Newcastle. During that admission, he absconded and threatened to cut himself and others with a razor.

- 3.10 On 6 March 1996, Phillip was transferred to the Kestrel Unit at Morisset Hospital, where he remained for about eight months. He was diagnosed with schizophrenia. During the admission, he seriously assaulted four patients, engaged in self-mutilation, and attempted to abscond by swimming into Lake Macquarie. He was commenced on clozapine, which is used for treatment-resistant schizophrenia. He was discharged in November 1996 on a Community Treatment Order (**CTO**).
- 3.11 After discharge, Phillip moved to White Cliffs, near Wilcannia, where his father lived. By this time, Phillip's mother had moved to Casino with Phil.
- 3.12 On 31 August 1997, Phillip suffered a relapse of his illness. He attempted to harm his dog, telling doctors he was responding to internal voices. Two days later, he assaulted his father and smashed a window. Police were called and Phillip was restrained with the help of bystanders. He was taken to Bloomfield Hospital and detained. During that admission, he assaulted two female patients. There is a suggestion in the records that while in the community, Phillip had not been taking his medication for about five months.
- 3.13 Phillip was released from the hospital and entered police custody, although the criminal charges that were laid against him were later dismissed under the *Mental Health (Forensic Provisions) Act 1990*. He was transferred to Long Bay Hospital and later transferred back to Morisset Hospital. After his discharge from Morisset, Phillip's mental health settled.

Relationship with Lynda Garde

- 3.14 In 2001, Phillip formed a relationship with Lynda Garde. She was undergoing treatment for cancer at the time and living with her two sons at Evans Head. Phillip moved in with Lynda, and they remained together for a number of years. They lived at Evans Head, Yamba and Palmers Island. Lynda recalls that Phillip was still smoking cannabis when they first met.
- 3.15 In early 2004, one of Phillip's friends persuaded him to stop taking his medication, so they could work together on a boat. On 3 February 2004, Phillip suffered a relapse of his schizophrenia. He attempted to strangle Lynda, then attended his mother's home and ran

through a window. Police were called and they found Phillip in the back yard headbutting a wall. He was restrained, sedated by paramedics, and taken to the Richmond Clinic for treatment.

- 3.16 Phillip had been smoking cannabis daily. Following this incident, Lynda asked Phillip to stop using cannabis. Although Lynda knew Phillip took pills, she did not know that the pills were for schizophrenia. It appears that from about 2004, Phillip did stop using cannabis, and his mental health stabilised. Between 2004 and his death in 2023, nearly twenty years later, Phillip experienced no further episodes of poor mental health.
- 3.17 Lynda and Phillip separated in about 2014 or 2015. They had been living together, although not in an intimate relationship, for some years. Phillip remained living at Palmers Island until July 2021, when the property he was renting was sold. He then returned to Casino to be close to his mother.
- 3.18 On 23 July 2021, Phillip moved to a unit at 8/88 Barker Street, Casino. He remained living there until his death.
- 3.19 By all accounts, Phillip was a quiet man in the later years of his life. He saw his mother most days, taking her to her appointments and cooking dinner for her and Phil. He was in regular contact with his siblings and had a small circle of friends, some of whom he had known for many years.

Phillip's mental health in the period prior to his death

- 3.20 After moving to Casino, Phillip was supported by Lismore Community Mental Health Service through their Casino clinic. From 2022 Phillip's case manager was Jacqueline Newton. Due to the potential side effects of clozapine Phillip was required to attend a monthly review by his prescriber and to undergo a blood test. Phillip's blood serum results show that he was generally compliant with his medication. This was confirmed by Phillip's family and friends.
- 3.21 Ms Newton described Phillip as *passionate about taking his clozapine medication*. Phillip's brother Ian also commented that *I can't think of a situation where [Phillip] wouldn't take his medication*. However, a search of Phillip's home after his death located three packets of clozapine, containing 28, 29 and 20 tablets. Phillip was usually dispensed a packet of clozapine every month and it is unclear why Phillip had so many unused tablets in his possession. It is possible that he was not taking them as prescribed, however, no-one who

saw Phillip in the weeks and months before his death thought that he presented as unwell.

4 Events in the days prior to Phillip's death

- 4.1 Ms Newton last saw Phillip on 9 March 2023, ten days prior to his death. According to her, he appeared normal. Phillip's monthly blood test results from 9 March showed a clozapine level of 437 ug/L, described by Tim McRae, the clozapine coordinator for Lismore Community Mental Health, as *lower than normal but still within the therapeutic range*.
- 4.2 On 13 March 2023, Hudsons Circus arrived in Casino. There was a tenancy inspection of Phillip's home that day. The house was clean and tidy.
- 4.3 On 15 March 2023, Phillip received his Disability Support Pension. He withdrew \$200 cash on 16 March, and again on 17 March, although this appears consistent with his normal spending habits.
- 4.4 On either 17 or 18 March Phillip spoke by phone with his sister, Loeen. She said that he seemed his normal happy self.
- 4.5 On the morning of Saturday 18 March 2023, Phillip briefly saw his friend, Jamie Ryan, who lived in the same apartment block. Jamie told Phillip that he was going camping.
- 4.6 At 3:20pm that afternoon, Phillip collected his neighbour, Sheree Flick, from Ballina airport. She had been away for six months. He drove her home, and that evening they had a few drinks on the balcony of their apartment block, until about 10.30pm. At some stage, Phillip's mother also brought him some pizza. According to her, he appeared normal.

5 Events of 19 March 2023

The events at Hudsons Circus

- 5.1 Phillip had arranged to visit Hudsons Circus at the Casino showground on the morning of Sunday 19 March 2023. He was going with a friend, Arthur John Raymond (**John**), John's wife, and her sister. Phillip was looking forward to the circus and he appeared excited. He especially wanted to see the animals.
- 5.2 Phillip later told police he had eaten a cookie, containing cannabis, at about 10:00am that day. It is not known where Phillip obtained the cookie. Phillip's friend, Jamie Ryan, sent

him a message that evening, after his death, asking *How'd cooky monster go*, however Mr Ryan denied that this was a reference to drugs.

- 5.3 At about 10:30am, Phillip and the rest of the group entered the circus and took their seats. Although the show was to include flashing lights and sound, it appears that the show had not yet commenced.
- 5.4 Within about 10 minutes of his arrival, Phillip told John he needed to find a toilet. When he did not return, John went looking for him. He found Phillip pacing around outside. Phillip said he did not feel well, and John suggested he pour water on his face. John decided to take Phillip home and left him under a tree while he went to tell his wife.
- 5.5 After John left, Phillip approached a circus worker, Clive Hilton-Smith, who was directing traffic. Mr Hilton-Smith asked if he could help, but, according to him, Phillip appeared vacant. Then, with no warning, Phillip swung a punch at Mr Hilton-Smith, missing him. He did this two more times, as Mr Hilton-Smith retreated. Mr Hilton-Smith went to tell his manager, Aaron Longford, what had happened. When Mr Longford approached Phillip, Phillip again raised his fist but then calmed down. Mr Longford directed him to leave the showground, which he did. Phillip began walking towards town along the main road, Summerland Way. Members of the public who were at the circus observed these events. Some say Phillip was leaning over and looked like he was finding it difficult to breathe.
- 5.6 At 11:01am, Mr Hilton-Smith called triple 0. He told the operator that someone had tried to punch him. Among other things, he said, *he's got mental health issues without a doubt*.
- 5.7 At 11:02am, the incident involving Mr Hilton-Smith was broadcast on NSWPF radio. It was acknowledged by Senior Constable (**SC**) Stacy Bunker and SC Mitchell Christie at 11:04am. They were on duty in full uniform in a vehicle with call sign Casino 21 (**CAS 21**). SC Bunker was the driver, and SC Christie was the passenger. SC Bunker was armed with a Taser and was the only one of the two to wear Body Worn Video (**BWV**). They attended the showground at 11:06am. The station supervisor, Sergeant (**Sgt**) Wayne Crotty, also acknowledged the incident, although he did not arrive until later.

The arrival of police

- 5.8 On arrival, officers Bunker and Christie saw Phillip walking along Summerland Way towards town. According to SC Christie, Phillip appeared agitated, with an angry look on this face.

- 5.9 SC Bunker parked CAS 21 in a position facing Phillip. SC Christie exited the police vehicle first and said to Phillip words to the effect of *Hey mate, how are you? Is everything alright.* As he did so, Phillip ran straight towards him screaming *just like an animal* and with clenched fists. SC Christie stepped out of the way, and Phillip lost his balance and fell face-first on the grass verge. They did not make physical contact.
- 5.10 SC Christie tried to restrain Phillip on the ground. He placed a knee on Phillip's right shoulder and took his right arm, instructing him to stay on the ground. Meanwhile, SC Bunker exited the vehicle and came to assist her colleague. She tried to handcuff Phillip, but she was unable to get his arm out from under him. During the subsequent struggle, Phillip struck SC Bunker on the left side of her head, causing her to fall backwards.
- 5.11 SC Bunker then sprayed Phillip in the face at close range with OC spray, although that did not incapacitate him and appeared to make him angrier. SC Christie said they would have to use a Taser on Phillip. He then rolled away to allow SC Bunker to discharge her Taser. SC Bunker described that during this interaction Phillip was *more or less growling...not really actually saying words as such.*
- 5.12 At 11:07am, SC Bunker discharged her Taser. Phillip had got to his feet at this point and was running towards her. One probe struck Phillip's hip, but the other one went past him and struck SC Christie's leg. He received a painful shock.
- 5.13 Two seconds later, SC Bunker discharged her Taser again. This appears to have incapacitated Phillip, and he fell onto his side on the grass verge. SC Christie moved in to handcuff Phillip while he continued to resist. SC Bunker again discharged her Taser while Phillip was on the ground.
- 5.14 Three workers from the circus assisted the police officers to handcuff Phillip, and then to place him in the cage of the police vehicle. Sgt Crotty arrived on scene after Phillip had been tasered and handcuffed and assisted in conveying Phillip to the police vehicle.
- 5.15 SC Bunker began to drive back to Casino police station. However, within a short while she experienced blurred vision. She stopped and swapped seats with SC Christie. At 11:13am, the officers made a request for an ambulance to attend at the police station, because Phillip had been tasered, and to assess SC Bunker's injury. During the trip back to Casino police station, SC Christie could hear what he believed to be the sound of Phillip kicking the door of the police vehicle.

5.16 Phillip's friend, John, who had remained at the circus, was unaware of these events. He had returned from speaking to his wife, to find that Phillip was gone. He sent Phillip a text at 11.15am, asking if he was okay as the show was starting.

Events at Casino police station

5.17 Subsequent events at Casino police station are recorded on CCTV and, in part, on SC Bunker's BWV.

5.18 The police van arrived at the police station at about 11.20am. An ambulance, with paramedics Tracey Wheeler and Shannon Chapman, arrived at the front of the station at about the same time. The paramedics came into the station but were told by Sgt Crotty to wait while Phillip was removed from the police vehicle and placed in the dock.

5.19 SC Bunker and SC Christie entered the station and had a discussion with Sgt Crotty and SC Brin De Lyster-Bird, who was performing station duties that day. All four officers then went to the van dock.

5.20 At 11:24am, Sgt Crotty introduced himself to Phillip and asked him to exit the caged vehicle. In response to Sgt Crotty asking Phillip what had happened, Phillip replied *head fucked*. Although his hands were handcuffed behind his back, Phillip was able to exit the van unaided. Sgt Crotty held him by the upper arms and walked him up a ramp and into the charge room. As he did so, Sgt Crotty said, *you're not well, mate, is that right? You suffer from mental illness?* The response was inaudible, but Sgt Crotty replied *No drama*.

5.21 Phillip was searched in the charge room, and his wallet, phone and keys were taken. On the video Phillip appears distracted and is pacing slightly. Sgt Crotty asks him *And how are you feeling at the moment?* Phillip replies *I'm fucked mate and my life's going to shit*. The police suggested removing the handcuffs to which Phillip replied, *no*.

5.22 At 11:26am, Phillip was placed in the dock. He took a step forward at this point, and Sgt Crotty stopped him with his hand, and guided him backwards and onto a bench seat. The door to the dock was then closed. Phillip appears somewhat confused in the video footage.

5.23 Phillip remained seated in the dock, apparently calm, for the next six minutes, until the paramedics assessed him. There is no audio accompanying the video footage at this stage, but it appears that at times Phillip is speaking to the police officers.

- 5.24 During this period, Phillip told Sgt Crotty he had had a cannabis cookie at about 10:00am. SC De Lyster-Bird said he was concerned about this, and asked Phillip if it affected his medication, which he denied, and Phillip said it was *small*. SC De Lyster-Bird reassured Phillip that he was not in trouble for it.
- 5.25 Shortly afterwards, SC Christie went to speak with the paramedics. He was joined by SC Bunker. They told the paramedics about the events at the showground. They also said Phillip had a history of schizophrenia and that he had eaten a cannabis cookie that day.

Assessment by paramedics

- 5.26 At 11:32am, the paramedics entered the charge room. Ms Wheeler had been allocated the role of the treating clinician and Ms Chapman had been allocated the role of the assisting clinician. Ms Wheeler approached the dock, initially talking to Phillip through the Perspex wall. She then told Phillip she would open the door and asked him to remain seated. She later recorded that Phillip appeared calm, alert and had mild sweating. She saw no evidence of shortness of breath, breathing difficulties, or red or teary eyes. Phillip told her he had no injuries or pain. She asked about the Taser barb, and police told her that it had been removed at the scene. She asked Phillip if he knew what day it was, and he told her, correctly, that it was the 19th.
- 5.27 When Ms Wheeler asked Phillip if he knew the day of the week, he made a sudden movement with his legs, although he remained seated. Ms Wheeler closed the door of the dock and moved away. Ms Wheeler informed police that no further assessment was required. The whole assessment took approximately 45 seconds.
- 5.28 The paramedics left the charge room at 11:33am. They had been in the charge room for just over a minute. SC Bunker and SC Christie also left the charge room and had a discussion with the paramedics in the hallway for a couple of minutes. Sgt Crotty remained speaking with Phillip.
- 5.29 At 11:35am Sgt Crotty and SC De Lyster-Bird put on gloves, intending to enter the dock to remove Phillip's handcuffs. As they approached the cell door, Phillip became agitated and launched himself against the front Perspex wall of the dock, hitting the front and back of his head against the side walls. He then fell to the floor. SC Bunker and SC Christie returned to the charge room at that point.

- 5.30 Meanwhile, the paramedics were in the process of leaving the police station. The *Ambulance Incident Detail Report* records that the attendance of the ambulance at Casino police station was complete at 11:37:21.
- 5.31 Phillip remained on the ground for a period, kicking the walls of the dock. Sgt Crotty told him to calm down. After a period, Phillip rolled onto his front, got onto his knees and sat back on the bench. He appeared to calm down.
- 5.32 Sgt Crotty asked SC Christie to get the paramedics back. SC Christie went to the front of the station and opened the door, to see the ambulance driving off. He returned inside. SC Bunker made a radio broadcast, asking the paramedics to return to the station. At 11:38 SC Christie sent a text message to another paramedic he knew, Sarah Woerner, also asking the ambulance to return to the station because, he said, Phillip needed to be sedated. SC Christie and SC Bunker then both went to the kitchen to have a drink. At this point, SC De Lyster-Bird was alone in the charge room with Phillip.
- 5.33 At 11:38am, Phillip became agitated again. He launched himself against the frame of the dock and headbutted it multiple times, approximately 12 times in total. Sgt Crotty returned to the charge room and tried to calm Phillip down. By then Phillip had cut his forehead above his right eye, and blood was visible on the front wall of the dock. SC Bunker also re-entered the charge room. She had activated her BWV, which recorded the events that followed with audio.
- 5.34 Sgt Crotty reassured Phillip that things would be ok. At 11:39am Phillip sat back down, but within twenty seconds, he became agitated again, and launched himself against the frame of the dock, hitting his head 3 more times. Sgt Crotty said, *we have to get him out*.
- 5.35 SC De Lyster-Bird opened the door of the dock. He took Phillip by the right arm, with Sgt Crotty on the left, and pulled Phillip out of the dock, causing him to fall to the floor, with his hands still handcuffed behind his back, and land on his left side.

The restraint

- 5.36 Police restrained Phillip face-down on the floor, although his face was turned towards his left shoulder. The restraint commences at 11:39:40 on the charge room CCTV.
- 5.37 SC De Lyster-Bird and Sgt Crotty were positioned on Phillip's right side. SC De Lyster-Bird placed his right knee on the left side of Phillip's head. He held Phillip's left wrist in a wrist lock. Sgt Crotty held Phillip's right arm behind his back and placed a knee on the back of

Phillip's right thigh. Phillip was struggling, trying to raise his hips off the floor. SC Bunker was initially standing over Phillip and then moved to control his left hip/leg and left arm.

- 5.38 SC Christie re-entered the charge room a few seconds later and asked what his colleagues needed. They said, *Ambos – urgent*. He then left the room to make a call via radio to the ambulance. SC Christie indicated to the ambulance that Phillip was *trying to commit suicide*. Police understood that the paramedics would return and sedate Phillip.
- 5.39 Phillip can be heard on the video yelling or grunting, saying *No*. Police were trying to get him to calm down. Sgt Crotty said *Take it easy...you're not well...we're here to help you...it's okay mate*.
- 5.40 Phillip continued to struggle, although his movements gradually decreased. At 11:41am, about a minute and 20 seconds after the restraint commenced, Phillip stopped moving.
- 5.41 SC Christie re-entered the charge room again at about this time and asked if he could swap with anyone. Sgt Crotty said *nah, nah, we're good*. Within approximately 10 seconds, SC De Lyster-Bird asked Phillip *you're alright, fella?* When there was no response, police released their grip and then rolled Phillip onto his back. The restraint ends on the video at 11:41:20, that is, it lasted about 1 minute 40 seconds.
- 5.42 SC De Lyster-Bird then commenced CPR, which was continued by police until the arrival of paramedics.

Attempted resuscitation

- 5.43 The paramedics returned to the charge room at 11:45am, around four minutes after Phillip had become unresponsive. They had brought some equipment, and Ms Chapman returned to the ambulance to get more equipment. The paramedics took over CPR. At 11:49am, a defibrillator was applied. This did not show a shockable rhythm.
- 5.44 A second paramedic crew arrived at 11:51am, and at 12:11pm, a third crew arrived. At 11:58am a LUCAS device was placed onto Phillip.
- 5.45 Tragically, Phillip could not be revived. He was declared deceased at 12:17pm.

6 Events after Phillip's death

Critical incident declaration

- 6.1 At approximately 12:24 pm on 19 March Phillip's death was declared a Level 2 Critical Incident by NSWPF Northern Region Commander Assistant Commissioner Peter McKenna. At 1:06pm, Assistant Commissioner McKenna revised the incident to a Level 1 Critical Incident.
- 6.2 Soon after, a Critical Incident Investigation Team was formed with Detective Chief Inspector Wayne Walpole of the Homicide Squad assigned to be the Senior Critical Incident Investigator.

Postmortem

- 6.3 An autopsy was performed by forensic pathologist, Dr Donovan Loots, on 23 March 2023. Dr Loots had access to some police material, including the charge room CCTV.
- 6.4 Dr Loots found no significant injury to Phillip's neck or the upper airways, although layered dissection of the neck and shoulders revealed dense subcutaneous soft tissue and intramuscular haemorrhages to the shoulders and focal subcutaneous haemorrhages behind the left ear. Layered dissection of the posterior surface of the torso showed extensive focal haemorrhages in the subcutaneous soft tissues and muscles. Dr Donovan felt that some of these haemorrhages may represent *the application of pressure/force onto the back and posterior neck of the deceased while in the prone position*.
- 6.5 Phillip had multiple abrasions on his elbows and knees and contusions to his head. He had injuries that had the morphological appearance of Taser injuries. These included both 'puncture' wounds and associated abrasions, and injuries that appeared to be caused by a Taser used in *drive stun mode* although Dr Loots found these injuries difficult to interpret.
- 6.6 An internal examination showed, among other things, that Phillip had chronic ischaemic heart disease, with a 50% focal narrowing of two coronary arteries and a focal area of scarring of the posterior wall of the left ventricle.
- 6.7 Phillip's brain was examined by Associate Professor Michael Buckland. There were no skull fractures or intracranial haemorrhages. However, Associate Professor Buckland identified low-grade chronic traumatic encephalopathy (CTE), age-related changes to the brain, and mild small vessel disease – including an old infarct in the left temporal lobe. The only known cause of CTE is repeated head trauma in sport (although Phillip had previous instances of *headbanging* behaviour).

6.8 Toxicology revealed a potentially toxic level of clozapine, at 1.1mg/L (1100ug/L). A low level of cannabis metabolite was also detected, including in the stomach contents.

6.9 Dr Loots found the cause of Phillip's death to be *unascertained*.

7 The issues examined in the inquest

7.1 An issues list was developed to guide the coronial investigation and the conduct of the inquest. However, as is often the case, during the inquest, some of these issues gained more prominence, and some less, and additional issues arose for consideration. I have addressed the issues that ultimately emerged from the evidence as the most important under the headings below.

8 The cause of the decline in Phillip's mental health on 19 March 2023

8.1 Phillip had been diagnosed with treatment-resistant schizophrenia. He responded well to clozapine and had been maintained for many years on a low dose with no residual positive symptoms. According to forensic psychiatrist, Associate Professor Sullivan, it is *likely he had some negative symptoms but a range of collateral information from mental health clinicians, GPs, family and acquaintances indicated his stability*.

8.2 Associate Professor Sullivan's view was that Phillip's schizophrenia was well managed with clozapine. He concluded that the monitoring of Phillip's use of clozapine was ideal and included clozapine levels. According to Associate Professor Sullivan, these levels demonstrate that Phillip was maintained at a level which is considered therapeutic, consistent with his clinical presentation over the years preceding his death.

8.3 In the opinion of Associate Professor Sullivan, at the time of Phillip's death there was clear evidence of ongoing use of clozapine based on the statements of clinicians and relatives which documented his ongoing insight, and a high postmortem clozapine level. Against this is the evidence that there were unused boxes of clozapine found in Phillip's house after his death. Associate Professor Sullivan found that overall, however, there was no evidence of clozapine non-compliance.

8.4 According to toxicologist, Professor Jones, the target therapeutic concentration of clozapine is 350-600 ug/L. She agreed with Associate Professor Sullivan that all monitoring results for clozapine in the months prior to Phillip's death are consistent with Phillip taking his clozapine: 642 (16/08/22), 548 (10/10/22), 535 (31/10/22) and 446 (12/12/22).

However, in relation to this, Professor Jones comments *I am cautious not to ‘over infer’ from the reducing blood concentration over time that he was either failing to take tablets and/or storing them but 446 is significantly lower than 642*. Phillip’s test results from March 2023 (437 ug/L) showed a blood concentration of clozapine that was lower still than the results to which Professor Jones referred.

- 8.5 Phillip had used cannabis prior to his death. This was confirmed by postmortem toxicology findings, and his verbal statement to police at Casino police station. Collateral information indicates that Phillip used cannabis daily in the 1990s and early 2000s but had reportedly not used cannabis for many years. According to Associate Professor Sullivan, cannabis use is associated with increased rates of diagnoses of psychotic illness. In those who are prone to psychosis, the use of cannabis can precipitate an episode of psychosis.
- 8.6 Associate Professor Sullivan’s view was that on the morning of 19 March 2023 Phillip suffered an *acute onset of psychosis with disorganised, unpredictable, aggressive and agitated behaviour*. He considered Phillip’s behaviour consistent with psychosis because it was similar to previous behaviour in that he was uncommunicative and preoccupied, unpredictably aggressive without any provocation, and undeterred by the presence of police or others.
- 8.7 Associate Professor Sullivan considered that Phillip was *exquisitely sensitive* to cannabis, and that his use of cannabis precipitated what was likely a psychotic episode on the day of his death.

8.8 The evidence establishes that Phillip understood the importance of his medication in managing his mental illness, and that he was committed to taking it. While the unused boxes of clozapine found in Phillip’s house suggest that he may not have been taking his medication as prescribed, his blood serum results consistently place the levels of clozapine in his blood within the therapeutic range. I am satisfied that there is no compelling evidence that Phillip was not taking his medication.

8.9 Those who saw Phillip in the days leading up to 19 March 2023, did not notice any change in his presentation. The evidence establishes that Phillip ingested cannabis on the morning of 19 March 2023. I accept the evidence of Associate Professor Sullivan that Phillip’s use of cannabis precipitated what was likely a psychotic episode on the day of his death.

9 The police response to Phillip's behaviour at Casino showground

The use of OC spray and TASER

9.1 Phillip was clearly agitated and aggressive towards others at Casino showground, which was uncharacteristic for him. Once they engaged with Phillip, both SC Christie and SC Bunker struggled to gain control of him. During their attempts to obtain control of him, Phillip struck SC Bunker to the head.

9.2 SC Christie described his attempts to handcuff Phillip

I was attempting to get into the handcuffing position where you have one knee across the top of the shoulder and then one across the bottom and then get the arm in-between your legs, so you can effectively hold that arm with your legs and then get the other arm and get your handcuffs so your hands are free but he was too strong to get into that, so I had my left leg and knees on the, like, small part of the back and was attempting to get my other knee onto the top of his shoulder but that was when I was getting thrown off.

He explained that this technique is something that he had been taught to do and that police are taught to think about positional asphyxia when they restrain someone, including thinking about where the officer's legs are positioned when someone is restrained, although he explained that the priority was to get control of Phillip: *I was not thinking of positional asphyxia at the time of attempting to get control of him. No.*

9.3 When SC Bunker deployed the OC spray in an effort to bring Phillip under control, it made him *grunt and scream louder and made him angrier and stronger.*

9.4 SC Christie explained that the Taser was ultimately used because *I was not strong enough and she [SC Bunker] was not strong enough to do it with weaponless control.* Even after the TASER was deployed the first time, it was not immediately successful. SC Christie explained that when a person is tasered, they are incapacitated for only five seconds. This, he said, was insufficient time for him to put the handcuffs on Phillip.

9.5 SC Bunker ultimately discharged her taser three times. She discharged two cartridges and then discharged a further cycle in drive stun mode. This led to Phillip's incapacitation and handcuffs were able to be applied. Ultimately the officers required the assistance of three civilians to restrain Phillip and to get him into the police van.

9.6 The NSWPF policy document *Use of Conducted Energy Weapons (Taser 7)* dated September 2022 provides that the Taser may be discharged after an assessment of the situation and environment:

- to protect human life;
- for an officer to protect him/herself or others where violent confrontation or violent resistance is occurring or imminent;
- to protect an officer in danger of being overpowered or for an officer to protect him/herself or another person from the risk of actual bodily harm.

9.7 The use of OC spray and the Taser inevitably caused Phillip pain and likely made him more agitated. However, the use of both means of controlling Phillip was clearly available to police and their use was appropriate and in accordance with policy, particularly as weaponless control of Phillip, even with two officers, had been unsuccessful.

The use of BWV

9.8 As of 19 March 2023, police use of Body Worn Video (BWV) was guided by the November 2022 version of the NSWPF *Body-Worn Standard Operating Procedures (the BWV SOPS)*. The SOPS provide that *All police officers wearing police uniform, whilst engaged in duties of operational response, must where practicable, wear as part of their uniform, a BWV camera for use in accordance with these SOPs*. The BWV SOPs go on to explain that *[a] police officer will activate their BWV camera when it is appropriate to do so*. The BWV SOPS outline when BWV should be used, including *when a police power is anticipated or being exercised, or whilst performing a policing function*.

9.9 SC Christie was not wearing his BWV camera when he approached Phillip near Casino showground. His evidence was that this was because of the awkwardness of the clip that attached the camera to his uniform and the ease with which it could be dislodged. In his evidence he conceded that although it was *practicable* to wear the camera on his uniform, he did not do so on 19 March 2023. He accepted that had he been wearing BWV, the circumstances as he approached Phillip were such that he should have activated the camera.

9.10 SC Bunker's evidence was that although she was wearing BWV as part of her uniform, she did not have time to activate it. She was, however, travelling with SC Christie to a job

involving an alleged assault, and it was reasonable in those circumstances for her to anticipate that police powers were going to be used, and that her BWV should be activated.

9.11 Sgt Crotty also did not wear BWV when he attended the area near Casino showground. His evidence was that this was not intentional, just that he did not do so, perhaps he suggested because he had intended doing vehicle inspections that day. He said he would ordinarily wear BWV as part of his duties. It should be noted, however, that Sgt Crotty attended the showground in somewhat urgent circumstances when he was otherwise rostered as station supervisor.

9.12 The NSWPF BWV SOPs were not complied with by either SC Christie, SC Bunker or Sgt Crotty. Of the three officers, only SC Bunker was wearing BWV, and she did not activate it. Although this is an instance where BWV footage would have been useful to gain a greater understanding of Phillip's behaviour at Casino showground, both police and civilian witnesses gave consistent and undisputed evidence as to his presentation.

Transportation of Phillip to Casino police station

9.13 Although part of the narrative on the NSWPF Computer Aided Dispatch (**CAD**) in relation to events at the circus might have alerted police to the possibility that Phillip was experiencing a mental health crisis: *POI APPEARS POSS MH, KEEPS THROWING PUNCHING AT THE CIRCUS STAFF*, the evidence showed that this information was not transmitted over the police radio and was not accessed by responding police on the mobile data terminal (**MDT**) in CAS 21.

9.14 At the showground none of the attending police formed the view that Phillip was in fact mentally ill or showing signs of mental illness. SC Christie says he thought that Phillip was either mentally ill or drug affected and he was leaning towards the latter because *he was very strong and that's obviously most when they're drug-affected their strength is increased*. SC Bunker believed Phillip was *having a moment*. Her impression was that there was something going on but she did not consider that Phillip was mentally ill at the time he was at the showground. Sgt Crotty's evidence was that at the showground he also had no concerns for Phillip's mental health.

9.15 As none of the police officers formed the view that Phillip was mentally ill, they did not turn their minds to exercising the powers available to police officers in certain

circumstances under s22 of the *Mental Health Act 2007* to take a person who appears to be mentally ill or mentally disturbed to a declared mental health facility.

9.16 The officers took Phillip to Casino police station because there was a criminal process to go through both in relation to the alleged assault on Mr Hilton-Smith and that involving SC Bunker. They did, however, arrange for an ambulance to attend the police station, which was appropriate in circumstances where a Taser and OC spray had been deployed.

9.17 The decision by police to arrest Phillip was appropriate in view of the unprovoked assault on the circus workers and the subsequent assault on SC Bunker.

10 The paramedics' assessment of Phillip at Casino police station

Before the assessment

10.1 On 19 March 2023 paramedics Tracey Wheeler and Shannon Chapman were working together as a team out of Casino ambulance station.

10.2 Ms Wheeler was the station supervisor at Lismore Ambulance Station, although she had been deployed to Casino on 19 March 2023, due to staff shortages at Casino that day. As at this time, she was an ambulance officer of more than 25 years' experience. Her evidence was that during her time as an ambulance officer, she had attended police stations *a lot* to assess persons in custody.

10.3 Ms Chapman was stationed at Casino. As of 19 March 2023, she had 3½ years' experience as a paramedic. Her evidence was that although she knew Ms Wheeler, she had never worked in a team with her before.

10.4 Ms Wheeler was allocated the role of treating clinician. Ms Chapman was allocated the role of assisting clinician. The evidence of Adjunct Professor Hucker, who gave expert evidence to the inquest as to the practice of paramedicine, was that although they were allocated specific roles, the paramedics were jointly responsible for assessing and treating patients and for any documentation.

10.5 After they arrived at Casino police station but before Ms Wheeler and Ms Chapman entered the charge room, the two paramedics spent some time speaking to police officers in the hallway. Sgt Crotty's evidence was that in the course of this conversation he told Ms Wheeler that Phillip had schizophrenia, to which she replied *99 per cent of the population do*. When he replied that he must be one of the 1 percent, she commented *You just*

haven't been diagnosed. In her evidence Ms Wheeler confirmed that this conversation had taken place and conceded that her comments were inappropriate.

The assessment

10.6 NSW Protocol P6 outlines the requirements for paramedics managing patients under the control of another agency. This Protocol mandates, among other things, that prior to leaving the scene paramedics must:

- (i) have made all reasonable attempts to obtain all relevant information related to the patient's current medical/mental health history status and history if the paramedic was unable to complete a clinical assessment;
- (ii) have made all reasonable attempts to clinically assess the patient; and
- (iii) documented on the clinical record all the relevant reasons why information was not obtained and/or the patient was not assessed.

10.7 Ms Wheeler's evidence was that her assessment of Phillip commenced as soon as she entered the charge room. She observed that Phillip was sitting calmly, that he wasn't agitated and that he was making eye contact. She said that he was answering her questions bluntly but appropriately. In terms of visual observations, she observed that his pupils were neither pinpoint nor dilated but were reacting and that he was looking at her directly. She felt that the fact that Phillip was looking at her directly indicated that he was not experiencing a mental health episode as *[a] lot of mental health patients having a mental health episode will not engage in eye contact.* She did not observe any of the usual physical indicators of someone who was suffering the effects of OC spray – redness to the face or eyes, shortness of breathing or complaints of stinging or burning. She recalled asking Phillip a few questions: whether he had any injuries or any pain, what the date was and what day of the week it was. Her evidence was that Phillip had then jerked towards her, which she took as a threatening movement. She then closed the door of the dock and said to Sgt Crotty that Phillip was *more bad than mad.*

10.8 She accepted that once she had closed the cell door, she no longer felt intimidated and that there was, at that point, no immediate risk to her. She also accepted that although at the time she felt she had sufficient information to make the assessment that Phillip was *more bad than mad,* on reflection she did not have sufficient information to assess Phillip's mental health and could have asked more questions. She did not recall hearing

Phillip banging on the cell walls after she and Ms Chapman had exited the charge room, or at this point, Ms Chapman saying to her words to the effect of *I can hear them banging on the cell door. I think we should go back* nor the reply that Ms Chapman said she gave: *They will call us back if they need us.*

10.9 The evidence establishes that Ms Wheeler engaged Phillip for 45 seconds and based her assessment on this interaction and the information provided to her by the police prior to her entering the charge room. After stepping back and closing the cell door, she glanced at Phillip once but made no further attempt to interact with him.

The adequacy of the physical assessment

10.10 NSW Protocol A1 *Principles of Care* provides that it is the responsibility of paramedics to *perform a comprehensive patient assessment* in accordance with Protocol A2, which includes a *minimum of two sets of physiological observations for all patients*. The Protocol goes on to provide that *[i]n cases where a minimum of two sets of observations are not taken and/or recorded, paramedics must document the reason/s as part of the free text on the clinical record*. Protocol A2 *Patient Care* provides that paramedics must *[d]etermine if the patient or person responsible has the capacity and competency to give consent to treatment and/or transport decisions*.

10.11 According to paramedicine expert, Adjunct Professor Hucker, the paramedics *had a responsibility to take a thorough history and physically examine Phillip along with taking all the core observations including – conscious state, pulse, blood pressure, respiration, oxygen saturation and blood glucose level*. The NSW standard 9 step history taking process is outlined in Protocol R47 as:

1. Introduction
2. Presenting problem
3. History of presenting problem
4. Past medical history
5. Allergies
6. Medications
7. Family History
8. Social History

9. System review

- 10.12 Ms Wheeler's examination of Phillip was described by emergency physician, Associate Professor Anna Holdgate, as *very cursory*. Ms Wheeler did not attempt to obtain any physiological measurements such as pulse rate, blood pressure, oxygen saturations or temperature. However, Associate Professor Holdgate acknowledged that the nature of Ms Wheeler's physical examination was understandably limited by her concerns about Phillip's physical aggression.
- 10.13 Ms Wheeler agreed that all vital sign observations were made where she had not physically touched Phillip and without the benefit of any equipment. Her evidence was that she was able to determine Phillip's respiratory rate by counting his breaths for approximately 15 seconds, which she did not by using a watch, but by *estimation* and that she was able to assess the reactivity of Phillip's pupils as *[w]hen people blink and open their eyes, you can see that their pupil will change sizes*. She said she did this when the Perspex door to the cell was open and she was asking questions of Phillip.
- 10.14 Associate Professor Holdgate appeared to express some scepticism as to the accuracy of the vital signs measurements. She agreed that *we would commonly make some general assessment of the level of respiratory effort with someone clothed but I'm not sure how accurately you would have been able to see the rapidity of his breathing without actually getting [him] to sit up and lift up his shirt to show*. She conceded, however, in response to a question asked on behalf of NSWA that Phillip would not have been able to lift his shirt as his hands were handcuffed behind his back.
- 10.15 Associate Professor Holdgate's evidence was that to assess pupil reactivity one would have to be relatively close to a patient and be able to shine a light in their eyes. Her evidence was that it was not possible to assess pupil reactivity by watching someone blink as *pupil reactivity is about how the pupil responds to light*. This, she explained, required a *sustained change in light intensity*. She added *we all blink hundreds of times every hour, our pupils don't shrink and dilate every time*. Adjunct Professor Hucker's evidence was that to examine the normal function of the pupils properly, *usually it always involves shining a light into the eye*, but also noted that he has also examined pupil reactivity by *getting someone to close their eyes and hold their eyes closed, and then open them*. Adjunct Professor Hucker had not carried out this test using blinking.

- 10.16 Although she was aware that both a Taser and OC spray had been used to subdue Phillip at the Casino showground, Ms Wheeler conceded that she had not complied with the relevant NSW Protocol S11 in relation to the treatment of patients who had been affected by an *incapacitating agent* particularly in relation to checking for probe injuries and assessing for cardiac symptoms.
- 10.17 In the opinions of both Adjunct Professor Hucker and Associate Professor Holdgate, Ms Wheeler should have attempted to re-engage Mr Walton after she stepped back and the door to the dock was closed. In the view of both experts, although it was entirely reasonable for Ms Wheeler to withdraw once she became concerned for her physical safety, there was no reason not to continue the assessment through the closed door.
- 10.18 Adjunct Professor Hucker suggested that a physical examination could still have been conducted by placing Phillip in a seat with the assistance of police officers. It was submitted on behalf of Phillip's family that this should have taken place. However, it is difficult to know whether Phillip would have complied. Associate Professor Holdgate expressed some reservations about the use of what she termed a *show of force* to obtain physical observations. Her view was that such an approach would require a consideration of *[h]ow important it is to get those physiological parameters balanced against how much distress and agitation is that going to cause Phillip in doing that.*
- 10.19 Ms Chapman's evidence was that at the point where Ms Wheeler said words to the effect of *We are done here*, after she closed the door to the dock, she, that is, Ms Chapman, still believed that there was a need to further assess Phillip's physical state, although she acknowledged that she did not say anything to Ms Wheeler in relation to that at that time. In her evidence, Ms Chapman said that in retrospect she *certainly wouldn't allow* a 45 second assessment. Her evidence was that as she and Ms Wheeler were leaving the police station she heard banging in the charge room and said to Ms Wheeler *Tracey, I think we should go back.* According to Ms Chapman, Ms Wheeler responded *They can call us back if they need us.* She said she did not raise her concerns until this point because *..there was a part of me that was quite afraid of him and, I think I was just trying to work out how to approach it with Tracey in my head, to be honest.* Ms Wheeler had no recollection of this conversation taking place.
- 10.20 Associate Professor Holdgate considered that the physical examination conducted by the paramedics was brief and did not seek to identify any hidden physical injuries. Adjunct

Professor Hucker concludes that *the paramedics failed to meet the requirements of the ASNSW protocols by not completing a patient history, a physical assessment to rule out significant injury and take a set of core observations*. He adds *[t]his is the expectation of a paramedic demonstrating reasonable care*.

The adequacy of the mental health assessment

10.21 NSW Protocol MH1 *Mental Health Emergency* outlines the procedures to be undertaken by paramedics when performing a mental health assessment. In her evidence, Ms Wheeler accepted that she had not performed the assessment of Phillip's mental health that the protocol envisaged, despite having been told that he suffered from schizophrenia, that he took medication to manage his mental illness, and that he had behaved in a violent and aggressive manner at Casino showground. She confirmed that she had asked Phillip nothing about the medication he took to manage his mental health condition and had asked nothing further of the police officers other than what had been conveyed to her in the hallway prior to entering the charge room about Phillip's behaviour at the showground.

10.22 Adjunct Professor Hucker commented that while the paramedics had been called by the Police to assess both SC Bunker and Phillip for physical injuries, he would expect that as health professionals the paramedics would consider the context of Phillip's arrest and respond appropriately to his acute behavioural disturbance. Acknowledging the importance of protecting herself and others from injury, Adjunct Professor Hucker felt that Ms Wheeler should have attempted to undertake an assessment to identify the possible cause of Phillip's agitation and distress and his potential for violence. Adjunct Professor Hucker acknowledged that while this can be very challenging, it is a core role of health professionals.

10.23 In the context of police presence and with Phillip contained behind a locked door, in Adjunct Professor Hucker's opinion Ms Wheeler could have safely attempted to further engage with Phillip to assess his mental state. She should have taken into consideration the circumstances under which he had been brought to the station, as his acutely erratic and violent behaviour in the context of known schizophrenia and recent drug ingestion was highly suggestive of psychosis. Ms Wheeler agreed that she could have continued to ask questions of Phillip with the door to the cell closed and the police officers standing beside it.

10.24 Adjunct Professor Hucker suggests that had an appropriate assessment been conducted and Phillip's severe behavioural disturbance and risk of violence been identified, the paramedics and police could have worked together to arrange safe transport to hospital for further assessment and management. He acknowledges, however, that even with the immediate support of paramedics, Phillip's behaviour was so erratic and violent that he would have been difficult to safely restrain and transport. He concedes that given the rapidity of Phillip's behavioural deterioration as the paramedics left, and given the difficulty the police had in safely removing him from his cell and restraining him, with rapid progression to cardiac arrest, even with the best of coordinated paramedic and police care the same outcome may have occurred.

10.25 Ms Wheeler agreed that her assessment of Phillip at Casino police station was inadequate, although she added *[w]ith the years of experience I'd had and the visual observations that I had of him, you know, he wasn't displaying acute psychosis at the time.* The importance of both paramedics understanding that they are jointly responsible for the patient receiving appropriate care was underscored at the conclusion of Ms Wheeler's evidence: *I guess I didn't second guess myself because everyone in the room, nobody else in the room stood up and said anything different. So, I can see now, wrongly, I put it down to him being angry on that day and not mentally disturbed.*

10.26 Adjunct Professor Hucker concludes that although police had provided information to paramedics that Phillip was medicated for schizophrenia and had eaten a cannabis cookie, *[t]he paramedics did not conduct a thorough mental health assessment.* Associate Professor Holdgate agreed that no assessment was made of Phillip's mental health, and this ought to have occurred. She acknowledged, however, that it would have been challenging to seek to transport Phillip to hospital.

10.27 The evidence establishes that before they entered the charge room, the paramedics knew that police had wrestled with Phillip at the showground, that they needed the assistance of bystanders to control him, that he had assaulted a police officer, and that police had used both OC spray and a TASER to subdue him. They knew that Phillip had a history of schizophrenia, and that he took medication, although it wasn't clear what the medication was. They knew that Phillip had consumed a cannabis cookie that morning. It was apparent that on this evidence, the paramedics should have conducted both a physical and mental health assessment of Phillip.

10.28 In my view, Ms Wheeler should not be criticised for being concerned for her safety in response to Phillip's sudden movement and for closing the door to the dock, nor should she be criticised for not conducting a further assessment with Phillip restrained outside the dock on a chair. It is a matter for individual clinicians to determine the circumstances in which they feel sufficiently safe to provide clinical services. There was, however, no basis for Ms Wheeler not to continue the assessment of Phillip through the closed door to the dock.

10.29 The evidence establishes that the assessment that the paramedics conducted of Phillip while he was in the charge room at Casino police station was inadequate in relation to both his physical and mental state. It did not comply with the policy of NSW and it fell below the reasonable standard of care expected of paramedics.

The record of the paramedics' assessment of Phillip

10.30 The evidence of treating paramedic Ms Wheeler was that she created *Ambulance Electronic Medical Record 40428 (the EMR)*, relating to the first attendance of the paramedics at Casino police station in relation to Phillip, back at the Ambulance Station *quite a while* after Phillip's death, but during the afternoon of the same day. The EMR was signed by both paramedics.

10.31 The charge room CCTV establishes that the paramedics entered the charge room at 11:32 and left at 11:33. The total time that Ms Wheeler engaged with Phillip in the charge room at Casino police station was 45 seconds. Despite this, the EMR indicates that two sets of limited vital signs were taken at 11:23 and 11:30, that is, at 7 minutes apart. This is clearly false.

10.32 In her oral evidence Ms Wheeler admitted that whatever vital sign observations she had made of Phillip were made within the 45 seconds that she engaged with him. She explained *[s]o, the first one is when I first walk in and the second one is how he was when I left*. She agreed that somebody reviewing the record would get the impression that she had taken two sets of signs seven minutes apart and that this would be incorrect. Ultimately, she accepted that she had simply copied the first column of observations into the second column because *he hadn't changed in that time*, that is, in the 45 seconds that she had observed him.

10.33 The evidence of Ms Chapman was that she believed that the EMR was accurate at the time that she signed it. It is difficult, however, to reconcile this evidence both with Ms Chapman's account that she was concerned at the time about the cursory nature of Ms Wheeler's assessment of Phillip but did not know how to raise this issue with Ms Wheeler, and with the evidence she gave during the following exchange with Counsel Assisting:

Q. Can you explain why you signed this document if what it records is not accurate?

A. At the time, it felt like we were there a lot longer. I certainly don't remember looking at that and going and believing that that was wrong or inaccurate at the time. But certainly in hindsight, I can see now that that's inaccurate.

Q. You agree it's inaccurate, correct?

A. Yes Yes.

*Q. **And you'd agree with me, even at the time you signed this, you could not have had the impression that Phillip Walton had two sets of vital signs taken from him. Do you agree with that?***

A. Yes.

10.34 Ms Chapman also agreed in response to questioning on behalf of Phillip's family that the reference in the EMR to a mental health assessment having been conducted at 11:23 was incorrect because no mental health assessment had taken place.

10.35 It was submitted to me, and I accept, that it was not suggested to either paramedic that in creating, or signing, an EMR that was inaccurate in significant respects, they had done so with the intention to deliberately mislead. Nevertheless, the creation and signing of the EMR created a record of the paramedics' assessment of Phillip that was *in fact* misleading in the following respects:

- (i) the duration of the assessment;
- (ii) that two sets of vital signs had been taken; and
- (iii) that a mental health assessment had been conducted.

10.36 While it was suggested in submissions that their distress at Phillip's death may have affected the paramedics at the time they produced the EMR leading to its inaccuracies, neither paramedic gave evidence to this effect.

The NSW Incident Detail Report

10.37 NSW Protocol P2 provides that patients *who demonstrate capacity and competency (A3) may refuse to provide consent for clinical assessment, treatment, transport or a combination of these three*. Protocol P2 goes on to provide that *[p]aramedics must, in consultation with the patient...make recommendations on the assessment, proposed treatment and disposition options available for the patient's condition*. During her oral evidence, Ms Wheeler conceded that although she was in the process of determining Phillip's capacity, by asking him the date and day, she did not complete this process as he had moved suddenly.

10.38 Protocol A10 provides as follows:

Paramedics must determine the most appropriate treatment and referral decisions which form part of the overall clinical care they provide for patients. This can only be done after a comprehensive patient assessment and an adequate period of observation.

10.39 Ms Wheeler conceded in her evidence that she had not done sufficient assessment of Phillip to determine whether he was competent, nor to determine whether Phillip should be transported to hospital in accordance with NSW policy.

10.40 In the NSW *Incident Detail Report* created in relation to the attendance of the paramedics on Phillip at Casino Police Station, against *disposition* is recorded the words *No Transport* and against *Cancel Reason* is recorded *Rx refused against advice – P2*. It is understood that *Rx* means *treatment*. This suggests that Phillip refused treatment in accordance with his right to do so pursuant to NSW Protocol P2. Both paramedics conceded that this did not accurately reflect the reason for the paramedics ending their initial attendance on Phillip at Casino police station.

10.41 The evidence establishes that Ms Wheeler incorrectly recorded the reason for cancellation of the paramedics' attendance on Phillip as *Rx refused against advice – P2*, in circumstances where this was inaccurate.

10.42 After Phillip's death, but within hours of their initial attendance on him, the paramedics created and affirmed the accuracy of an electronic medical record of that attendance that was false in several fundamental respects.

11 Whether the actions of police in restraining Phillip on the ground of the custody room contributed to his death

- 11.1 The video footage of Phillip's behaviour in the dock was very confronting to watch. It is difficult to suggest that police should not have intervened in circumstances where Phillip was causing himself harm by repeatedly headbutting the door and wall. The evidence of both SC De Lyster-Bird and Sgt Crotty was that they believed that Phillip was going to kill himself if he was not removed from the dock. That evidence is supported by the contemporaneous radio broadcast that SC Christie made to the effect that the ambulance was required to return because Phillip was attempting suicide in the cell.
- 11.2 Associate Professor Holdgate felt that it was a judgment call about whether police should remove Phillip from the dock in circumstances where he was agitated and apparently causing himself harm. She described the choices of either leaving Phillip in his cell or removing him from the cell as *both fraught with risk*. Once out, Phillip was very hard to control, despite him remaining handcuffed.
- 11.3 By the time Phillip was removed from his cell he had been extremely physically agitated for several minutes and was audibly short of breath. When he is pulled from the cell he falls onto his right side and rolls into a near-prone position. SC De Lyster-Bird places his right knee on the left side of Phillip's head near the ear and neck pinning his head to the floor, he also uses his arms and possibly his other knee to hold the left side of Phillip's trunk down on the floor. Over the ensuing minute, Phillip gradually becomes less responsive and the colour of his face changes. He eventually becomes unresponsive and is found to be in cardiac arrest when he is rolled over a minute later.
- 11.4 SC De Lyster-Bird weighed approximately 130 kilograms at the time of Phillip's death. SC De Lyster-Bird's evidence was that he was using his weight to keep Phillip down, but he said *I made sure to keep my weight to the side of Phillip in order to avoid compromising his breathing*. His evidence was also that he turned Phillip's head to the side, watched his eyes, and watched his chest or abdomen rise and fall. He also said he was using his knee to prevent further injury to Phillip's head.
- 11.5 SC Brent Davey is an Operational Safety Instructor with the NSWPF. In his opinion it was necessary for police to remove Phillip from his cell, given the risk of self-harm. He noted that there are very few options available to police where an individual is handcuffed but

still resisting, other than the use of body weight to restrain them. He also noted the urgency of the circumstances that were facing police. Associate Professor Holdgate also appears to appreciate the difficulties police faced in safely restraining Phillip: *for a patient with extreme agitation as Phillip had, I think partly the fact that his hands were cuffed behind his back contributed to the difficulties in keeping him in a safe position.*

- 11.6 In the view of SC Davey, restraining Phillip on the ground was an appropriate action. In his evidence he pointed out that police are trained to use their body weight to restrain individuals and that sometimes it is the only effective tactic that police can use. SC Davey said that police are explicitly trained to avoid placing weight on the neck and they're explicitly trained about the risks of prone restraint and positional asphyxia. He described the way police restrained Phillip on the ground as being acceptable, albeit the position of SC De Lyster-Bird's knee on Phillip's head was not ideal. He accepted, however, that SC De Lyster-Bird was left with little choice as to how to control Phillip's head. Specifically, when restraining a person, SC Davey said that police are told to monitor a person and to maintain communication.
- 11.7 Understandably, there was considerable focus in the inquest on the positioning of SC De Lyster-Bird's right knee during the restraint, particularly whether it was positioned at least for some of the time, on Phillip's neck. However, Associate Professor Holdgate's evidence was to the effect that the restriction of breathing by compression of the chest, rather than restriction of blood flow by compression of the neck, was the major issue in the restraint. She stated *even partial compression of the chest can...restrict the amount of breathing you can effectively do...particularly if you're someone who's at risk of developing hypoxia.*
- 11.8 Associate Professor Holdgate gave evidence about what she considered to be the optimal way to restrain a person, the five point restraint: one person on each limb and the fifth managing the head. Unfortunately, there were insufficient police officers present in the charge room to restrain Phillip in this way. As Associate Professor Holdgate commented, having made the decision to remove Phillip from the dock, the police officers *were then faced with a man who really was beyond the capacity of those three officers to safely restrain.*
- 11.9 She acknowledged that the police had been placed in a very difficult situation and had removed Phillip from his cell solely to prevent him causing any further injury to himself. He was a large man, in an extremely agitated state and there were only three officers

available to assist in the restraint. The police were unable to visualize Phillip's face from the positions that they were in and would not have noticed the change in the colour of Phillip's face that was apparent on the video. In response to questions asked on behalf of Phillip's family, Associate Professor Holdgate agreed that *the method of restraint that they were forced by their circumstances to use was inherently unsafe.*

11.10 The NSWPF Use of Force Manual provides:

You must consider the circumstances you are faced with and only use force that is appropriate and proportionate to that situation...use of force will not be unlawful just because it didn't involve an approved tactical option. As long as the force used is reasonable, appropriate and proportionate to the circumstances it will be lawful.

11.11 One of the tactical options available to police is weaponless control, which SC Davey explained includes techniques which *rely on pain compliance, physical incapacitation, or simply bodily control.* He explained that *bodily control...effectively relies on positioning the subject and/or police in such a manner that police officers can use their own weight or positioning to control a subject.*

11.12 According to SC Davey, the restraint applied to Phillip by SC De Lyster-Bird was not a technique in relation to which police receive specific training. Although it was similar to the *prone handcuffing position*, it was not the same. SC Davey concluded that taking all that evidence into account the restraint of Phillip on the ground was a reasonably necessary use of force and the actions of police, including SC De Lyster-Bird was *not inconsistent* with police training or policy.

11.13 In the opinion of Associate Professor Holdgate, it is likely that the compression on Phillip's head and trunk impeded his breathing and may have resulted in consequent hypoxia (lack of oxygen). She pointed to the change in Phillip's face colour as supportive of this. In the context of Phillip being a large man with underlying coronary artery disease and in a state of severe agitation, in her view it is likely that this hypoxia may have been the final step which induced a fatal cardiac arrhythmia.

11.14 Associate Professor Holdgate concluded that it is probable that the method of restraint contributed to Phillip's death. She says that in ideal circumstances, the police should have avoided any pressure on Phillip's head and trunk and remained mindful of whether their interventions were affecting his breathing, although she queried whether it would have

been possible to place Phillip in a safer position, avoiding pressure on his chest and head, without putting the police at risk themselves.

11.15 Once Phillip began harming himself in the dock, police had little option but to remove him. Having done so, and in view of Phillip's agitation and continued resistance, they were forced to use a method of restraint that was inherently unsafe.

11.16 The evidence establishes that SC De Lyster-Bird exerted weight on Phillip's upper torso and on the head or the top of the neck area. However, there is no basis on which I can determine how much weight was placed on any part of Phillip's body at any time, nor whether such weight as was placed on Phillip was excessive.

11.17 I am not satisfied that the restraint of Phillip on the floor of the charge room involved a use of force on the part of the police officers that was unreasonable, inappropriate, or disproportionate to the circumstances in which the police officers found themselves such that their actions could be said to be unlawful or contrary to NSWPF policy.

11.18 The evidence supports the probability that the restraint of Phillip by the police on the floor of the charge room contributed to his death by impeding his breathing, although the exact method by which this occurred is not clear.

12 The adequacy of resuscitation efforts

12.1 Both prior to, and immediately after, Phillip was removed from his cell Sgt Crotty requested that the ambulance return. Approximately one minute after being removed from his cell and restrained on the floor by the police Phillip stopped vocalizing and his movements rapidly diminished. Less than two minutes after being removed from his cell, the police recognized that he had become unresponsive and rapidly rolled him onto his back and began effective CPR 15 seconds later. The police continued effective CPR until the ambulance arrived and then continued to assist the paramedics in their attempts to resuscitate Phillip.

12.2 According to Associate Professor Holdgate, the police appropriately and rapidly identified the need for ambulance backup, appropriately and rapidly identified that Phillip had become unresponsive and performed effective CPR until the ambulance arrived. Once the paramedics arrived, they continued effective CPR and initiated appropriate advanced life support measures. They called for backup to assist in managing Mr Walton's cardiac arrest. The resuscitation was conducted in keeping with recognized advanced life support

guidelines. The decision to terminate resuscitation after multiple rhythm checks confirmed a non-shockable rhythm and with no response to resuscitative measures was appropriate.

12.3 In Associate Professor Holdgate's view, the resuscitation efforts of both police and paramedics were reasonable and appropriate.

12.4 There was no defibrillator at Casino Police Station at the time of Phillip's death. In his evidence Sgt Crotty confirmed that a defibrillator has since been installed at Casino.

12.5 Both police and paramedics made reasonable and appropriate efforts to resuscitate Phillip.

13 The cause of Phillip's death

13.1 Clinical toxicologist, Professor Alison Jones, notes that the postmortem level of clozapine recorded in Phillip's system overlapped the toxic and potentially fatal ranges. However, clozapine undergoes post-mortem redistribution. Because the postmortem blood samples were taken six days after Phillip's death, Professor Jones' view is that the levels might have been higher at that stage than they were when Phillip was alive. She considers it unlikely that clozapine directly contributed to Phillip's death, although it, and other factors, may have increased the chance of a sudden cardiac death. When corrected for likely postmortem distribution she calculated that the actual blood concentration at the time of Phillip's death was 0.78 mg/L (780 ug/L), putting it in the supratherapeutic or low toxic range. Her view was that the level of cannabis detected is consistent with Phillip's report of consuming a cannabis cookie, or recreational use.

13.2 According to Professor Jones, the corrected range of clozapine concentration is compatible with normal dosing or taking a few extra tablets but not a significant overdose of the drug, such that the clozapine found at postmortem is unlikely to have directly caused Phillip's death by direct toxicity.

13.3 Cardiologist, Associate Professor Mark Adams agreed that the clinical features of Phillip's death didn't fit the adverse effects or overdose effects profile of clozapine. According to Professor Adams, the video footage of Phillip in the charge room looks compatible with a sudden cardiac death. He explained that although he could not completely exclude clozapine as a possible contributory factor to this, the postmortem redistribution corrected blood concentration was not in the mid or high toxic range at the time of death.

His view was that the contribution in Phillip's case of restraint hypoxia needed to be assessed.

- 13.4 Associate Professor Adams considered the most likely cause of Phillip's death to be a sudden cardiac death, likely an arrhythmia. In his view, Phillip had a number of risk factors for arrhythmia, including cardiovascular disease, obesity, clozapine use, and the circumstances proximate to his death, including physical exertion and hypoxia caused by the restraint.
- 13.5 According to Professor Adams, the cardiac findings largely rule out an acute myocardial infarction as a cause of death although the postmortem report lists a number of findings that may be relevant as potential factors that may have led to sudden cardiac death. He points to a number of cardiac and other health issues that would have predisposed Phillip to developing a fatal arrhythmia including myocardial fibrosis, obesity and high levels of clozapine, and his vigorous exertion and need for restraint may have also contributed.
- 13.6 Counsel Assisting submitted that I could comfortably find the cause of Phillip's death was cardiac arrhythmia. He submitted that I also ought to record in the findings those factors which Professor Adams identified as conditions which may have contributed to the arrhythmia.

14 The need for recommendations pursuant to s82 of the Act

- 14.1 It was submitted on behalf of Phillip's family that a recommendation ought to be made to the effect that NSWPF *develop some sort of training and protocol in relation to the use of ..weighted prone restraint* along the lines of the recommendation made by Deputy State Coroner Ryan (as she then was) in the *Inquest into the Death of Michael Peachey*.¹
- 14.2 I pause to note that one of the key issues in *Peachey* was the length of the restraint – 45 minutes – in circumstances where Mr Peachey had already been sedated by paramedics and the restraint continued well past the point where Mr Peachey had ceased struggling, was barely moving, and no longer posed any threat. That was not the situation in Phillip's case where the total restraint lasted for one minute and forty seconds and Phillip was released from the restraint and turned onto his back almost immediately after he had ceased to struggle.

¹ [2024] NSWCORC 70 (28 November 2024)

14.3 The recommendation made by then Deputy State Coroner Ryan in *Peachey* was in the following terms:

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.

14.4 By letter dated 21 May 2025, the then Commissioner of the NSWPF advised that the NSWPF did not support the first of the recommendations made in *Peachey* on the basis that:

Policies are most effective when they are specifically applicable to the circumstances. In operational contexts, the variability of restraint is limitless, there is no "safe" duration for restraint, and resources can be inconsistent and often limited. Therefore, any policy is likely to be too generic that it offers minimal practical guidance to police.

14.5 The second recommendation was supported. The Commissioner advised that the NSWPF was developing a training program to address the risks associated with sudden death during an arrest that would include a theoretical best practice response incorporating early recognition and the use of appropriate resources before resorting to restraint.

14.6 The evidence in the inquest was that training in the risks involved with prone restraint was provided to police officers as part of their initial training in defensive tactics and subsequently. All three police officers had completed training that involved information about the risks of prone restraint, and all demonstrated an understanding of the risks. The evidence did not establish that there was any inadequacy in the training currently offered to police officers. In view of this, it is neither necessary nor desirable to make the recommendation that Phillip's family submits ought to be made.

15 Operation of s151A(2) of the Health Practitioner Regulation National Law (NSW)

- 15.1 It was submitted on behalf of Phillip's family that the two paramedics, Ms Wheeler and Ms Chapman, should be referred to *New South Wales Ambulance...with a view to investigating whether any appropriate disciplinary or other proceedings were appropriate.*
- 15.2 In relation to the actions of the two paramedics Counsel Assisting submitted that *on any view their conduct did not meet what was expected of them and amounts to an inadequate assessment and falsely recording information on the electronic medical record.* The inadequacy of both the physical and mental health assessment both paramedics conducted in relation to Phillip at Casino police station and the inaccuracy of the EMR produced in relation to this attendance was conceded in oral submissions made by counsel appearing for NSW and by counsel appearing for each paramedic. Counsel for NSW made no submissions as to whether either paramedic should be referred for disciplinary proceedings, stating only *It is a matter for your Honour whether you wish to refer them back to us...but your Honour can take it from us that we are looking [at] the evidence in this inquest.* Counsel for both paramedics joined Counsel Assisting in submitting that neither paramedic should be referred to the relevant professional body.
- 15.3 By letter dated 28 November 2025 those assisting me advised all parties that I was considering referring the two paramedics to an appropriate body for investigation and inviting the parties to make further written submissions or provide further material in relation to this issue should they wish to do so. In response to this correspondence, written submissions were provided on behalf of each of the two paramedics. NSW advised by letter dated 15 January 2026 that *on 14 November 2025, NSW Ambulance (NSWA) referred paramedics Tracey Wheeler and Shannon Chapman to the Australian Health Practitioner Regulation Agency (AHPRA) for investigation.* The letter from NSW was tendered as an exhibit in the inquest.

The disciplinary regime applying to paramedics in NSW

- 15.4 I have been greatly assisted in my understanding of the disciplinary regime applying to health practitioners in NSW by Deputy State Coroner Lee's very thoughtful and comprehensive exploration of this issue in the *Inquest into the death of Adam Fitzpatrick.*²

² [2023] NSWCORC 80 (31 October 2023) [28.21] – [28.37]

Although I have come to my own independent understanding of the relevant legislation, many of the following paragraphs draw heavily on Deputy State Coroner Lee's findings in *Fitzpatrick*.

- 15.5 The Australian Health Practitioner Regulation Agency (**AHPRA**) (in partnership with a number of National Boards) *ensures the community has access to a safe health workforce across all professions registered under the National Registration and Accreditation Scheme*. One of the core regulatory functions of AHPRA is to *manage complaints and concerns raised about the health, performance and conduct of individual health practitioners on behalf of the National boards, except in New South Wales and in Queensland*. Although in NSW AHPRA plays a role in managing notifications which are referred to it, concerns about registered health practitioners should be directed to the NSW Health Professional Councils Authority (**Councils Authority**) or the Health Care Complaints Commission (**HCCC**). The Councils Authority lists the Paramedicine Council of NSW in its list of NSW health professional councils. The Paramedicine Council of NSW manages *complaints about the clinical care and treatment, professional behaviour or health of registered paramedic practitioners and students in NSW*. It appears appropriate therefore, that any complaint about Ms Wheeler and Ms Chapman should be directed to the Paramedicine Council of NSW.

Legislative framework of the Health Practitioner Regulation National Law (NSW)

- 15.6 Section 151A(2) and (3) of the *Health Practitioner Regulation National Law (NSW)* (**National Law**) provides that:

(2) *If a coroner has reasonable grounds to believe the evidence given or to be given in proceedings conducted or to be conducted before the coroner may indicate a complaint could be made about a person who is or was registered in a health profession, the coroner may give a transcript of that evidence to the Executive Officer of the Council for the health profession.*

(3) *If a notice or a transcript of evidence is given to the Executive Officer under this section*

(a) *a complaint is taken to have been made to a Council about the person to whom the notice or transcript relates;...*

- 15.7 *Council* as it is used in s151A(2) is defined in s138 to mean *a Council established under section 41B*. The Paramedicine Council of NSW is established under section 41B.
- 15.8 Section 144 of the National Law sets out the grounds for complaint about a registered health practitioner including *[a] complaint the practitioner has been guilty of unsatisfactory professional conduct or professional misconduct. Unsatisfactory professional conduct* is defined in s139B(1) to include *conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner's profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience. Professional misconduct* is defined in s139E to include *unsatisfactory professional conduct of a sufficiently serious nature to justify suspension or cancellation of the practitioner's registration*.
- 15.9 Therefore, having regard to the legislative framework described above, if there are reasonable grounds to believe that evidence given during the inquest may indicate that a complaint could be made about paramedics, Tracey Wheeler and Shannon Chapman, then a transcript of that evidence may be given to the Executive Officer of the Paramedicine Council of NSW. It is noted that the use of the words *believe, may indicate* and *could* in section 151A(2) of the National Law individually and collectively impose a relatively low threshold by which that provision might be engaged.

Matters to be taken into account when considering the application of section 151A(2)

15.10 Among the submissions made on behalf of Ms Wheeler was that she:

- (i) had engaged with the coronial investigation and inquest process;
- (ii) did not attempt to deflect, blame someone else, or excuse her lapses, and demonstrated insight into her shortcomings;
- (iii) had undertaken additional education and training, and had adopted new practices since the events of 19 March 2023; and
- (iv) is an asset to public health and safety being an experienced paramedic who serves her local community.

15.11 Among the submissions made on behalf of Ms Chapman was that:

- (i) NSWA continues to employ both paramedics who are providing essential services in a regional area;
- (ii) referring her to her employer is unlikely to be of any utility; and
- (iii) NSWA has made its own complaint to AHPRA which will be dealt with by that body, so there seems little to be achieved by the court also referring Ms Chapman to the same body for investigation.

15.12 The use of the word *may* in s151A(2) suggests that there is a discretion as to whether a coroner gives a transcript of the relevant evidence to the Executive Officer of the Council for the health profession. There is, however, no assistance given in the words of the legislation as to what a coroner should consider in determining whether that discretion should be exercised. The remainder of s151A(2) directs a coroner only to a consideration as to whether they believe on reasonable grounds that the evidence indicates a complaint could be made.

15.13 However, it is noted that the guiding principles set out at section 3A of the National Law provides that *[t]he main guiding principle of the national registration and accreditation scheme is that the protection of the health and safety of the public must be the paramount consideration.*

15.14 I agree with Deputy State Coroner Lee that in determining whether a complaint should be made, consideration of what he terms 'the Subjective Factors' *is akin to consideration of mitigating factors in a sentencing exercise in criminal proceedings which is concerned with the penalty phase of criminal proceedings and not with the commencement phase.* I also agree with his conclusion that *the Subjective Factors would appear to have no relevance in the equivalent commencement phase provided by section 151A(2) of the National Law.*

15.15 For this reason, my consideration of the application of section 151A(2) of the National Law in the present matter will be limited to the evidence given in the proceedings as to the conduct of both paramedics.

Tracey Wheeler

15.16 As set out above, the available evidence establishes that Ms Wheeler:

- (i) made inappropriate comments to Sgt Crotty in the hallway of Casino police station when she was advised by him that Phillip had schizophrenia;
- (ii) along with Ms Chapman conducted an inadequate assessment of both Phillip's physical and mental health;
- (iii) entered into the MDT a reason for the termination of the paramedics' assessment of Phillip that was false; and
- (iv) produced and signed an EMR after Phillip's death that was inaccurate in several fundamental respects.

15.17 It was submitted on behalf of Ms Wheeler that she had already been referred to the Professional Conduct Unit of her employer. This submission appears to be a reference to paragraph 220 in the statement of Detective Chief Inspector Wayne Walpole of 8 June 2023, which was as follows: *Mr Moon concluded by writing, the matter is referred to you for consideration, with a recommended action for referral to the Professional Conduct Unit.* Other than this statement, there was no other evidence adduced either during or subsequent to the inquest, as to whether the recommended action had been taken, and if so, when it had been taken, the terms of any referral, and the outcome of any disciplinary process, if indeed one took place.

15.18 I note also that Ms Wheeler and Ms Chapman have been referred to AHPRA by NSW. The terms of these referrals and the material provided in support of the referrals are not known. For that reason, I intend to also refer both paramedics to their professional body.

15.19 Having regard to the above, there are reasonable grounds to believe that the evidence given during the inquest may indicate a complaint could be made about paramedic Tracey Wheeler, who is a person registered in a health profession, namely that Ms Wheeler has engaged in unsatisfactory professional conduct and/or professional misconduct in the practice of a health profession. As these are matters relevant to the protection of the health and safety of the public, a transcript of the evidence is to be given to the Executive Officer of the Paramedicine Council of NSW.

Shannon Chapman

15.20 As set out above, the available evidence establishes that Ms Chapman:

- (i) along with Ms Wheeler conducted an inadequate assessment of both Phillip's physical and mental health; and
- (ii) signed an EMR produced by Ms Wheeler after Phillip's death that was inaccurate in several fundamental respects.

15.21 Having regard to the above, there are reasonable grounds to believe that the evidence given during the inquest may indicate a complaint could be made about paramedic Shannon Chapman, who is a person registered in a health profession, namely that Ms Chapman has engaged in unsatisfactory professional conduct and/or professional misconduct in the practice of a health profession. As these are matters relevant to the protection of the health and safety of the public, a transcript of the evidence is to be given to the Executive Officer of the Paramedicine Council of NSW.

16 Findings required by s81(1)

16.1 I make the following findings required pursuant to s81(1) of the Act

Identity

The person who died is Phillip Mark Walton.

Date of death

Phillip died on 19 March 2023.

Place of death

Phillip died at Casino police station, Casino, NSW.

Cause of death

The cause of Phillip's death was cardiac arrhythmia which occurred in the context of physical exertion and hypoxia caused by restraint.

Manner of death

Phillip died while in the lawful custody of police, following an episode of agitation and self-harm that caused police to remove him from the dock and restrain him on the floor of

the custody room. During the restraint, which lasted less than two minutes, he lost consciousness and could not be resuscitated.

17 Close of Inquest

17.1 I thank counsel assisting, Jake Harris, and his instructing solicitor, Penelope Smith, of the Crown Solicitor's Office, for all the assistance they have provided in preparing and conducting this inquest.

17.2 I also thank Detective Sergeant Darren Simpson and Detective Senior Constable Tom Stillwell and before them, Detective Chief Inspector Wayne Walpole, for the very comprehensive investigation they conducted into the circumstances of Phillip's death.

17.3 Once again on behalf of the Coroners Court, I offer my sincere and respectful condolences to Phillip's friends and family.

17.4 I close this inquest.

A handwritten signature in black ink, appearing to read 'Kasey Pearce', followed by a period.

Kasey Pearce

Deputy State Coroner

20 March 2026