



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 14th and 22nd days of July, the 5th day of August, the 29th and 30th days of September, the 6th day of October 2022 and the 13th day of October 2023, by the Coroner's Court of the said State, constituted of Naomi Mary Kereru, Coroner, into the death of Michael Gerard Adams.

The said Court finds that Michael Gerard Adams aged 62 years, late of 37-39 Sussex Street, Glenelg, South Australia died at Glenelg, South Australia on the 14th day of February, 2020 as a result of cardiac arrest complicating psychotic episode. The said Court finds that the circumstances of his death were as follows:

1. Introduction and background

- 1.1. Michael Gerard Adams was 62 years old when he died on 14 February 2020 at Glenelg.
- 1.2. Mr Adams suffered from catatonic schizophrenia. He became ill at the age of 27 years and required multiple admissions to mental health facilities over the ensuing years, including inpatient stays at the Glenside Hospital. When Mr Adams was not being treated as an inpatient in a mental health institution, he resided with his very supportive parents.
- 1.3. In January 2014, Mr Adams became a resident at The Oaks on Sussex, a Supported Residential Facility on Sussex Street in Glenelg (The Oaks). The Oaks is a supported care facility for people with disabilities or mental health conditions who require a limited amount of care in their day-to-day activities.

- 1.4. From time to time Mr Adams would become unwell, suffering psychotic episodes which saw him behave in a violent manner, usually towards himself. Staff at The Oaks would respond to these episodes by calling the SA Ambulance Service (SAAS) and South Australia Police (SAPOL) to have him conveyed to a mental health treatment facility for assessment. These episodes did not appear to have a specific trigger as Mr Adams was compliant with his medication and did not drink alcohol or use illicit substances.
- 1.5. On 14 February 2020, Mr Adams was noted by a staff member to be clenching his fists and raising them to his temples, coupled with a notable disengagement in his behaviour. These actions were recognised by staff of The Oaks as signs of a looming psychotic episode. The attendance of SAPOL and SAAS was requested. However, at 1:12pm, Mr Adams was observed to be improving and police were notified that their attendance was no longer required. The attendance of SAAS was not cancelled.
- 1.6. At approximately 3pm, SAAS contacted The Oaks to enquire as to Mr Adams' condition and to advise that it would be approximately another two hours before paramedics could attend. At that time Mr Adams' behaviour had settled to his baseline which was described as '*calm and happy enough*'.¹
- 1.7. At approximately 5:30pm on the same day, Mr Adams' health deteriorated, and he was observed to be in a highly distressed state, running into walls and falling down. He was seen to be kicking at the office door and breaking glass and photo frames while screaming. Mr Adams was then observed to make his way outside the facility and throw himself forwards and backwards against some concrete stairs. A carer contacted SAAS to escalate the tasking at 5:19pm.²
- 1.8. SAAS arrived at 5:37pm to find Mr Adams lying on his back and throwing his arms and legs in the air, while throwing his head back towards the concrete. Paramedics assisted him to his feet and Mr Adams walked to the ambulance stretcher and climbed onto it.
- 1.9. Once on the stretcher, Mr Adams began flailing his arms and legs around and a decision was made to apply the restraint blanket. The stretcher was lowered to reduce the risk of Mr Adams falling from it.

¹ Exhibit C1a, page 5

² Exhibit C26, SACAD Summary

- 1.10. A SAPOL officer, fitted with a body worn camera, arrived at 5:46pm while the restraint blanket was being applied. The footage (BWF) showed Mr Adams motionless on the stretcher.
- 1.11. From 5:46pm until 5:49pm there was general discussion recorded on the BWF between paramedics and police about whether Mr Adams had been sedated and about his usual colour. In addition, there was an assessment of his pupils and radial pulse. It was not however until 5:50pm that a cardiac arrest was identified and cardiopulmonary resuscitation (CPR) commenced. At 5:52pm artificial respiration by way of Ambu-bag³ began.
- 1.12. Resuscitation efforts continued until 6:31pm when Mr Adams was declared life extinct.
- 1.13. For the reasons detailed below, I find the care provided to Mr Adams by SAAS paramedics inadequate. This was due to a delay in the identification of Mr Adams having suffered a cardiac arrest. I find this delay was caused by a failure to adequately assess and observe Mr Adams when there was a sudden change in his behaviour.

2. **Reason for Inquest**

- 2.1. Mr Adams' death occurred during the process of detention by members of SAAS who were applying a restraint blanket (or safety net). An authorised SAAS officer has the power to detain an individual pursuant to Section 56 of the *Mental Health Act 2009* if they consider:

‘that person to have a mental illness and the person has caused, or there is a significant risk of the person causing harm to himself or herself or others or property or the person otherwise requires medical examination’.⁴

- 2.2. Section 3 of the Coroners Act 2003 (the Act) defines a death in custody as:

‘... the death of a person where there is reason to believe that the death occurred, or the cause of death, or a possible cause of death, arose, or may have arisen, while the person was being detained in any place within the State under any Act or law.’

As a decision had been made to detain Mr Adams by the attending paramedics, his death met this definition and, accordingly, his death was the subject of a mandatory Inquest pursuant to section 21(1)(a) of the Act.

³ Artificial manual breathing unit – designed to deliver positive pressure ventilation to any patient with insufficient or ineffective breaths

⁴ Section 56(c)(i), (ii) of the Mental Health Act 2009 SA

- 2.3. Quite aside from the mandatory nature of the Inquest, it became apparent through the viewing of police BWF that there was a period of time that Mr Adams appeared unresponsive while on a stretcher outside the supported care facility. Further, that those tasked with detaining him were not aware of his unresponsive state and did not render lifesaving treatment for approximately four minutes. This was during the application of the restraint blanket.
- 2.4. It was therefore necessary to hear oral evidence from the paramedics and the police officer who attended the scene to determine the reason for the apparent delay in Mr Adams receiving lifesaving treatment. This included the examination of whether policies and procedures relating to the restraint of an individual by paramedics were followed by the two paramedics on scene.

3. **Cause of death**

- 3.1. A post mortem examination of Mr Adams' remains was conducted on 20 February 2020 by Dr John Gilbert who is a forensic pathologist at Forensic Science South Australia (FSSA). Dr Gilbert prepared a post mortem report detailing his pathological findings.⁵
- 3.2. Dr Gilbert was unable to find an anatomical cause for Mr Adams' death. However, based on the Mr Adams' mental health history, the medication he was prescribed, his pre-existing coronary artery disease and the reported circumstances leading up to his death, Dr Gilbert reported that the cause of death was '*cardiac arrest complicating psychotic episode*'.⁶
- 3.3. For reasons that I will detail later in these findings, I have accepted Dr Gilbert's cause of death. It is necessary however to pause here in order to touch on the multi-factorial elements to Mr Adams' death.
- 3.4. A cardiac arrest is a non-specific cause of death. It simply means that the heart has ceased to beat and as a result is no longer pumping blood around the body. There are a number of different mechanisms to cause a heart to stop beating. It was therefore necessary, in the post mortem process, to examine Mr Adams' heart.
- 3.5. Mr Adams' heart was submitted for specialist cardiac pathology testing by Professor Anthony Thomas, Anatomical Pathologist at Medical and Pathology Interpretation Pty

⁵ Exhibit C2b

⁶ Exhibit C2b

Ltd. Professor Thomas prepared a heart examination report,⁷ the findings of which were incorporated into Dr Gilbert's report. Professor Thomas found moderate coronary artery narrowing due to atherosclerotic disease. However, he did not find any acute changes such as thrombus or ischaemic damage. Mr Adams' heart was also examined for myocarditis due to previous episodes. Professor Thomas found no evidence of this.

3.6. Professor Thomas made the following comment at the conclusion of his report:

‘Although there is significant coronary artery disease, in the absence of plaque fissuring or thrombosis and significant myocardial scarring, this would not be expected to have caused unexpected death per se. However, sudden cardiac death related to either psychological or physical stress with a morphologically normal heart has been highlighted in the literature. It is possible that the coronary artery disease, which in its own right is insufficient to account for a cardiac death, may be significant in the presence of psychological and/or physical stress. Correlation with the circumstances surrounding the death and the remainder of the autopsy findings is required.’⁸

3.7. On external examination Dr Gilbert found multiple, though relatively minor abrasions, bruises and a few superficial incised wounds that he thought were attributable to the glass broken by Mr Adams inside the facility. On internal examination, Dr Gilbert found five, likely antemortem, rib fractures over the left lateral aspect of the chest with an underlying subpleural contusion of the left lung. Dr Gilbert postulated that the fractures were caused when Mr Adams fell onto his left side, or by running into a wall as was reported by his carer. These rib fractures were distinct from the fractures found at the anterior aspect of the 2nd rib, the anterolateral aspects of the left 6th to 8th ribs inclusive, the chondrosternal junctions of the left 5th to 7th ribs and the anterolateral aspects of the right 3rd to 8th ribs inclusive. Due to the lack of bruising and the overall pattern, Dr Gilbert opined that they were in keeping with cardiopulmonary resuscitation.⁹

3.8. Toxicological analysis did not reveal any clear evidence that blood results showing elevated levels of the drugs clomipramine, olanzapine and amisulpride, were other than therapeutic. This was likely due to the interval of six days between death and autopsy, which could have seen post mortem drug redistribution. In further support of this, analysis of liver levels of clomipramine and olanzapine showed therapeutic levels.

⁷ Exhibit C4a

⁸ Exhibit C4a, page 5

⁹ Exhibit, C2b

- 3.9. As noted above, Dr Gilbert came to the conclusion that no anatomical cause could be identified in Mr Adams' death. However, Dr Gilbert opined that death may have resulted from a cardiac arrhythmia contributed to by pre-existing moderate coronary artery atherosclerosis, physical exertion and mental stress associated with agitated psychotic behaviour.¹⁰ Dr Gilbert also noted that the psychotropic medication prescribed (olanzapine and amisulpride) and found in the toxicological analysis, may each have caused QT prolongation¹¹ and their combined presence could possibly have increased the risk of cardiac arrhythmia in the presence of the aforementioned stressors.
- 3.10. It is well-established that there is an association between psychological stress and sudden cardiac death. Both chronic and acute psychological influences have been found to play a role in cardiac rhythmic disturbances, even in the absence of coronary artery disease. There is also an increased risk of sudden death in psychiatric patients, and in association with psychotropic drugs.¹²
- 3.11. Expert evidence was heard from Professor Anne-Maree Kelly, Senior Emergency Physician, in her capacity as an expert in emergency medicine. Professor Kelly is an experienced clinician who is a fellow of the Australasian College for Emergency Medicine.¹³ She currently holds the posts of Professor and Academic Head of Emergency Medicine and Senior Emergency Physician at Western Health in Footscray, Victoria and Adjunct Professor at the Australian Centre for Health Law Research, Queensland University of Technology. Professor Kelly has more than 30 years' experience in Emergency Departments (ED) as a specialist in South Australia, New Zealand and Victoria. She has worked in large, medium-sized and small EDs and in public (rural and urban) and private hospital settings treating both adults and children.
- 3.12. Professor Kelly, in her oral evidence, confirmed that sudden cardiac death is something that ED clinicians are aware of. She told the Court that there was a connection between someone experiencing a psychological event (such as psychosis) and the risk of sudden cardiac death. She explained that while the mechanism is not completely understood, patients are often severely agitated with high levels of adrenaline and other hormones that narrow blood vessels and increase the heart rate which can trigger a cardiac arrest.¹⁴

¹⁰ Exhibit C2a

¹¹ QT Prolongation - An extended interval between the heart contracting and relaxing

¹² Krexi Lydia et al, 'Sudden Cardiac death with stress and restraint: The association with sudden adult death syndrome, cardiomyopathy and coronary artery disease', *Medicine, Science and the Law* (2016) Vol 56(2), pages 2-5

¹³ Elected to fellowship in 1990

¹⁴ Transcript, page 161

After the hearing Professor Kelly provided further literature to the Court detailing this connection.¹⁵

- 3.13. Professor Kelly told the Court that there is a low but real incidence of abnormal cardiac rhythms in patients taking certain classes of psychiatric drugs.¹⁶ She confirmed that the psychiatric medications that Mr Adams was prescribed, and that were found in his toxicological analysis, were those which heightened the risk of abnormal cardiac rhythm.¹⁷
- 3.14. In light of the evidence of Professor Kelly and Dr Gilbert's report, I find the cause of Mr Adams' death to be cardiac arrest complicating psychotic episode.

4. Evidence at Inquest

- 4.1. The documentary evidence at this Inquest comprised 41 exhibits.
- 4.2. During the course of the Inquest oral evidence was heard from:
- Rhianna Grigor - SAAS Paramedic
 - Bria Smith - SAAS Intensive Care Paramedic
 - Brevet Sergeant Edward Etheridge - SAPOL
 - Professor Anne-Maree Kelly - Expert Senior Emergency Medical Physician
- 4.3. Senior Constable Daland Lahiff was summonsed to give oral evidence, but was excused due to illness. Officer Lahiff provided an affidavit during the course of the investigation which was tendered to the Court.¹⁸ Officer's Lahiff's BWF was also viewed during the course of the Inquest and tendered as an exhibit.¹⁹

¹⁵ (1) Strömmer EMF, Leith W, Zeegers MP, Freeman MD. The role of restraint in fatal excited delirium: a research synthesis and pooled analysis. *Forensic Sci Med Pathol*. 2020 Dec;16(4):680-692. doi: 10.1007/s12024-020-00291-8. Epub 2020 Aug 22. PMID: 32827300; PMCID: PMC7669776.

(2) Stratton SJ, Rogers C, Green K. Sudden death in individuals in hobble restraints during paramedic transport. *Ann Emerg Med*. 1995 May;25(5):710-2. doi: 10.1016/s0196-0644(95)70187-7. PMID: 7741355.

(3) Park KS, Korn CS, Henderson SO. Agitated delirium and sudden death: two case reports. *Prehosp Emerg Care*. 2001 Apr-Jun;5(2):214-6. doi: 10.1080/10903120190940155. PMID: 11339735.

(4) McGuinness T, Lipsedge M (2022). 'Excited Delirium', acute behavioural disturbance, death and diagnosis. *Psychological Medicine* 52, 1601–1611. [https:// doi.org/10.1017/S0033291722001076](https://doi.org/10.1017/S0033291722001076)

(5) Towards evidence-based emergency medicine: best BETs from the Manchester Royal Infirmary. BET 1: excited delirium syndrome and sudden death. *Emerg Med J*. 2013 Nov;30(11):958-60. doi: 10.1136/emered-2013-203139.1. PMID: 24142942.

¹⁶ Transcript, page 150

¹⁷ Transcript, page 168

¹⁸ Exhibit C15

¹⁹ Exhibit C15a

5. Policies in place at the time of Mr Adams' death

- 5.1. The two SAAS policies relevant to the date of Mr Adams' death (February 2020) were tendered to the Court by way of annexure to the affidavit of Catherine Wright, Acting Executive Director, Clinical Services, SAAS.²⁰ The two clinical practice guidelines were entitled Basic Care and Life Support (BCLS)²¹ and Challenging Behaviours (CB).²² The policies were considered as guidance in relation to paramedic restraint in 2020 and were relevant to the response of the two paramedics when they attended at The Oaks on 14 February 2020.
- 5.2. The BCLS policy stated that attention to basic care and life support provides a foundation for extended clinical practice. Further, that genuinely lifesaving treatment was not to be overlooked. That involved, amongst other things, continuous regular monitoring of observations, including vital signs occurring in the context of extended clinical practice.²³ The CB policy's principal focus was to, wherever possible, treat the underlying cause or condition of the behaviour, with the aim of managing patients with challenging behaviours using the least restrictive and least invasive practices to achieve safe assessment and connection with care. If restraint was required, it should be used cautiously, with patient and clinical safety being of paramount importance. That included (where possible) at least five people involved in the patient restraint, with one person holding each limb and the lead clinician at the head of the patient. Oxygen should be applied whenever possible.²⁴
- 5.3. It became evident, particularly through the viewing of the BWF, that aspects of both policies were not followed by Ms Smith and Ms Grigor. I will deal with this in more detail below.

6. Mr Adams' psychiatric history

- 6.1. Mr Adams' psychiatric history extended over 35 years, since 2008. He primarily suffered from chronic treatment-resistant schizophrenia with a catatonic component, but was additionally diagnosed with obsessive compulsive disorder in 2015. Mr Adams was originally prescribed the psychotropic medication, clozapine to treat his

²⁰ Exhibit C24

²¹ Exhibit C24, Annexure CW-1

²² Exhibit C24, Annexure CW-2

²³ Exhibit C24, paragraph 9

²⁴ Exhibit C24, paragraph 10

schizophrenia. However, this caused a suspected myocarditis which is a known complication of the medication. He was subsequently changed to olanzapine and amisulpride.

- 6.2. Mr Adams was not employed. He was in receipt of NDIS funding. In her final report, Brevet Sergeant Nadia De Bellis chronicled 32 presentations and inpatient stays at mental health institutions between 1984 and 2020.²⁵ Sadly, Mr Adams had been disabled by his mental illness for most of his adult life.
- 6.3. Notwithstanding his debilitating mental illness, it was evident that Mr Adams was well-supported by his parents when in the community and was a much-loved member of his family. Mr Adams' father, Mr Sidney Adams, provided an affidavit which was tendered to the Court.²⁶ Mr Adams Snr described his son's numerous stays in multiple mental health facilities from the age of approximately 27, following the diagnosis of schizophrenia. As Mr Adams Snr and his wife grew older, management of their son's illness became more difficult and, in 2013, Mr Adams was admitted voluntarily to The Oaks. Mr Adams Snr referred to the care his son received at The Oaks in a positive light, noting that he received assistance with his meals, health care and medication and that his mental health was well managed. Mr Adams Snr stated:

‘I never had an issue with the care provided to Michael at Sussex Street. The staff [were] always friendly and helpful and Michael seemed to like it there.’²⁷

- 6.4. Mr Adams Snr noted in his affidavit that in the last six months of his son's life his psychotic behaviour had become more unpredictable and more frequent. On 30 January 2020, two weeks before his death, Mr Adams was seen for a routine appointment at the Marion Community Health Team by psychiatrist Dr Matti who said that Mr Adams' mental state was stable. In response to the reported increase in psychotic episodes, Dr Matti ordered olanzapine to be administered when necessary (PRN),²⁸ in conjunction with his regular dose of olanzapine to assist the staff at The Oaks to manage Mr Adams when he became agitated.²⁹

²⁵ Exhibit C18, pages 4-12

²⁶ Exhibit C10

²⁷ Exhibit C10, paragraph 8

²⁸ Pro Re Nata which is Latin for *as the circumstance arises* – in the context of the administration of medication it means – as required

²⁹ Exhibit C21

- 6.5. Mr Adams regularly visited his parents in Clovelly Park. These visits were facilitated by Ms Jennifer Zuffi (Mr Adams' sister) and her husband Julian Zuffi who would collect him from The Oaks. Mr Adams last visited his parents on 8 February 2020 for approximately three hours. Mr Adams Snr described him as happy with no suggestion of psychotic behaviour. Mr Adams was in high spirits due to the purchase of a new guitar for a good price and told his father towards the end of the visit that he loved him.³⁰
- 6.6. Mr Adams Snr last contacted The Oaks on 14 February 2020 at approximately 4pm to check on his son. He was told that Mr Adams was okay, but was awaiting an ambulance as he had displayed psychotic behaviour earlier in the day. Due to the recent escalation in psychotic episodes, and an episode requiring a hospital visit only the week prior, Mr Adams Snr was not overly concerned and left the staff to manage it. Later that evening police attended Mr Adams Snr's home to inform both he and his wife that their son had died.

7. Circumstances leading up to death

- 7.1. An affidavit was received from Ms Debbie Newell, Facilities Manager at The Oaks.³¹ Ms Newell had worked at The Oaks for 20 years and described the facility as a low-care facility, providing accommodation and support for vulnerable people with disabilities and mental health conditions.³² Ms Newell had known Mr Adams since his admission to the facility on 21 January 2014. Noting that there had been an escalation of Mr Adams' psychotic episodes in the six months preceding his death, she annexed four incident reports for this time period to her affidavit.³³ The incident reports described a similar pattern of behaviour to that which unfolded on 14 February 2020, namely an escalation in behaviour with Mr Adams often throwing himself against walls and screaming, but calming down with the assistance of staff and on occasion the attendance of SAAS and SAPOL.
- 7.2. Ms Newell described the day of Mr Adams' death, 14 February 2020, as starting normally with Mr Adams having his medication between 7am and 9am. There were no warning signs of abnormal behaviour at that time. Just before 12:30pm, Ms Newell

³⁰ Exhibit C10, paragraph 5

³¹ Exhibit C1a

³² Exhibit C1a, paragraph 2

³³ Exhibit C1a, Annexure B

observed Mr Adams to be seated in the TV/lounge area and noticed him to be clenching his fists and raising them up to his temple. She observed a vacant look in his eyes. This was the previously described precursor to the psychotic events from which Mr Adams suffered. Ms Newell contacted both SAAS and SAPOL in accordance with the usual protocol. The time of these calls being 12:27pm³⁴ and 12:28pm³⁵ respectively. The SAAS tasking was allocated a priority 4, which required a response within 60 minutes, but without lights and sirens.³⁶

- 7.3. Over the next 60 to 90 minutes Ms Newell observed Mr Adams carefully. His behaviour continued, but it did not escalate. Ms Newell encouraged Mr Adams to go to his room for a lie down, to which he agreed. Following this Ms Newell contacted SAPOL at 1:12pm and advised that their attendance was no longer required. Ms Newell made it plain in her affidavit that she did not cancel the attendance of SAAS as she still considered it important for Mr Adams to be assessed.³⁷
- 7.4. Ms Newell described Mr Adams waking at approximately 2pm and then walking between his room and the rear lounge area. She noted that he appeared calm. Ms Newell had a conversation with Mr Adams about playing his guitar as she was aware that he found this to be a relaxing activity and helped regulate his behaviour.
- 7.5. Shortly after 3pm SAAS called The Oaks to enquire as to Mr Adams' status. Ms Newell conveyed that Mr Adams had calmed down but that they would still be required to attend. The ambulance operator conveyed that the estimated arrival time was in the next two hours. Ms Newell indicated in her affidavit that it '*was not abnormal for residents to wait 5 - 6 hours in some cases*'³⁸ for paramedics to attend.
- 7.6. Ms Newell finished her shift at 3:30pm and conducted a handover with the incoming supervisor, Ms Rebekah McCarthy. Ms Newell detailed the events of the day, and in particular Mr Adams' unsettled behaviour. Ms Newell asked Ms McCarthy to immediately contact SAAS if there was any escalation to Mr Adams' behaviour and to contact her as well. Upon Ms Newell leaving the facility, she said goodbye to Mr Adams who was sitting in the TV/lounge area. According to Ms Newell, Mr Adams appeared to be back to his baseline behaviour.³⁹

³⁴ Exhibit C20, Background Event Chronology, page 1

³⁵ Exhibit C26 – SACAD (South Australian Computer Aided Dispatch System) Summary

³⁶ Transcript, page 38

³⁷ Exhibit C1a, paragraph 10

³⁸ Exhibit C1a, paragraph 11

³⁹ Exhibit C1a, paragraph 13

- 7.7. Ms McCarthy provided an affidavit which was tendered to the Court.⁴⁰ She described receiving the handover from Ms Newell along with her advice that an ambulance was still to attend to assess Mr Adams. From the commencement of her shift Ms McCarthy monitored Mr Adams' behaviour at approximately 15 minute intervals. Mr Adams conveyed to her that he felt 'okay'. Just after 5pm another resident informed Ms McCarthy that there was something wrong with Mr Adams.⁴¹ Ms McCarthy walked from the office area into the hallway and observed Mr Adams to be in a state of high distress, screaming and running into walls and then falling to the ground.⁴² Ms McCarthy informed the other residents to move to another area and away from Mr Adams. She secured herself in the office and contacted Ms Newell who instructed her to contact SAAS and inform them their attendance was now required as a matter of urgency. Ms Newell contacted SAPOL remotely to request their urgent attendance. She then returned to the facility.
- 7.8. Ms McCarthy contacted SAAS at 5:21pm.⁴³ She attempted to reassure Mr Adams through the locked office door as he was at that time pulling down pictures from the wall and breaking glass while screaming. After trying to get into the office without success, Mr Adams proceeded to exit the facility through the front door and moved into the front garden area. Ms McCarthy contacted Ms Newell again and was instructed to lock the front gate to stop Mr Adams from running onto the road and risk being hit by a car. Ms McCarthy could see the outside area from the office and observed Mr Adams throwing himself onto the pavement and stairs, hitting his head and body. After repeating this a number of times, Mr Adams lay on the pavement and kicked his legs in the air. Mr Adams had taken off his pants and his legs and arms were bruised and bloody.
- 7.9. The arrival of SAAS
- 7.10. The SAAS Patient Clinical Record (PCR) completed by paramedic Ms Bria Smith⁴⁴ reflected that the ambulance she was travelling in, with paramedic Ms Rhanna Grigor, was tasked at 12:27pm and dispatched to Mr Adams at 5:23pm. This ambulance arrived at The Oaks at 5:37pm. It was allocated a priority 2, which required a response time within 16 minutes.⁴⁵ The response of the ambulance after the escalation of the tasking

⁴⁰ Exhibit C9

⁴¹ Exhibit C9, page 2

⁴² Exhibit C9, page 2

⁴³ Exhibit C20, Background Event Chronology, page 5

⁴⁴ Exhibit C20

⁴⁵ Agency Objectives, 2019-20 Annual Report for SA Ambulance Service

was within this 16 minute timeframe. However, the original tasking was received at 12:27pm, some five hours earlier. I will return to the topic of this delay later in this Finding.

- 7.11. Ms Bria Smith provided an affidavit to the Court⁴⁶ and gave oral evidence at the Inquest. At the time of Mr Adams' death she was a paramedic with SAAS based at the Campbelltown station. Ms Smith completed her paramedics degree at the Flinders Medical Centre (FMC) in 2012. When Ms Smith gave oral evidence in September 2022 she had completed a Post Graduate Diploma of Critical Care Paramedics at Charles Sturt University. Ms Smith was the clinical lead for the tasking and, accordingly, she was the passenger in the ambulance with Ms Grigor driving. Ms Smith indicated in her affidavit that she understood the general details of the tasking to include a mental health patient at a care facility whose behaviour had been escalating throughout the day.⁴⁷
- 7.12. Ms Rhanna Grigor also provided an affidavit to the Court and gave oral evidence at the Inquest. Ms Grigor completed her paramedics degree in 2010 at FMC and worked interstate and overseas in this capacity. In April 2018 she returned to Australia and commenced working in South Australia. In February 2020, Ms Grigor was working at the SAAS Campbelltown station and was partnered with Ms Smith. Ms Grigor was allocated to drive the vehicle during that particular shift.⁴⁸
- 7.13. Ms Smith gave evidence that after receiving the priority 2 tasking on the radio, further information was available on the mobile data terminal (MDT) inside the ambulance. The information from the MDT was that the initial call was a number of hours earlier and there were multiple call backs throughout that time relating to a mental health episode at a mental health facility with the patient's behaviour escalating and then settling.
- 7.14. While travelling to the tasked location, Ms Smith contacted and spoke with an extended care paramedic (ECP) via radio communication to gather more information. Ms Smith told the Court that the information she was given was to attend on a:

‘...schizophrenic patient that has long-term treatment resistant schizophrenia and that we would just go to scene and assess and if we thought there was scope to leave them at the facility, then that would be ok to ring back and make plans at that point.’⁴⁹

⁴⁶ Exhibit C5

⁴⁷ Exhibit C5, page 2

⁴⁸ Exhibit C6, paragraph 4-5

⁴⁹ Transcript, page 76-77

- 7.15. Ms Smith and Ms Grigor were the first responders to arrive on the scene at The Oaks. In their affidavits they both described observing Mr Adams inside the fence line of the premises lying on his back with his legs and arms moving in the air and hitting his head on the concrete step. He was noted to have bloodied knees.⁵⁰ Ms McCarthy met them on their arrival and explained that Mr Adams was exhibiting behaviour that was consistent with him experiencing a psychotic episode.⁵¹ She said that when this occurred the staff would not approach Mr Adams as he could lash out and, although it was not an intentional act of violence, he would sometimes accidentally cause harm to himself and others.⁵²
- 7.16. Ms Smith described approaching the front gate of The Oaks and observed Mr Adams' behaviour to be '*labile*', explaining that '*he would lie still at some moments and then he would sort of thrash about in other moments*'.⁵³ When Ms Smith asked for the front gate to be unlocked she noticed that Mr Adams' behaviour escalated from wriggling around on the ground to picking his head up and throwing it back onto the bricks as he edged closer towards the brick step edging. Ms Smith entered the front yard of the premises and approached Mr Adams in an attempt to prevent him from sustaining a head injury.⁵⁴
- 7.17. Ms Smith described approaching Mr Adams and introducing herself, using Mr Adams' name, and suggesting that he stand up and fix his clothing to protect his dignity. This was a de-escalation technique she employed for patients who were experiencing psychotic episodes. Mr Adams responded to Ms Smith by obeying her commands and Ms Smith felt he had a level of cognition at that point.⁵⁵ Based on her assessment at that time, Ms Smith made the decision to direct Mr Adams onto the stretcher and held out her hands, which he took. She led him out of the gated front yard and onto the stretcher.⁵⁶
- 7.18. Ms Grigor gave evidence that while climbing onto the stretcher Mr Adams appeared quite calm and was following directions. However, once he was on the stretcher he began kicking his arms and legs around. Ms Grigor lowered the stretcher to the lowest

⁵⁰ Exhibit C5, paragraph 7; Exhibit C6, paragraph 6

⁵¹ Exhibit C9, page 2; Exhibit C5, page 3

⁵² Exhibit C5, paragraph 7

⁵³ Transcript, page 80

⁵⁴ Transcript, page 80

⁵⁵ Exhibit C5, page 4

⁵⁶ Transcript, page 81

setting to reduce the risk of injury if Mr Adams fell off, and asked Ms Smith if she would like her to retrieve the restraint blanket. Ms Grigor was asked why she considered the restraint blanket to be appropriate at that time. Her response was:

‘A. Because he was at risk of hurting himself and us.

Q. How did you think he might hurt himself.

A. Well, he had already inflicted harm on himself prior, earlier in the day, and as per the NDT information and the SAAS recollection that they told us when we arrived, and the fact that when he was on the stretcher it's about a metre in the air, once it is at full height, and he was throwing his body weight around and he could potentially knock himself off the stretcher or the stretcher can go over with him and injure himself again.’⁵⁷

7.19. The restraint blanket

7.20. It is necessary to pause here to briefly describe the restraint blanket that was used by Ms Smith and Ms Grigor at the time Mr Adams was placed under their care and control pursuant to section 56 of the Mental Health Act 2009. The restraint blanket is a full body restraint for total immobilisation of a person in a supine position. It is indicated for use in patients assessed to be in danger of injury to themselves or others and used to ensure safe transport to an appropriate treatment facility, against the patient’s wishes. Once the patient is on the stretcher, the blanket is placed over the patient with their arms being placed through the allocated holes. There is a padded neck area designed to sit just under the patient’s chin. The restraint straps nearest the patient’s head are connected to the stretcher first, and in such a way as to allow the head of the stretcher to be raised if necessary. The middle leg strap is connected to the foot end of the stretcher next. The arms and legs are restrained using upper and lower Velcro restraints with a specific colour for smaller (red) and larger (blue) arms and legs and white Velcro restraints for the wrists and ankles.⁵⁸ Pictures of the restraint blanket and the process to secure it were tendered to the Court during the inquest.⁵⁹

7.21. The decision to apply the restraint blanket

7.22. This aspect of the evidence can be dealt with swiftly and in two parts; namely the reason for the decision to apply the restraint blanket, and the appropriateness or otherwise of the decision.

⁵⁷ Transcript, page 33

⁵⁸ Exhibit C24, Annexure CW-3, SAAS Paramedic Internship OSCE Assessment Book

⁵⁹ Exhibit C24a

- 7.23. Ms Grigor and Ms Smith both gave evidence that they understood their attendance at The Oaks was to respond to a mental health episode. Ms Grigor gave evidence that there had been no discussion on how to manage Mr Adams prior to their arrival on the scene.⁶⁰ Ms Grigor emphasised that every patient is different and that their priority was to *'get someone in a safe place so we can actually figure out what's causing their behaviour and try and treat it appropriately'*. The primary focus of their attendance was to undertake an assessment, potentially administer treatment and then consider a transfer to hospital.⁶¹ There was no evidence to suggest that they arrived on the scene with the preconceived notion that Mr Adams was to be detained. I accept the evidence of Ms Grigor and Ms Smith that the use of the restraint blanket was only raised when Mr Adams' behaviour escalated shortly after he was guided onto the stretcher.
- 7.24. Ms Grigor⁶² and Ms Smith⁶³ both gave evidence that a less restrictive means of responding to the situation would have been to administer Mr Adams' oral medication, lorazepam.⁶⁴ This is a benzodiazepine and is relatively slow acting. As Mr Adams was considered to be at immediate risk, this was not an appropriate measure. Further, due to his condition he was unable to give consent to taking a tablet, and it was required to be self-administered rather than parenteral administration. The alternatives to physical restraint were chemical restraints (droperidol and midazolam) which were only able to be administered by an intensive care paramedic. Neither Ms Smith nor Ms Grigor were qualified (at that time) to administer this medication.
- 7.25. Professor Kelly noted that protecting a patient from foreseeable danger is an important part of a paramedic's role. She stated:
- '[i]f Mr Adams was at risk of hurting himself (e.g. by falling from the stretcher), and that risk could be safely mitigated by use of a restraint blanket, in my opinion, its use was reasonable. Mr Adams had also exhibited a pattern of erratic behaviour interspersed with periods of relative calm. The risk of another period of erratic behaviour and its associated risk of injury, in my opinion, made it necessary for some actions to reduce this risk to be taken.'⁶⁵
- 7.26. Taking into account the evidence of Professor Kelly, in addition to the background of the priority 4 tasking being escalated to a priority 2, the physical state Mr Adams was

⁶⁰ Transcript, page 33

⁶¹ Transcript, page 40

⁶² Transcript, page 37

⁶³ Transcript, page 86

⁶⁴ A depressant/sedative drug which slows down messages between the brain and the body

⁶⁵ Exhibit C25 Professor Kelly's report, page 17

observed to be in (dishevelled with cuts and bruises to his limbs), lying on the ground outside the facility and coupled with the unpredictability of his behaviour, I am of the view that the decision to detain Mr Adams and use the restraint blanket was an appropriate decision at the time, and I so find.

- 7.27. It is important to note that at no time did it appear from the footage that the restraint blanket was restricting Mr Adams' ability to breathe. Professor Kelly noted in both her report and oral evidence that the straps of the restraint blanket were not tightened or fixed until well after the police arrived on scene. In her opinion, at that time, Mr Adams was already in cardiac arrest. I am satisfied that the physical application of the restraint blanket played no causal role in Mr Adams' cardiac arrest. I will return to the timing of the cardiac arrest later in the finding.
- 7.28. The issue that arose, through the viewing of the BWF, was the failure to adequately monitor Mr Adams' condition while the restraint blanket was being applied.
- 7.29. The arrival of SAPOL
- 7.30. Even though SAPOL had already been contacted to attend the scene, Ms Smith escalated the tasking for SAPOL to attend with lights and sirens. This request was made at the point that Mr Adams was on the stretcher, flailing his arms and legs again. Ms Smith did this in order to expedite the arrival of SAPOL and to assist keeping Mr Adams safe.⁶⁶ The sound of the sirens was audible on the BWF as Officers Lahiff and Ethridge approached and then arrived on scene at 5:46pm in an unmarked police vehicle.
- 7.31. Professor Kelly reviewed all materials, including the BWF, prior to providing her expert report. In that report she provided the below table which sets out a sequence of what could be seen on the BWF of Officers Lahiff and Ethridge.⁶⁷ There was no challenge to the accuracy of this table by any of the interested parties. I have watched this footage a number of times and adopt the table as an accurate representation of what occurred on the day.
- 7.32. While the table sets out what can be seen at the different times in a (necessarily) dispassionate and objective manner, the footage itself was confronting and distressing

⁶⁶ Transcript, page 85

⁶⁷ Exhibit C25

to watch. The footage, played to the three material witnesses in Court, revealed that from the time Officers Lahiff and Etheridge arrived, Mr Adams appeared cyanosed⁶⁸ and unresponsive on the stretcher. This was at a time when Ms Smith and Ms Grigor were focused on applying the restraint blanket and were unaware of Mr Adams' moribund condition.

- 7.33. The other troubling aspect of the footage was the light-hearted atmosphere between the paramedics and police. While there is no suggestion that any of those present were aware of Mr Adams' dire condition at the beginning of the footage, there was what could be fairly described as an unhurried response from the paramedics to comments relating to Mr Adams' '*ashen grey-blue colour*' and the observation from both police officers who remarked that he looked '*dead*' when they arrived.

| Time | Observation | Camera |
|-------------|---|------------------|
| 17:46:55 | Officer first view of Mr Adams Blue to face, lying flat Restraint blanket not yet in place – loose, only one side of top straps fixed, arm and chest straps not fixed or tightened No movement of limbs or face seen | Lahiff |
| 17:47:07 | First view No movement Restraint blanket not yet in place | Etheridge |
| 17:47:33 | Officer moves Mr Adams' arm to apply restraint blanket – limp, no resistance | Lahiff |
| 17:48:03 | Officer questions if Mr Adams has been sedated Chest strap being put in place | Etheridge |
| 17:48:50 | Paramedic at head end of stretcher, checking eye and pupils Paramedic questions Mr Adams' colour | Lahiff/Etheridge |
| 17:48:57 | Male voice says – when I got out, I thought he was dead | Lahiff/Etheridge |
| 17:48:58 | Male voice responds – so did I | Etheridge |
| 19:49:02 | Paramedic asks if Mr Adams normally has ashen, grey-blue colour | Lahiff |
| 17:49:13 | Mr Adams' name called by paramedic | Etheridge |
| 17:49:18 | Paramedic is at the head end of the stretcher looking at Mr Adams' face, etc | Etheridge |
| 17:49:21 | Police officer asks if Mr Adams is breathing Paramedic is checking Mr Adams' eyes | Lahiff/Etheridge |

⁶⁸ A bluish purple hue to the skin due to decreased oxygen to the blood stream usually from either the heart or lungs

| | | |
|----------|---|------------------|
| 17:49:30 | Paramedic checks Mr Adams' pupils | Lahiff |
| 17:49:31 | Paramedic palpating for radial pulses | Lahiff |
| 17:49:40 | Paramedic calls Mr Adams' name and feels for neck pulses | Lahiff/Etheridge |
| 17:49:47 | Paramedic applies pain stimulus to left hand – no response | Lahiff |
| 17:49:55 | Paramedic feels for carotid pulse, cardiac monitor being set up | Lahiff/Etheridge |
| 17:50:05 | Cardiac monitor attached | Lahiff |
| 17:50:14 | Restraint blanket loosened from top and later pulled down with assistance of police | Lahiff/Etheridge |
| 17:50:44 | Paramedic feels for carotid pulse | Lahiff |
| 17:50:52 | Paramedic states rhythm is asystole | Lahiff |
| 17:50:54 | CPR started | Lahiff |
| 17:52:30 | Ambu-bag ventilation started | Lahiff/Etheridge |

7.34. Bria Smith

7.35. As touched on above, Ms Smith was the clinical lead on 14 February 2020 when she and Ms Grigor attended on Mr Adams. Ms Smith stated that she had used the restraint blanket '*routinely*' over a number of years.⁶⁹ She acknowledged that she was aware of the CB policy,⁷⁰ but did not know it word for word. In particular, the requirement for five people, where possible, being involved in the restraint was not something she could recall in 2020. Further, it was her understanding that oxygen was to be used once the restraint blanket had been applied and not before. She described the appropriate time to use the oxygen to be '*when safe and possible to do so*'.⁷¹ Ms Smith described the practical difficulties administering oxygen on a patient who was distressed and moving their head around. Ms Smith stated it was not possible, as the lead clinician on the day, to stay at the head of the stretcher, as it was necessary for her and Ms Grigor to move around Mr Adams to secure the restraint blanket buckles so he would not fall from the stretcher.⁷²

7.36. The issues raised by Ms Smith were reasonable in a general sense. It should be acknowledged that there was some ambiguity in the wording of the policies relating to whether it was five paramedics required to assist with restraint, or whether that number

⁶⁹ Transcript, page 92

⁷⁰ Exhibit C24, Annexure CW2

⁷¹ Transcript, page 102

⁷² Transcript, pages 101-102

could be made up with other first responders such as police. The point at which the application of oxygen was required was also not specified. However, it was clear that the underlying basis of the two policies was to highlight the focus of the paramedic's role: basic care and life support. The use of oxygen and the requirement that the lead clinician be at the head of the patient could only serve to ensure that basic care and life support were of paramount importance.

- 7.37. Applying the policies to the restraint of Mr Adams, it was evident from the BWF that, upon the arrival of the police officers, there were at least four people available to secure the restraint blanket, under direction from Ms Smith or Ms Grigor. Oxygen could have been easily retrieved by either Ms Grigor or one of the police officers and applied to Mr Adams who was not moving. Once police had arrived at the scene, Ms Smith could have remained at the head of the stretcher to observe Mr Adams while giving directions to others. I am of the view that the issues raised by Ms Smith, that could potentially compromise a paramedic's ability to comply with the policy, were not apparent during the restraint of Mr Adams.
- 7.38. Officer Lahiff's BWF was played to Ms Smith during the course of her evidence. This was done in stages between the beginning of the footage and when CPR commenced. Ms Smith told the Court that she had viewed this footage for the first time a few weeks prior to giving oral evidence.⁷³
- 7.39. Between the commencement of the footage at 17:46:30 and 17:47:20, Ms Smith agreed that Mr Adams appeared cyanotic, and his colour was an indication that his cardiac output was compromised. She accepted that Mr Adams did not respond to the noise of the police sirens and agreed it was possible that Mr Adams was in cardiac arrest.⁷⁴ Ms Smith made it clear in her evidence that as her focus was on securing the restraint blanket, she was not making observations of Mr Adams' face and she had not appreciated that he was cyanotic.
- 7.40. Ms Smith was shown the footage between 17:47:20 and 17:47:38, which reflected her moving around the area of Mr Adams' head to secure the restraint blanket over his shoulders. Even at this point, Ms Smith agreed that she was not observing Mr Adams. This was despite the police on scene assisting with the application of the restraint

⁷³ Transcript, page 89

⁷⁴ Transcript, page 108

blanket. Ms Smith told the Court that if she had appreciated Mr Adams' condition at that time, she would have stopped applying the restraint blanket.⁷⁵

- 7.41. Ms Smith agreed the footage between 17:47:38 and 17:48:10, reflected her moving from the head of the stretcher to the foot, and that no one was making visual observations of Mr Adams. Taking into account the time that passed following the arrival of police, Ms Smith was asked whether the change in Mr Adams' demeanour should have triggered a response, namely to stop fastening the restraint blanket and assess Mr Adams. Ms Smith stated that she and Ms Grigor did ultimately do that, but agreed it should have occurred earlier, including during the timeframe seen in this portion of footage.⁷⁶
- 7.42. Between 17:48:43 and 17:49:14 the footage recorded an exchange between Ms Smith and one of the carers from The Oaks, believed to be Ms McCarthy. Ms Smith queried whether Mr Adams was normally an '*ashen grey-blue*' colour.⁷⁷ Based on the footage, this was the first occasion Ms Smith appeared to have conducted visual observations of Mr Adams, noting his colour was unusual. The carer was heard to respond, '*he's not normally that pale*'.⁷⁸ Officer Etheridge then remarked '*to be honest, when I got out of the car, I thought he was dead*'. Officer Lahiff agreed and stated, '*so did I*'.⁷⁹ Ms Smith stated that had she had heard comments such as these from a police officer or bystander, it would cause her to reassess the patient. However, she did not remember hearing those comments on the day. Ms Smith stated that her memory of the event was that it passed quickly, but '*...on watching the video, it is painfully longer than I recall it being in the moment*'.⁸⁰
- 7.43. Between 17:49:19 and 17:49:32 Ms Smith agreed that the footage reflected her lifting Mr Adams' eyelids. Ms Smith told the Court that while she could not remember undertaking this assessment on the day, she would have done so in an attempt to illicit a response from Mr Adams, rather than to check for cardiac output. Similarly, Ms Smith was seen to roll her torch over Mr Adams' nail bed, and she stated she would have done this to test for a pain stimuli response. It was put to Ms Smith that Mr Adams was in cardiac arrest and these assessments were an inadequate response to the

⁷⁵ Transcript, page 109

⁷⁶ Transcript, page 109

⁷⁷ Exhibit C15a (Lahiff's footage) at 17:48:50

⁷⁸ Exhibit C15a (Lahiff's footage) at 17:48:57

⁷⁹ Exhibit C15a (Etheridge's footage) at 17:48:58

⁸⁰ Transcript, page 112

situation. Ms Smith accepted that Mr Adams appeared to be in cardiac arrest on the footage, but said it was not evident to her in the moment.⁸¹ Ms Smith also accepted that it was possible Mr Adams had been in cardiac arrest for the entire four minutes, commencing from the moment police arrived on scene to when cardiopulmonary resuscitation was initiated.

7.44. Ms Rhanna Grigor

7.45. Ms Grigor was taken through the same portions of Officer Lahiff's BWF⁸² in her evidence. Again, this was done in stages from the beginning of the footage to when CPR commenced.

7.46. Between the commencement of the footage at 17:46:30 and 17:47:20, Ms Grigor accepted the following propositions that were put to her:

- As Officer Lahiff alighted from the police vehicle and approached the scene, Mr Adams was lying on the stretcher, not moving, with the colour of his face suggesting he was cyanotic. Further, he was not responding to any external stimuli such as the noise of the police siren.
- That Mr Adams' colour suggested he required supplemental oxygen and an assessment to determine why he was cyanotic. She agreed that the oxygen was kept in a portable carry case in the rear of the ambulance, which was only a short distance from the stretcher Mr Adams was on.⁸³

7.47. Ms Grigor accepted that between 17:47:20 and 17:47:38, she was securing the restraint blanket at the foot of the stretcher. She had assumed Ms Smith was undertaking observations of Mr Adams as she was at the head of the stretcher, but she was not actively thinking about taking observations at that time.⁸⁴

7.48. Ms Grigor agreed that between 17:47:38 and 17:48:10 the footage showed her moving towards the head of the stretcher and Ms Smith moving towards the foot end. Ms Grigor accepted that neither she nor Ms Smith were, as the two paramedics on scene, making observations of Mr Adams despite the drastic change in his demeanour.

⁸¹ Transcript, page 115

⁸² Exhibit C15a

⁸³ Transcript, page 52

⁸⁴ Transcript, page 53

Mr Adams had gone from behaving in a volatile manner on the stretcher, to not responding at all. Ms Grigor explained that she thought he was not moving at this time because he was being restrained.⁸⁵ She agreed that Mr Adams' lack of movement should have been the prompt to stop applying the restraint blanket and assess him. However, she explained that:

‘...he has a sudden escalation in his behaviour, so just because he appeared calm and cooperative for a time doesn't mean that in the future he wouldn't escalate again, so I guess the unpredictability of it was in the forefront of my mind as well.’⁸⁶

- 7.49. Between 17:48:10 and 17:48:40 Ms Grigor agreed that she and Ms Smith were at the foot of the stretcher with no paramedic standing at the head, with no attempt to either visually observe Mr Adams' face or assess his condition. She accepted that this portion of the footage reflected a period of 1 minute and 50 seconds from the point at which Officer Lahiff alighted the police vehicle and walked towards the stretcher where Mr Adams was lying motionless with a bluish hue to his face.⁸⁷ Ms Grigor gave evidence that she or Ms Smith should have assessed Mr Adams' vital signs, such as his carotid pulse and respiratory function. This could have been done quickly and easily as it did not require any equipment from the ambulance.⁸⁸
- 7.50. Ms Grigor agreed that the footage between 17:48:44 and 17:48:52, revealed her walking to the head of the stretcher and pulling back the upper eyelids of Mr Adams. This was on a background of Officer Ethridge enquiring whether Mr Adams had been sedated⁸⁹ and Ms Smith enquiring of Ms McCarthy as to Mr Adams' usual colour as he was '*pretty pale*'. Ms Grigor told the Court she had no independent memory of pulling back Mr Adams' eyelids but accepted that it occurred. She also accepted that she undertook this assessment due to a level of concern about his condition at that time.⁹⁰ Ms Grigor agreed she did this to assess Mr Adams' pupillary reaction to light. The time stamp of the footage was 17:48:55, approximately two minutes after the footage commenced. This was the first time Ms Grigor appeared to be alerted to the possibility that Mr Adams was not conscious.

⁸⁵ Transcript, page 54

⁸⁶ Transcript, page 55

⁸⁷ Transcript, page 55

⁸⁸ Transcript, page 56

⁸⁹ Exhibit C16, page 3

⁹⁰ Transcript, page 58

- 7.51. Ms Grigor agreed that in the period between 17:49:12 and 17:49:25 there were attempts by both her and Ms Smith to illicit a response from Mr Adams and an assessment of his radial pulse for a heart rate. Ms Grigor accepted the more accurate and appropriate response would have been an assessment of Mr Adams' carotid pulse to determine whether there was any output of his cardiac function.⁹¹
- 7.52. Ms Grigor also conceded that between 17:49:25 and 17:50:00, a period of 35 seconds, Mr Adams appeared to be in cardiac arrest. The footage reflected that after Ms Smith called Mr Adams' name loudly, she checked for pupillary response and a pain stimuli response with his hand. She called his name again and shook his shoulders. When this did not illicit a response, Ms Grigor started unpacking the defibrillator. The restraint blanket was then removed, and resuscitation efforts commenced at 17:50:54. This was approximately four minutes after the arrival of police.
- 7.53. Before the footage was shown to her in Court, Ms Grigor had already accepted that during the application of the restraint blanket she was not performing any clinical observations or monitoring Mr Adams. Further, that there were aspects of the two relevant SAAS policies that she did not follow, in particular Mr Adams was not being closely monitored while the restraint blanket was being applied,⁹² and the oxygen was not retrieved and used.⁹³ It logically followed that had these aspects of the policies been complied with, attention would have been drawn to Mr Adams' condition earlier than it was. Ms Grigor accepted this conclusion. She also agreed with the expert opinion of Professor Kelly, that Mr Adams looked to be in cardiac arrest when the SAPOL officers arrived. Ms Grigor agreed that there was a delay in the identification and treatment of cardiac arrest and that this delay may have impacted the outcome for Mr Adams.⁹⁴
- 7.54. I found Ms Smith and Ms Grigor to be honest and credible witnesses who made appropriate concessions. Their evidence was that whilst on scene it did not feel as though four minutes had passed between the arrival of SAPOL and resuscitation efforts commencing. However, they accepted the accuracy of the timeframe after watching the BWF. Another similarity between their evidence was that upon arrival at the scene they held a preconceived view that they were responding to a mental health episode and

⁹¹ Transcript, page 60

⁹² Transcript, page 35

⁹³ Transcript, page 66

⁹⁴ Transcript, page 66

not an acute situation, let alone a cardiac arrest.⁹⁵ Ms Grigor candidly stated that, based on her understanding of the tasking, she was not alert to the possibility of an acute event unfolding.⁹⁶ Ms Smith stated she was not anticipating a medical episode.⁹⁷ They were both focused on securing the restraint blanket.

- 7.55. A likely explanation for the failure to appreciate an acute episode involving Mr Adams was the lack of awareness of the connection between psychotic conditions and sudden cardiac arrest. Neither of them were aware of such an association.⁹⁸ Ms Grigor was also unaware that the use of antipsychotic medication could pre-dispose a person to a fatal cardiac arrhythmia.⁹⁹ Ms Smith was not sure whether she knew this at the time but did have an awareness when she gave evidence due to her recent ECP training.
- 7.56. Professor Kelly was asked whether paramedics should be educated about the relationship between psychological stress and sudden cardiac death, in the context of mental health taskings. She stated:

‘In my opinion the more important part of the training is around the recognition of patients whose condition is deteriorating. Be that any type of patient. So a change in the condition of a person who has reported chest pain who then becomes left blue etc., is the same general principles apply. I think it is helpful for paramedics to be informed that medications may increase that risk but in fact the more important is about responded, detecting and responding to a patient whose condition has changed or deteriorated.’¹⁰⁰

Professor Kelly did however agree that paramedics should at least be aware of the increased risk of sudden cardiac arrest occurring in a psychiatric patient as opposed to the general public.¹⁰¹ Professor Kelly’s evidence highlighted the importance of adhering to the policies that were in place at the time which, if followed, were designed to detect a deteriorating patient.

- 7.57. Professor Kelly was asked whether it was unreasonable for Ms Smith and Ms Grigor to not have anticipated or expected Mr Adams’ sudden cardiac arrest, in the context of a mental health tasking. Professor Kelly gave this evidence:

‘Unfortunately, this is common in similar situations as are relative to the police restraint issues, and there was a coronial case in New South Wales I think last year where a patient

⁹⁵ Transcript, page 62, page 116

⁹⁶ Transcript, page 63

⁹⁷ Transcript, page 116

⁹⁸ Transcript, page 116, page 62

⁹⁹ Transcript, page 62

¹⁰⁰ Transcript, page 160

¹⁰¹ Transcript, page 161

has been restrained and suddenly goes into cardiac arrest which was unexpected. So this is quite a usual pattern here. In other words, it is unpredictable, and that's why observation is important.¹⁰²

8. Expert evidence

8.1. Professor Kelly's expert oral evidence was not subject to serious challenge. Professor Kelly's evidence can be summarised as follows:

- When applying any restraint apparatus, it was important that a member of the clinical team maintained constant observation of the patient to ensure that there was not an abrupt deterioration, underscoring the importance of always having one clinician at the head of the patient.
- With the patient lying down, the patient's ability to breathe can be inhibited and there are a small proportion of patients that may deteriorate. This is addressed by having oxygen on-hand and in use during the restraint.
- Between the arrival of the police on the scene and the point at which CPR commenced, no clinician (Ms Smith or Ms Grigor) assumed the role of undertaking the tasks that were required in the relevant restraint policies; primarily observing and assessing Mr Adams with the secondary consideration of delivering oxygen.
- To have assumed a period of calm after a period of volatility (an abrupt change in demeanour) due to the previously observed labile behaviour, ran the risk of not detecting a serious deterioration in the patient's condition.¹⁰³ This risk was realised in Mr Adams' case.
- Upon arrival of SAPOL to the scene at Glenelg (as reflected on the BWF), Mr Adams was in cardiac arrest.¹⁰⁴ This opinion was based on Mr Adams' unresponsiveness to external stimuli (sirens of police vehicle and noise around him), the ashen-blue colour of his face, and the limpness seen in his hands when moved by paramedics and police. Professor Kelly also observed the continuous nature of Mr Adams' condition until the cardiac arrest was identified.¹⁰⁵

¹⁰² Transcript, page 178

¹⁰³ Transcript, page 150

¹⁰⁴ Transcript, page 155

¹⁰⁵ Transcript, page 155

- In the four minutes between the arrival of police and the commencement of CPR, there was no urgency for both paramedics to be focused on applying the restraint blanket, as Mr Adams' unresponsive condition did not change.¹⁰⁶
- The level of care provided to Mr Adams by Ms Smith and Ms Grigor was not adequate and below that which would be expected of a trained paramedic. Professor Kelly based her opinion on the lack of continuous observations and the failure to act promptly on Mr Adams' change in behaviour and change in colour.¹⁰⁷
- Had Ms Smith and Ms Grigor been conducting continuous monitoring, the time between his changing condition and the diagnosis of a cardiac arrest was likely to have been significantly shorter.¹⁰⁸
- When cardiac arrest was identified, Mr Adams was in asystole (no cardiac rhythm) and subsequently had approximately a 10% chance of survival.¹⁰⁹ Professor Kelly provided literature on the topic of out of hospital cardiac arrests which were tendered to the Court.¹¹⁰ These papers outlined the dire outcomes of patients suffering a cardiac arrest in an out of hospital setting.
- Even if Mr Adams' cardiac rhythm was identified to be in ventricular fibrillation, which was amenable to defibrillation, his chance of survival was low. It was not helped by the four-minute delay in commencing CPR.
- Mr Adams' death was most likely not preventable due to the cardiac arrest taking place in an out of hospital setting.

8.2. I accept Professor Kelly's evidence in its entirety. I make findings in accordance with her evidence as set out above.

¹⁰⁶ Transcript, page 157

¹⁰⁷ Transcript, page 159

¹⁰⁸ Transcript, page 159

¹⁰⁹ Transcript, page 158

¹¹⁰ (1) Adnet F et al. Cardiopulmonary resuscitation duration and survival in out-of-hospital cardiac arrest patients. *Resuscitation* 2017; 111:74–81

(2) Sasson C, Rogers MA, Dahl J, Kellermann AL. Predictors of survival from out-of-hospital cardiac arrest: a systematic review and meta-analysis. *Circ Cardiovasc Qual Outcomes*. 2010 Jan;3(1):63-81

(3) Yan S et al. The global survival rate among adult out-of-hospital cardiac arrest patients who received cardiopulmonary resuscitation: a systematic review and meta-analysis *Critical Care* 2020; 24:61

9. Critical incident review

9.1. Following Mr Adams' death, SAAS undertook a critical incident review, with the review being requested on 26 February 2020 and completed on 10 June 2020.¹¹¹ The review focused on a number of issues, including the delay in response to the initial tasking at 12:27pm. It also touched on the lack of patient monitoring while securing the restraint blanket. It was evident that as part of the review the BWF was viewed as it is referenced in the document which stated there was a '*delayed recognition of and response to a clinically deteriorating patient*'.¹¹² This was confirmed by Ms Alison Doecke, counsel for SAAS.¹¹³

9.2. The review highlighted a number of system failures, with two clear areas of recommendation and review.¹¹⁴ They were as follows:

- Delayed response time due to SAAS demand and system capacity; and
- Management of the case once the final SAAS crews were dispatched.

9.3. Dealing with the first issue, the review found:

'Concerns from the review are around the delayed response (+5hrs) based on a number of factors, one being failure of the information being provided to allow adequate assessment of the patient's presentation. This is from the initial 000 crew. This bias towards the Mental Health consumer was evident and created delays to the patient. It was identified during the review that the patient had several escalations of behaviour previously, considered to be from a medical cause. The unavailability of such information has contributed to a bias and a delay to occur. Whilst we are unable to state if a more timely response would have changed the outcome, it would be beneficial to ensure such information is provided in some form to support optimal response and care to consumers.'¹¹⁵

9.4. It was evident from the review document that during this five-hour delay, there were three occasions when staff at The Oaks contacted SAAS to request an assessment of Mr Adams or to enquire as to the estimated time of arrival. Based on the evidence given by Professor Kelly about the survivability of out of hospital cardiac arrests, there is a strong inference that if SAAS had arrived earlier, Mr Adams' chances of survival

¹¹¹ Exhibit C26

¹¹² Exhibit C26

¹¹³ Transcript, page 198

¹¹⁴ Exhibit C26

¹¹⁵ Exhibit C26

would have been better than they ultimately were. This was acknowledged by counsel for SAAS in closing addresses. Ms Doecke told the Court:

‘SAAS accepts that had an ambulance been dispatched in a more timely manner, there was a much better chance of a better outcome for Mr Adams.’¹¹⁶

She submitted that the delay in the arrival of the ambulance was an organisational failure.

- 9.5. Had paramedics arrived on scene earlier, and before Mr Adams’ behaviour escalated later in the afternoon, it is likely that they would have transported him to a treatment facility for assessment. This may have prevented the escalation of the psychotic episode which saw Mr Adams become highly agitated and contributed to his death. Alternatively, if Mr Adams still experienced an escalation of behaviour, there was a likelihood that it would have occurred in a hospital setting where his chance of survival (according to the statistical information) upon suffering a cardiac arrest, would have been improved. While there are a number of variables to this scenario, I agree with counsel’s submission that there was an undue delay in the arrival of SAAS. I so find. Furthermore, that if they had arrived sooner, Mr Adams’ death was more likely to have been prevented. How much more likely, I am unable to say.
- 9.6. Dealing with the second issue, the critical incident review also found that there was a clear requirement to review and provide education and support into the management of behavioural emergencies with a focus on the monitoring and management of a patient whilst the restraint blanket is being applied. Ms Wright in her affidavit outlined the changes that were made to the two policies relevant to the clinical care provided by the paramedics on 14 February 2020.¹¹⁷ In addition, a policy entitled ‘*Application of Patient Restraint in SAAS Care*’ (the Patient Restraint Procedure) was drafted and presented at a 2021 Statewide Professional Development Workshop for the education of SAAS clinical staff.¹¹⁸

¹¹⁶ Transcript, page 201

¹¹⁷ Exhibit C24, Annexure CW-4, CW-5

¹¹⁸ Exhibit C24, Annexure CW-4

9.7. The draft Patient Restraint Procedure highlighted the risk of restraint asphyxia and cardiac arrest in the setting of physical restraint. It made reference to the point at which to cease physical restraint, namely:

- if a patient appears to become compliant throughout the application of restraint, relaxation or removal of physical restraint;
- If medicines have been administered clinicians should ensure they have allowed ample time, where possible, for medicine to elicit an effect;
- If challenging behaviours continue and the patient requires restraint due to safety concerns, then coordinating safe movement to a stretcher needs to be undertaken so a safety net can be applied.¹¹⁹

9.8. Following the Inquest, correspondence was received by the Court to confirm that the draft policy was formalised, coming into effect on 24 May 2023. Some changes had been made to the formalised document. On the topic of when to cease physical restraint it stated:

- The patient appears to relax, re-engage and no longer poses a risk to themselves or others, and after a risk assessment by clinicians;
- Medicines administered by clinicians have been allowed ample time, where possible, for the medicine to elicit an effect, and after a risk assessment by clinicians;
- ***The patient's presentation changes to indicate deterioration, with physical restraint no longer necessary and patient requiring urgent care (e.g. rapid reduction in conscious state, changes to respiratory rate and effort).***¹²⁰

The emphasised passage (above) in the formalised policy was of particular relevance to the issues that arose in Mr Adams' death. I consider this to be an important inclusion in the policy.

9.9. In relation to the need to increase the awareness of paramedics about the relationship between psychological conditions and sudden cardiac arrest, the formalised policy detailed the range of clinical considerations that could increase the risk of physical restraint for patients, particularly when restrained in the prone position. One of the considerations was:

Mental Illness & Previous Psychological Trauma:

Patients with a history of complex or chronic trauma can have a disproportionate and prolonged sympathetic response to stress due to a hyperactive limbic system. ***In addition to this, patients who are acutely unwell, particularly if manic or psychotic, may***

¹¹⁹ Exhibit C24, Annexure CW-4, page 3

¹²⁰ Exhibit C24a, page 2 (*emphasis added*)

*experience additional stress and fear. In both cases this places the patient at greater physical risk due to catecholamine release.'*¹²¹

9.10. While Professor Kelly emphasised the importance of ongoing clinical observations to detect and respond to any deterioration over and above a detailed understanding of the relationship between psychological stress and sudden cardiac arrest, she gave evidence that knowledge of this relationship would be beneficial. Similarly, the understanding that some psychotropic medications increased the risk of cardiac arrhythmia would be desirable.

10. Recommendations

10.1. Pursuant to section 25(2) of the Coroners Act 2003 I am empowered to make recommendations that in the opinion of the Court might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the Inquest.

10.2. It is important to acknowledge that SAAS undertook a timely and thorough review of the events leading up to Mr Adams' death. The issues identified in the review saw changes to SAAS policies. Taking into account the changes and improvements already implemented by SAAS, there is just one matter that requires addressing by way of recommendation. This is the issue relating to the connection between psychological stress (particularly psychosis) and/or psychotropic medication and sudden death.

10.3. I therefore make the following recommendation directed to the Chief Executive Officer of the SA Ambulance Service:

10.3.1. That education and training be provided to explore and further analyse the increased risk of psychiatric patients suffering out-of-hospital sudden cardiac events and the impact of psychiatric medication upon the likelihood of a cardiac event.

¹²¹ Exhibit C24a, page 3 (emphasis added)

11. Acknowledgements

11.1. I acknowledge the valuable assistance of all counsel in this matter.

11.2. I convey my sincere condolences to Mr Sidney and Mrs Ronda Adams and Mrs Jennifer and Mr Julian Zuffi and the other four siblings of Mr Adams and their families.

Key Words: Death in Custody, South Australian Ambulance Service, Mental Health

In witness whereof the said Coroner has hereunto set and subscribed her hand and

Seal the 13th day of October, 2023.

Coroner