CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF ADAM TROY SHEPLEY

[2026] SACC 7

Inquest Findings of her Honour Deputy State Coroner Kereru

26 March 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a man while under police restraint following a mental health or drug-induced incident. The Inquest explored whether manual restraint played a role in the death and whether there was a failure by paramedics to administer prompt medical treatment.

Held:

1. Adam Troy Shepley, aged 30 years of Salisbury North, died at Salisbury North on 24 October 2020 as a result of an unascertained cause.

2. Circumstances of death as set out in these findings.

Recommendation made.

Counsel Assisting: MR M KIRBY

Family: MS S AUSTIN
Counsel: MS C O'CONNOR SC - Solicitor: CAMATTA LEMPENS

Interested Party: COMMISSIONER OF POLICE & SA HEALTH
Counsel: MR M ROBERTS KC - Solicitor: FINLAYSONS LAWYERS

Witness: CONST B RIDDLE, MR C TIMMINS, CONST T ELY, MS S REVELL, CONST L BENNETT, SGT M FRANKCOM & MR S PRZIBILLA
Counsel: MR M ROBERTS KC - Solicitor: FINLAYSONS LAWYERS

Hearing Date/s: 16/04/2024-18/04/2024, 07/05/2024, 09/09/2024-11/09/2024 & 13/09/2024

Inquest No: 25/2024 **File No/s: 2152/2020**

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Introduction

1 Adam Troy Shepley was 30 years old when he died at about 1:30 am on 24 October 2020 following his arrest by SA Police (SAPOL) officers. In the hours before his death Mr Shepley was exhibiting erratic and paranoid behaviour consistent with drug use. He was known to SAPOL as he had come to their attention previously with similar incidents of paranoid and aggressive behaviour believed to have stemmed from drug-induced psychoses.

2 In the hours leading up to his death, Mr Shepley had called both SAPOL and the SA Ambulance Service (SAAS), however there was no evidence to suggest that either SAPOL or SAAS associated these earlier calls with their eventual attendance upon Mr Shepley. The calls did not result in any in-person interaction.

3 Following the calls, SAPOL were tasked to attend the residence of Ms Karen-Gaye Clissold who reported that a man not known to her was outside her home in distress. She thought he appeared frightened and drug affected. The man asked for a drink and then climbed Ms Clissold's fence.[1] He had climbed onto the roof by the time police arrived. When they engaged with the unidentified man, one of the members of police recognised him to be Mr Shepley from previous dealings.

4 Despite several attempts officers were unable to convince Mr Shepley to descend from the roof and he began to move away from police across nearby rooftops. Senior Constable Benjamin Riddle made the decision to climb onto the roof to follow Mr Shepley, continuing to encourage him to climb down. When Mr Shepley reached the end of the sequence of roofs he was able to traverse, he rushed at Senior Constable Riddle. A tussle ensued during which Mr Shepley fell from the roof to the ground. Thereafter, Senior Constable Riddle engaged with him in an effort to restrain and arrest him. Mr Shepley actively resisted Senior Constable Riddle until other members of police who had arrived on scene assisted him. Mr Shepley was effectively restrained at about 12:25 am.

5 SAAS paramedics arrived at approximately 12:50 am.[2] Mr Shepley was not medically examined. After a period of approximately five minutes Mr Shepley was placed onto a barouche. It was at that time that paramedics realised Mr Shepley was not conscious, was not breathing, and was without circulation. Resuscitation efforts commenced but were unsuccessful.

6 Despite great efforts, post-mortem examinations were unable to ascertain a specific cause of Mr Shepley's death.

7 The involvement of both SAPOL members and SAAS paramedics was captured on body worn video (BWV) footage which was received into evidence during the Inquest.[3]

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[1] Exhibit C5 at [10]
[2] Exhibit C60 Annexure MD19 at 4
[3] Exhibits C50 and C50a

Reason for Inquest

8 Mr Shepley's death occurred while he was in custody and had been restrained by SAPOL officers. Section 21 of the *Coroners Act 2003* therefore requires an Inquest into Mr Shepley's death to be held. In addition to this requirement, the circumstances leading up to Mr Shepley's death (as captured on BWV) gave rise to the question of whether earlier medical intervention may have prevented his death. The Inquest therefore focussed on the manner in which SAPOL members approached their dealings with Mr Shepley and the care that was provided by SAAS paramedics.

Evidentiary considerations

9 The standard of proof applicable to coronial findings is the civil standard; the balance of probabilities. If findings which imply or express criticism of individuals are considered, I shall not make such a finding unless the evidence leads me to a comfortable level of satisfaction that the finding should be made. In this regard, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[4] The effect of this and similar authorities is that coroners should exercise caution when considering adverse findings against, or comments about, individuals or entities. Proof of facts underpinning a finding that would, or may, have a deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts under consideration. Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or reliable evidence.

10 I am also cognisant of the potential intrusion of hindsight bias whereby the decisions of those involved are assessed more harshly in light of the known adverse outcome. A description of 'hindsight bias' is given in the *Australasian Coroner's Manual*, namely, 'the tendency after the event to assume that events are more predictable or foreseeable than they really were'. It is further stated that:

> What is clear in hindsight is rarely as clear before the fact. If it were, there would be far fewer mistakes made. It is an obvious point, but one that nonetheless bears repeating, particularly when Coroners are considering assigning blame or making adverse comments that might damage a person's reputation.
>
> Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. The distinction needs to be understood and rigorously applied.

11 There is an unfairness in applying hindsight bias and I will endeavour to assess the behaviour of those involved in Mr Shepley's death on the basis of the circumstances as they knew, or ought to have known, at the time they made relevant decisions.

Evidence at Inquest

12 The documentary evidence received at Inquest comprised 75 exhibits. In addition to the documentary evidence, I heard oral evidence from:

- Associate Professor Neil Langlois, forensic pathologist, Forensic Science SA

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[4] (1938) 60 CLR 336

- Senior Constable Benjamin Riddle, SAPOL member
- Mr Clarke Timmins, paramedic, SAAS
- Constable Timothy Ely, SAPOL member
- Ms Sally Revell, paramedic, SAAS
- Constable Liam Bennett, SAPOL member
- Sergeant Mark Frankcom, SAPOL member
- Professor Anne-Maree Kelly, independent expert emergency physician

13 In these findings I will not summarise all the evidence tendered or heard at the Inquest but will refer to it only in such detail as is warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

Post-agitation restraint deaths - an important context

14 The Coroners Court has investigated a number of incidents involving people under detention following heightened behaviour as a result of mental health issues and/or drug intoxication.[5] In many cases, strange and aggressive behaviour of agitation occurs, with a display of what is often described as 'super human' strength during attempts to subdue or control the behaviour. The Court's experience is that once restrained, the heightened behaviour usually suddenly ends and the person becomes calm and quiet. This is often reported as reassuring and somewhat of a relief by those responding to the incident.

15 A difficulty that is commonly encountered is an underappreciation of the true state of affairs; that the sudden change in state actually reflects the person experiencing a medical episode, rather than having simply given up the fight. The Court has observed occasions of the seriousness of the situation remaining unnoticed for some time. Another contributing factor to the delay in this realisation is that some first responders appear to have an expectation that illicit drug use will bring about varying states of consciousness. That is, a low state of consciousness is thought to reflect a 'come down' from drug use rather than of a purely medical origin. I explored during the Inquest whether this was a possible contributor in Mr Shepley's case.

16 Forensic pathologists have explained that what likely occurs in these situations is that the extreme physical and psychological exertion experienced by the person during their period of crisis can trigger physiological responses in the body (such as a surge of adrenaline and noradrenaline) which can initiate an abnormal heart rhythm. This can occur in people with a normal heart who are otherwise healthy.

17 An analogous situation is where someone in the face of a perceived threat feels what is often described as a 'fight or flight' response. They may experience physiological responses which put stress on the body. Once the danger or perceived threat is gone, the body then returns to a normal, relaxed state. However, this physiological process can create a heightened risk for those who are under the influence of illicit substances (usually

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[5] For example, *Inquest into the death of Michael Gerard Adams*; *Inquest into the death of Wayne Fella Morrison*; *Inquest into the death of Clinton John Duffield*; *Inquest into the death of James Wiliam Wallace*; and *Inquest into the death of Ricky James Bais*

stimulants), and/or take antipsychotic medications for mental illness, and/or have an underlying heart condition (often undiagnosed).

18 What can further complicate the investigation into deaths in these circumstances is that there are often no positive pathological signs found during post-mortem examination which might determine what the aetiology of the death was. The Court's experience is that, in cases as I have described, the forensic pathologist conducting the examination often reaches a conclusion of an 'unascertained' or 'undetermined' cause of death. It is important to note, in particular, that cardiac arrythmias (abnormal signal conduction through the heart) generally leave no evidence to be found during post-mortem examination. On its face, this can leave an unsatisfactory impression that there were unnatural forces at play at the time of death. However, that is not always so. In assessing this question, the Court must carefully look at the precise manner in which first responders interacted with the person and identify whether there was or was not any concerning interaction. If there was not, then the cardiac consequences of post-agitation restraint would be more likely to have brought about the death.

19 It is also important to recognise that a death resulting from the cardiac consequences of post-agitation restraint often bears no responsibility upon anyone involved. It is usually a physiological phenomenon that arises independently of the manner in which restraint is effected.

20 This phenomenon is described in many ways, for example sudden cardiac death or post-excitement death. Fundamentally it relates to a sudden death following a period of intense psychological and physical stress which suddenly ends. The name ascribed to the concept is less important than that it is properly considered and explored during the proceedings.

21 Given the existence of this phenomenon that the Court has observed many times, it is critical for first responders to not only effect restraint in a safe way, but also to detect any signs of diminishing responsiveness as soon as possible in situations where there is a sudden reduction in heightened behaviour. Early detection is the key to the safety of the person being restrained. I will return to assess this important issue later in the Finding.

Adam Troy Shepley

22 Adam Shepley was 30 years old at the time of his death. He was living with his grandmother, Mrs Katherine Saunders, at her home in Salisbury North. He had lived with her and his late grandfather since the age of eight or nine, as his mother worked full time. Though he lived with his grandmother, he saw his mother regularly and was living with her up until approximately two weeks prior to his death, when he returned to live with Mrs Saunders.

23 It was well documented that Mr Shepley had recurring trouble with the abuse of illicit drugs and alcohol. In 2009, he presented to Drug and Alcohol Services SA (DASSA) for help navigating withdrawal services relating to his use of amphetamines, cannabis and alcohol. Over the next few years, Mr Shepley engaged with DASSA services on nine occasions, up to and including October 2020.[6]

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[6] Exhibit C28

24 Mr Shepley was also engaged in methadone therapy on and off for many years up to the time of his death.

25 Between 2016 and 2018 Mr Shepley presented at the Lyell McEwin Hospital on nine occasions, usually facilitated by SAPOL, and usually exhibiting behaviours of paranoid and aggressive behaviour which was thought to be the product of, likely, drug-induced psychosis. Notwithstanding these incidents, he did not have any formally diagnosed psychiatric illnesses.

26 Mr Shepley's use of methadone and his presentations to the Lyell McEwin Hospital took on significance during the Inquest, specifically in relation to his likely cause of death, as I will explain in more detail later in this Finding.

Events leading to death

27 The events leading to Mr Shepley's death began on 23 October 2020. He was observed by his grandmother, Mrs Saunders, to leave the house, taking with him what appeared to be a large bottle of wine.

28 At about 11:15 pm, Mr Shepley arrived by taxi to the On the Run (OTR) service station on the corner of Waterloo Corner Road and Bagster Road at Salisbury North. He was witnessed by Mr Ronit Vantare, an employee of the service station. Mr Vantare's affidavit, received into evidence, described behaviours that suggested Mr Shepley was experiencing paranoia.[7]

29 At 11:26 pm an emergency call was made from Mr Shepley's mobile phone to SAPOL, with the SIM card having been removed.[8] He gave his correct name during this call. He told the call taker that he did not feel safe. When asked why he did not feel safe, he said it was because he was stranded at OTR and needed a ride home. He said it had been difficult to get a taxi. Mr Shepley did not identify an emergency or convey behaviours that would have warranted emergency assistance. SAPOL's response to this call was entirely appropriate.

30 Almost immediately following the call to police, at 11:31 pm, Mr Shepley made an emergency call to SAAS where he complained that he was feeling sick and nauseous.[9] This time, the call taker advised Mr Shepley that help would be arranged, and to phone back if anything changed in the meantime.

31 At 11:41 pm Mr Shepley was recorded on CCTV leaving the service station and heading in a northernly direction. At 11:45 pm Mr Shepley approached a nearby house. The resident of the house, Ms Clissold, spoke to Mr Shepley through her screen door. He did not identify himself to her and she did not know who he was. Ms Clissold recalled Mr Shepley telling her that he needed help as a car was chasing him, and that he was scared. Ms Clissold described in her affidavit that Mr Shepley was sweating profusely, flushed, and speaking very fast, and she thought he had the appearance of a person who was on drugs.[10] Ms Clissold phoned and reported his presence to police.

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7 Exhibit C4 at [5] and [8]
8 Exhibit C60, Annexure MD24; transcribed in Exhibit C60, Annexure MD48
9 Exhibit C60
10 Exhibit C5

32 Following Ms Clissold's call, a police patrol was dispatched with Senior Constable Benjamin Riddle and Constable Timothy Ely attending. They conducted a search of the area around Ms Clissold's house, but were unable to locate anyone, and they left to attend another incident.

33 At 12:15 am, now 24 October 2020, Ms Clissold called triple zero a second time as she could hear sounds of someone moving across her roof. Senior Constable Riddle and Constable Ely returned to the premises and saw Mr Shepley on the roof. Senior Constable Riddle spoke to Mr Shepley and directed him to descend from the roof. He was aware that Mr Shepley was possibly on drugs and that he was frightened.[11] During this interaction Senior Constable Riddle recognised Mr Shepley from previous dealings and addressed him by name, though Mr Shepley had falsely claimed his name was 'Chris Whittle' when he was asked.

34 Unbeknownst to the attending officers, one minute earlier, at 12:14 am, Mr Shepley had called triple zero himself. He said that he was 'on Waterloo' and that he was in danger and needed help. He was asked for his name and he responded, 'does that matter' and then said 'Chris'. The call taker tried to ascertain the precise location. In the background a male voice can be heard saying 'get off the fucking roof' before the call was terminated.[12]

35 During oral evidence, Senior Constable Riddle explained that his last involvement with Mr Shepley had been a couple of weeks or months earlier, in response to a call from Mrs Saunders, but that Mr Shepley had been 'fine' and that encounter was 'normal', with Mr Shepley not appearing to be affected by drugs or alcohol on that occasion.[13]

36 Senior Constable Riddle explained that, on 24 October 2020, he felt no particular reason to be concerned about Mr Shepley's reaction or behaviour towards police.[14] He was, however, concerned for Mr Shepley's behaviour in general, given his obvious drug or alcohol affected behaviour and his presence on a roof.

37 After unsuccessful attempts by Senior Constable Riddle to engage with him, Mr Shepley jumped from Ms Clissold's rooftop to a neighbouring rooftop and began to move away from police. Senior Constable Riddle told the Court that he was concerned about Mr Shepley getting away, but purely from a welfare perspective.[15] He said his approach was not focussed on apprehending an offender, but for looking after Mr Shepley's safety given his obvious intoxication or mental health issue. He was concerned that Mr Shepley needed help to remain safe.[16] This evidence was consistent with his interactions with Mr Shepley as I observed in the BWV. I accept Senior Constable Riddle's evidence about his motivations.

38 Senior Constable Riddle then climbed up onto a rooftop and followed after Mr Shepley as he travelled along several rooftops in the neighbourhood, jumping from house to house.

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11 Transcript, page 79
12 Exhibit C60 Annexure MD25
13 Transcript, pages 51-52
14 Transcript, page 66
15 Transcript, page 88
16 Transcript, pages 90-93

While following, Senior Constable Riddle continued to direct Mr Shepley to get down off the roof.

39 Mr Shepley came to a point where he was unable to jump to another rooftop. Senior Constable Riddle approached him, continuing to direct him off the roof. Unexpectedly, Mr Shepley rushed at Senior Constable Riddle and a physical altercation took place. Ultimately, Mr Shepley fell from the roof and landed on the ground next to the house.[17] Senior Constable Riddle then jumped down from the roof and engaged again with Mr Shepley in an effort to restrain and arrest him. Senior Constable Riddle called for help and was soon joined by Constable Ely who had followed their journey from the ground.

40 Both members described a violent struggle with Mr Shepley, who they described as displaying 'unusual strength'.[18] Police tactics and methodology were implemented which brought about control over Mr Shepley in a manner that I consider was reasonable in the circumstances. Eventually, Constable Ely and Senior Constable Riddle managed to get Mr Shepley handcuffed behind his back, but he continued to thrash and resist. In the course of the scuffle, Senior Constable Riddle was bitten by Mr Shepley and nine other members of police arrived to assist.

41 The table below, based on Professor Kelly's report, sets out the timeline of what occurred next and reflects her assessment of the BWV footage, with which I agree upon my own viewing:

Time	Event
00:23	Mr Shepley resists efforts to apprehend him.
00:24:43	Mr Shepley is restrained in the prone position for handcuffing. He continues to resist. A member of police and Mr Shepley are breathing fast and heavily, probably related to exertion.
00:26	Mr Shepley is seen trying to move purposefully and to speak normally.
00:26	Additional police arrive.
00:27	Police request SAAS attendance, reporting head wound and agitation; Mr Shepley is seen to move purposefully.
00:28	Mr Shepley is seen to move and vocalise purposefully.
00:29	Mr Shepley becomes quiet with more normal respirations.
00:30	Mr Shepley is rolled onto his left side; A member of police queries if Mr Shepley is alright; there is a hand on Mr Shepley' chest – looks like it is for the purpose of feeling his breathing. It is observed by those present that Mr Shepley has stuff in his mouth and dribble coming out his mouth. There is minimal attempt by Mr Shepley to clear his mouth. The total time in the prone position was 5 minutes and 43 seconds.
00:30	Police request to expedite SAAS response due to laboured breathing and semi-conscious state.

[17] Senior Constable Riddle's BWV camera became dislodged during the scuffle with Mr Shepley on the roof and only audio was recorded. The footage does not allow a determination of whether Mr Shepley jumped or fell from the roof, and Senior Constable Riddle could not say.

[18] Transcript, pages 76 and 330

Time	Event
00:31	Mr Shepley is unable to maintain position on his side independently; Police ask Mr Shepley to take big breaths. There is minimal abdominal excursion; looks like some slow breathing but looks unconscious.
00:31:56	There is rhythmic muscle contraction; Professor Kelly queries whether this is seizure activity.
00:32:16	There is rhythmic muscle contraction; Professor Kelly queries whether this is seizure activity. Police note that Mr Shepley is 'shaking'; he is clearly breathing.
00:33	Mr Shepley is moved to a sitting position. He is breathing, making grunting or moaning sounds. At 00:33:53 when pulled to a sitting position, Mr Shepley appears to be having rhythmic muscle contraction; Professor Kelly queries whether this is seizure activity; there is some moaning.
00:34	Mr Shepley has his eyes open and is moaning intermittently; does not seem conscious.
00:35	Mr Shepley continues to make moaning sounds and makes some movement of his head. He is placed on his side. A member of police is continually at Mr Shepley's side and holds him until SAAS arrive.
00:36:03	Mr Shepley purposefully moves his head off the ground; he is breathing.
00:36:20	Mr Shepley makes some movements; Professor Kelly cannot tell if it is purposeful or not.
00:37	Mr Shepley makes some movement that looks purposeful.
00:38	Police provide information to SAAS regarding probable illicit drug use.
00:38	Mr Shepley makes some movement that looks purposeful.
00:41	Mr Shepley is spitting and making moaning sounds, he continues to move about for an additional four minutes. Mr Shepley appears to be trying to spit to clear his mouth.
00:44	Mr Shepley is moved back to a sitting position and spits at officers; he is moving about purposefully.
00:45	Mr Shepley is again placed on his side.
00:45	Police move Mr Shepley to the front lawn and place him on his side.
00:46	Mr Shepley is grunting and moving semi-purposefully.
00:48	Mr Shepley makes occasional leg movements and grunting sounds.
00:49	Police check Mr Shepley who has now become quiet. He is seen to move his legs and is breathing and moaning. He is not conscious or responsive.
00:50	Mr Shepley makes occasional leg movements and grunting sounds. This is Mr Shepley's last observed movement.
00:50	The ambulance pulls up beside the premises.

42 Between 12:35 am and 12:45 am a number of SAPOL members observed Mr Shepley and took turns holding him in the recovery position. He was twice assisted to a sitting position, but then was returned to his side after attempting to spit at police. Most of these interactions were captured on the BWV of Constable Liam Bennett and Constable Ely.[19] Mr Shepley's position was also moved at 12:45 am as he had been laying on bark chips and it appeared as though the bark chips were entering his mouth. When moved to a grassed area at the front of the house, Mr Shepley's demeanour quietened. While he could

[19] Exhibit C50a

be heard making noises, it was more like a moan or groan than an engaged conversation or anything responsive. I observed the police to be actively supporting Mr Shepley's position so he was not lying on his stomach with his face in the ground. From 12:35 am, Constable Bennett was seen continuously at Mr Shepley's side until paramedics arrived.

43 During the period between SAAS being tasked at 12:27 am and arriving at 12:50 am, there were two further calls from SAPOL members to request the ambulance attend more urgently, and to inform SAAS of Mr Shepley's probable illicit substance use. It is evident from these updates that SAPOL members had concerns for Mr Shepley's deteriorating condition that they were trying to action.

44 As will become clear, a difficulty that arose was that these increasing concerns were not communicated to the paramedics that had been tasked to attend.

Arrival of SA Ambulance Service

45 At about 12:50 am the first ambulance arrived on the scene, crewed by Mr Clarke Timmins and Ms Sally Revell. Both paramedics gave oral evidence during the Inquest, and the Court also had the benefit of viewing their involvement captured on the BWV.

46 The initial tasking was deemed as priority 3, which meant lights and sirens were not activated and the target response time was within 30 minutes. The information available to the paramedics was that a male was on a roof. Ms Revell explained in her oral evidence that while en route to the scene she could not remember whether there was information that the male had fallen off the roof, but she did recall that they received information about a member of police having been bitten. In response to this, a further paramedic crew was tasked to attend.

47 It was clear from the Event Chronology that the priority level was escalated by dispatchers at 00:40:28 am when information was received that Mr Shepley was having difficulty breathing. This corresponded with the evidence of Constable Bennett that he had contacted SAAS to convey these concerns.[20] What was also evident in the Event Chronology was that there appeared to be a communication difficulty between the police and the paramedics who had been tasked to attend, with the following recorded:

> SAPOL CALLED TO VERIFY THAT SAAS HAD SEEN RECENT MESSAGES RE: TROUBLE BREATHING, TEAMLEADER UPGRADED TO A 2 DURING CALL[21]

48 This was consistent with Ms Revell's evidence that they were not aware of the increasing concerns. It also demonstrates an increase in prioritisation of the response once SAAS became aware of them.

49 Ms Revell was the driver on this occasion and remained in the ambulance for a short time after its arrival.[22] Mr Timmins approached Mr Shepley in the meantime to attend to him. This was all captured on the BWV compilation and it is convenient to use video reference

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[20] Exhibit C33 at [13]
[21] Exhibit C60 Annexure MD19 at 3
[22] Transcript, page 373

points, helpfully established by Sergeant Mark Frankcom.[23] The following table is again based on Professor Kelly's report and reflects her assessment, with which I agree:

Time	Event
00:51:14	There is a conversation between a member of police and Mr Timmins while walking slowly towards Mr Shepley.
00:51:33	Mr Timmins arrives at Mr Shepley and speaks to him and examines something with a torch (possibly a cut on his head). There is no formal assessment of airway, breathing, circulation or conscious state. Professor Kelly says that breathing, if present, is shallow. There is no movement or vocalisation.
00:51	Ms Revell is instructed to bring the barouche.
00:52	Mr Timmins moves equipment to another location. He does not attach the monitor to Mr Shepley or attempt to take vital signs. Mr Timmins talks to police about injury to a member of police and about the circumstances of the event away from Mr Shepley.
00:53	Mr Timmins conducts a brief visual assessment of Mr Shepley. Mr Shepley is not moving or making any sounds. There appears to be no attempt to assess Mr Shepley's airway, breathing or state of consciousness. Mr Timmins is told that Mr Shepley was 'spasming'. Professor Kelly says that she is concerned that there may not be any chest movement or abdominal excursion at this time, but it is hard to tell because Mr Shepley is largely out of shot and the movement of the camera could be giving the impression of chest movement.
00:54:56	The ambulance barouche arrives beside Mr Shepley.
00:56	Mr Shepley is lifted onto the ambulance barouche by police. Mr Shepley is unconscious, with his eyes open, but there is no chest wall or abdominal movement. Professor Kelly's opinion is that Mr Shepley is in cardiac arrest at this time.
00:56	Removal of handcuffs is requested and a comment is made that Mr Shepley looks cyanotic.
00:57	The cardiac arrest is identified and CPR is commenced. Professor Kelly's opinion is that standard life support protocols were followed, but Mr Shepley's heart rhythm remained in asystole throughout.

50 Ms Revell described the steps she took to prepare the stretcher for Mr Shepley, then returning to the front yard, and then the process by which Mr Shepley was put onto the stretcher. She had not conducted any assessment of Mr Shepley herself and was not able to say if he was conscious.[24] She had been bringing out the barouche, gathering the items used to make 'sandbags' to assist in transporting Mr Shepley, and providing very brief assistance to Senior Constable Riddle regarding his bite injury. She was, therefore, not in a position to observe what Mr Timmins was doing.[25] Ms Revell's involvement with Mr Shepley was of little significance until after he had been placed on the barouche. It was Ms Revell who recognised Mr Shepley had gone into cardiac arrest and who initiated CPR immediately.

[23] Exhibit C50
[24] Transcript, page 387
[25] Transcript, page 374

51 Mr Timmins was the non-driving, or attending, paramedic on this occasion. He said in his evidence that he had no memory of any of the jobs he had done on this particular day, and no clear recollection of Mr Shepley's case, apart from having been at the scene.[26] He said, 'I don't even recall examining the patient or looking at the patient'.

52 It can be seen on the BWV, and was admitted by Mr Timmins, that he demonstrated no sense of urgency in his approach to Mr Shepley.[27] It can also be seen, and was accepted by Mr Timmins, that he made no proper assessment of Mr Shepley's consciousness, nor of his breathing and circulation.[28]

53 During his evidence, Mr Timmins was challenged on his actions extensively as, according to documentation he prepared following the incident,[29] and his affidavit executed on 24 October 2020,[30] he *had* conducted an assessment of Mr Shepley before the barouche was brought and identified that he had a Glasgow Coma Score (GCS) of 3, effectively unconsciousness, the lowest score available.[31] Mr Timmins agreed that if he had detected a GCS of 3, his first action ought to have been to check for a pulse and said that he could not recall doing so.[32] That is, his actions seen on the footage are inconsistent with him actually having identified unconsciousness. Mr Timmins also conceded that at no stage of his involvement with Mr Shepley did he do any of the assessments that would have enabled him to establish a GCS of 3, but did comment that if a person were in cardiac arrest, they would have a GCS of 3.

54 Professor Kelly's opinion, which I have set out above, was that while Mr Shepley appeared to be having breathing difficulties in advance, he did not enter cardiac arrest until he was lifted onto the barouche. In that light, Mr Timmins' evidence makes little sense.

55 Mr Timmins acknowledged that he should have been checking Mr Shepley's airway, checking for a pulse, and checking for consciousness.[33] He also acknowledged that he did not do those things, but was unable to give any explanation as to why.

56 Mr Timmins' evidence on this was unsatisfactory to say the least. Had the BWV not captured his movements and clinical interactions with Mr Shepley (or lack thereof), there would be no evidence to suggest anything other than appropriate clinical care based on what he wrote in the Patient Clinical Record.[34] That the clinical records did not reflect reality is a matter of great concern.

57 Professor Kelly gave evidence[35] that upon Mr Shepley being identified with a GCS of 3, a cardiac monitor should have been attached to him, which might have detected if he was bradycardic or was in ventricular fibrillation or ventricular tachycardia, all of which would have required further urgent attention.[36] It might also have warranted Mr Shepley

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[26] Transcript, page 218
[27] Transcript, page 220
[28] Transcript, pages 279 and 308
[29] Exhibit C55a
[30] Exhibit C55
[31] Exhibit C55 at [5]-[6]; Transcript, page 223
[32] Transcript, page 225
[33] Transcript, page 278
[34] Exhibit C57
[35] Transcript, page 544
[36] Transcript, page 545

being rushed to the nearest hospital, given what would have been the seriousness of the condition. However, the cardiac monitor was not in place until 00:58:32. I will conduct an overall assessment of the care provided by SAAS briefly.

Actions of SA Police

58 At the time Mr Shepley commenced running across rooftops he was alone on the roof. He was chased from that location by the actions of police. Senior Constable Riddle was challenged about his decision to climb onto the roof to pursue Mr Shepley, and he maintained that at that time he was not aware of anything that would make him believe Mr Shepley might react violently, nor did he foresee the physical altercation that ensued. His prior dealings with Mr Shepley had not given him concern.

59 With the benefit of hindsight, Senior Constable Riddle agreed that he should have anticipated the possible unpredictability of Mr Shepley's actions. He accepted during his evidence that he did not conduct a risk assessment when he was up on the roof and did not identify that Mr Shepley might attack him.[37]

60 However, it must be acknowledged that Senior Constable Riddle was making decisions in the heat of the moment under pressure, weighing competing considerations for Mr Shepley's safety, his own safety, and the protection of the community. Those assessments are difficult to make in the clinical forensic setting and would have been even more difficult in real time.

61 An internal investigation conducted into this matter, by then Detective Brevet Sergeant Shane Przibilla, found that Senior Constable Riddle's actions did not violate any of SAPOL's operating procedures or safety guidelines.

62 During Senior Constable Riddle's evidence I observed him to reflectively answer questions with forthright and honest responses. He had the benefit of reviewing his BWV to assist, and his memory was generally good. He was challenged about his decisions and maintained his position while making appropriate concessions, such as occasions where he could have made different decisions.

63 It could be tempting with the benefit of hindsight to follow a series of 'what if' hypotheticals to imagine what might have occurred had Senior Constable Riddle not pursued Mr Shepley over the rooftops, but I consider that to be a fruitless exercise. Evidence from SAPOL and medical records show that Mr Shepley had been violent and aggressive in the past, and had on occasion resisted and assaulted police under different circumstances.[38] I am of the view that if Senior Constable Riddle had made a different decision in the moment, with the consequence of not following Mr Shepley across the roof, it was unlikely to have led to a peaceful surrender on Mr Shepley's part.

64 On the basis of that assessment, I am satisfied that Senior Constable Riddle's decisions and actions in the leadup to Mr Shepley's arrest on the ground were appropriate.

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[37] Transcript, page 95
[38] Exhibit C60, MD17

Manual restraint

65 Bearing in mind findings made in a previous Inquest,[39] the restraint of Mr Shepley was examined with great scrutiny with the benefit of the BWV footage compiled for the Inquest. Upon that close review, I noted that:

a) Despite the fact that Mr Shepley was at times violently struggling with police and had bitten Senior Constable Riddle's arm, SAPOL members appeared to only use as much force as was necessary to control him.

b) While Mr Shepley was at times restrained in the prone position, SAPOL members displayed awareness of the risks to his health and took steps where they could hold Mr Shepley in safer and more suitable manner; attempting to roll him onto his side and maintain that position.

c) SAPOL members continued to monitor Mr Shepley's responsiveness, his breathing and his health, and provided regular updates about their concerns to SAAS via radio communication.[40]

d) Decisions were made to move Mr Shepley from where he fell with consideration to his wellbeing, his potential for injury, and also for operational requirements.[41]

e) Brevet Sergeant Warren and Constable Bennett remained in contact with Mr Shepley, monitoring his wellbeing (as best they could as non-medically trained responders) until paramedics arrived. Constable Bennett described his concerns for Mr Shepley's breathing and his change in conscious state, such that he ensured SAAS were updated on these issues.

f) After Mr Shepley had been moved to the front yard of the address, but before SAAS arrived, Senior Constable Shelley Henderson appeared to bend down and check on Mr Shepley, speaking to him and apparently examining his face.

66 Constable Bennett described in his evidence how he was positioned during the time he took over sitting with Mr Shepley in the front yard. He said that his hand was between Mr Shepley's upper arm and chest and as such he could feel the rise and fall of Mr Shepley's chest as he was breathing.[42] He said that at no point did Mr Shepley stop breathing while he was in this position, up until the time that he was being moved onto the barouche. When tested in cross-examination by Ms O'Connor SC, he explained that he was paying particular attention to Mr Shepley's breathing. He agreed that he had to make sure that Mr Shepley kept breathing.[43] He also confirmed that Mr Shepley's breathing was laboured, and that it was slow.[44] It is audible on the BWV at 12:31 am that members were concerned and aware of Mr Shepley's laboured breathing, and that they again notified SAAS. This alone establishes that Mr Shepley's breathing was not only monitored, but a concerning trend detected.

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[39] *Inquest into the death of Wayne Fella Morrison* [2023] SACorC 8 (DSC Basheer)
[40] Transcript, page 441
[41] Transcript, page 483
[42] Transcript, page 447
[43] Transcript, page 451
[44] Transcript, page 467

67 I found Constable Bennett to be a reliable witness. While it was difficult to see on the BWV whether or not Mr Shepley was breathing or moving at any given time, by viewing the footage of members other than Constable Bennett, it was evident that he was indeed beside Mr Shepley with a hand on his body. While not perfectly clear, the footage was consistent with his evidence.

68 It is relevant to observe that as diligent as Constable Bennett was in monitoring the rise and fall of Mr Shepley's chest, he is not medically trained and therefore would not have been expected to detect abnormal breathing or possible seizure activity as a medical professional would be expected to.

69 The actions of the SAPOL members were also subject to a review by Professor Kelly. She considered that the members' actions up to the arrival of SAAS were reasonable in the circumstances.[45] Having conducted my own assessment, I agree with this opinion and find that SAPOL displayed awareness of the risk to Mr Shepley's safety while he was restrained and made appropriate changes to his positioning and location when required. As pointed out by Professor Kelly, SAPOL members are not health practitioners,[46] they had contacted SAAS for assistance and escalated their concerns when appropriate. Beyond that, there was little to be done but wait for the paramedics to arrive.

70 In that light, I find that the actions of SAPOL members following Mr Shepley's fall to the ground were appropriate to the circumstances as they presented.

Assessment of the care provided by SA Ambulance

71 I am not critical of the actions of Ms Revell. In fact, it was her assessment of Mr Shepley once on the barouche that established he was in cardiac arrest. If Ms Revell had been in Mr Timmins' role on that morning, I consider it likely that Mr Shepley's deteriorating condition may have been appreciated some six minutes earlier.

72 I find that Mr Timmins, on the other hand, failed in his provision of care to Mr Shepley. He failed in three related ways; he did not conduct a proper assessment of Mr Shepley's condition upon arrival, he then failed to monitor Mr Shepley during his attendance, and he failed to take appropriate action in relation to Mr Shepley's condition, as a result of his first two failings.

73 Little more needs to be said about Mr Timmins' approach to Mr Shepley's care. I have once again given consideration to the consequences of such serious findings in respect of Mr Timmins. I am not only satisfied that Mr Timmins failed in the ways I have set out above, I am satisfied to a very high level on the basis of the clear video footage of Mr Timmins' actions, together with his inability to provide any insight or explanation, and the objective condition that Mr Shepley was in minutes later.

74 Another important aspect of SAAS' involvement that was explored during the Inquest was in relation to information provided to the paramedics en route. As I have explained above, SAPOL members gave evidence of updates on Mr Shepley that they sought to have relayed to SAAS. These efforts were reflected not only by the oral evidence of those

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[45] Exhibit C58, page 23
[46] Transcript, page 622

members, but also captured on the BWV, as well as in SAPOL's operational records.[47] Neither Mr Timmins, nor Ms Revell (who was driving), could say whether or not they received these updates en route. This reflected an overall poor memory on Mr Timmins' part, however Ms Revell did have some recollection of the system that was used at the time and was able to assist the Court.[48]

75 The Court also received an affidavit from Mr Damien Norsworthy,[49] the Operations Manager of Clinical Assurance at SAAS, which explained that at the time of this incident Mr Timmins and Ms Revell had significant issues with the portable data terminal in the ambulance. Each time further information was added to the tasking, the screen refreshed and the user would have to scroll to the most recent information, and the physical buttons were not working, making this difficult.[50]

76 This technological issue had the consequence that Mr Timmins and Ms Revell did not receive the numerous updates provided to SAAS by SAPOL members, including critical information that concerns about Mr Shepley's breathing were escalating. Mr Norsworthy described updates and improvements made to these systems and I am satisfied that there are no ongoing systemic issues that I need to consider.[51]

77 I note from the provision of materials attached to Mr Norsworthy's affidavit, from the evidence of Ms Revell, and also from the things Mr Timmins accepted he knew he should have done, that SAAS training in relation to attending emergencies such as occurred here has not been shown to be lacking. In short, Mr Timmins had all the training he required in order to properly execute his duties.

78 The assessment of Mr Timmins' approach is one in which a very careful consideration of the operation of hindsight bias is needed. It might be argued that Mr Timmins did not know about the true severity of Mr Shepley's condition and that it was not reasonable to expect him to have known. That position is superficially attractive. However, the hindsight bias principle does not operate to conceal those who are wilfully ignorant. The simple fact is that Mr Timmins had been called to the scene for the sole purpose of assisting Mr Shepley. Accepting that Ms Revell was performing other duties, there was no other medically trained person present who could assist Mr Shepley. The first responsibility of a paramedic is to assess the patient. As I have made clear, if Mr Timmins had actually assessed Mr Shepley, he would have identified the seriousness of his condition much sooner. This assessment was required whether Mr Shepley had significant injuries, minor injuries or no injuries at all.

79 The systems difficulties and lack of information about escalating concerns may go some way toward explaining the leisurely pace of Mr Timmins' approach to the front yard where Mr Shepley was lying in a critical condition. It does not, however, absolve him of his responsibility to render timely emergency care to a man he knew had fallen from a height. That was sufficient information to require an urgent and comprehensive assessment delivered in a dispassionate way. It is difficult to express the level of discomfort and disappointment one feels when viewing the footage of such a casual

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[47] Exhibit C60, Annexures MD1 and MD12
[48] Transcript, pages 366, 368, 370
[49] Exhibit C59
[50] Exhibit C59, page 228
[51] Exhibit C59, pages 4-5

approach to a medical situation of any level, but particularly in light of the facts as they were known to Mr Timmins at the time.

Cause of death

80 Forensic pathologist, Associate Professor (APrf) Neil Langlois gave oral evidence about the factors that likely contributed to Mr Shepley's death, as did Professor Kelly.

81 As I touched on at the beginning of this Finding, APrf Langlois' ability to establish a cause of death was frustrated by the fact that the likely provoking cause left no post-mortem evidence.

82 In considering the likely factors at play, APrf Langlois considered what was known from the circumstances at the scene and post-mortem findings, such as drug use (toxicological findings), fibrosis, physical and psychological exertion (as seen on the BWV), Mr Shepley's medical history and the mechanism of restraint. Professor Kelly was able to draw upon her experiences dealing with patients in emergency medicine as to the potential impact of some of these same factors.

83 Professor Kelly also drew upon research in her report discussing the issues of prone restraint cardiac arrest, methylamphetamine use and cardiovascular disease. A journal article by Lydia Krexi et al, relating to sudden cardiac death with stress and restraint, was received into evidence.[52]

84 In their individual opinions, there was a consensus as to some of the contributing factors in Mr Shepley's ultimate cardiac arrest, being the presence of drugs, and the effect of psychological and then physical exertion leading up to Mr Shepley being restrained.

85 In his post-mortem report, APrf Langlois recorded the cause of death as 'unascertained' and commented that factors that may have been involved in Mr Shepley's death included restraint, vigorous physical activity, heightened emotional state, presence of drugs (amphetamines and/or methadone) and a transient abnormality of the heart which had been seen on ECG during Mr Shepley's lifetime. Following his examination, in oral evidence APrf Langlois said he would prefer to leave the cause of death as 'unascertained' but that he would put more emphasis on the high level of methadone and the presence of long QT (an abnormality in the cardiac rhythm) in the past.[53] APrf Langlois was careful to note that there was nothing to be seen at post-mortem that could show the impact that long QT actually had.

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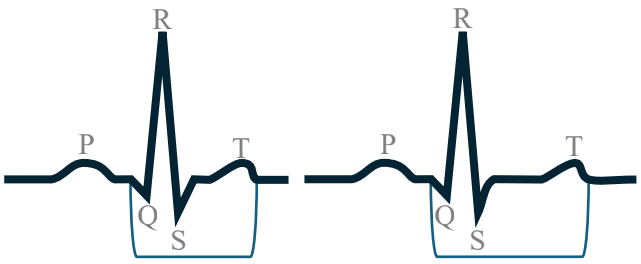
[52] Exhibit C54
[53] Exhibit C45, page 215 – with the prolonged QT interval returning to normal that afternoon

86 APrf Langlois explained that methadone lengthens the ventricular phase of the cardiac cycle.[54] He said that this can be observed on an ECG graph with an extended interval between the Q and T points, as depicted in the following schematic diagram:



Normal QT interval Long QT interval

87 APrf Langlois reiterated on a number of occasions that the impact of long QT cannot been seen at post-mortem as there is simply no evidence of it after the heart has stopped beating and all electrical activity capable of producing an ECG graph has ended.

88 APrf Langlois explained that patients with a long QT interval are at risk of experiencing an arrythmia. He explained that the result of Mr Shepley's participation on the methadone program was to potentially contribute to a long QT interval (to which he might also have been genetically predisposed) which then may have played a role in what happened after he was restrained. APrf Langlois was clear that it is '…not possible in any way to be sure of the effect of the … long QT because there's no way to test the effects' after death.[55] APrf Langlois said that the combination of methadone in a man with a predisposition to a prolonged QT interval is as likely as any of the other factors he had identified that might have brought about Mr Shepley's death.[56]

89 APrf Langlois said that typically, in cases where methadone use generates a long QT interval which brings about an arrythmia, the patient will have a gradual decline in respirations rather than a sudden cessation.[57] Notwithstanding that usual progression, APrf Langlois said that he was unable to conclusively opine that to have been the mechanism of Mr Shepley's death because the footage was not clear enough to reach any certain conclusions about the quality of Mr Shepley's breathing at any given time.[58] It is therefore not possible to determine whether this gradual progression, through reduced breathing effort, was occurring or not. During cross-examination by Mr Roberts KC, APrf Langlois did accept that the effect of methadone[59] is that 'it usually follows a gradual loss of consciousness, and that is what is seen in this case'. I understood APrf Langlois to be accepting that what was observable in the footage was consistent with the possibility of a contribution by methadone through the mechanism of a long QT provoked arrhythmia event.

90 In his oral evidence APrf Langlois confirmed his opinion that the mechanism of death was a cardiac one.[60] APrf Langlois was clear that, on his examination, there were no

[54] Transcript, pages 37-38
[55] Transcript, pages 39 and 42
[56] Transcript, page 165
[57] Transcript, page 179
[58] Transcript, page 179
[59] Transcript, page 181
[60] Transcript, page 127

physical injuries to Mr Shepley that might have contributed to his death. Acknowledging that there had been a fall from height with a head injury, in addition to manual restraint, APrf Langlois was able to exclude a physical injury as contributing to death due to this lack of injury.

91 APrf Langlois noted some increased fibrosis of the heart which he said was unusual in a man of Mr Shepley's age,[61] which he later considered might have been caused by methylamphetamine use.[62] He also explained the impact on the heart that would be caused by the use of amphetamines and also by stress. He explained that the situation in the lead up to Mr Shepley's death would have likely led to the release of 'a lot' of natural adrenaline which would have been causing the heart to beat very fast and strong.[63] He said that the elevated heart rate and strength leads to a risk of arrythmia and if that develops, the heart can fail.

92 What is clear from his evidence is that APrf Langlois considered that there was a very significant role for the external factors that were playing on Mr Shepley's heart function, which included drug use, heightened stress and exertion in the context of his apprehension and restraint.

93 Professor Kelly also provided her opinion on Mr Shepley's cause of death from the perspective of a clinician who deals with living patients suffering from similar conditions. It was appropriate for her to do so. She noted similar contributing factors as had been highlighted by APrf Langlois; drug use, exertion, restraint, but also possible seizure activity.[64] In her report, Professor Kelly referred to research and articles relating to possible seizure activity. I was asked to consider the article by Alon Steinberg titled, *Prone restraint cardiac arrest: a comprehensive review of the scientific literature and an explanation of the physiology*,[65] which was referenced by Professor Kelly. This report discussed, among other things, the impact of physical activity on metabolic acidosis and how it can contribute to post-restraint cardiac arrest. Professor Kelly put greater emphasis on Mr Shepley's drug use and noted an article titled, *Methamphetamine Use and Cardiovascular Disease – In search of Answers* which was authored by Christopher G Kevil et al.[66] Professor Kelly observed from this study that it was shown that methylamphetamine users have a 27% increased risk of sudden cardiac death. I also considered the discussion in this article. It establishes that 6.5% of all non-accidental deaths in Australian methylamphetamine users are due to sudden cardiac causes. The article discusses the cardiac effect of long-term use. I observe that Mr Shepley struggled with drug addiction and that he had methylamphetamine in his system at the time of his death. It is likely that there was a role played by long-term methylamphetamine use in his death.

94 During the Inquest, an article familiar to the coronial jurisdiction was also referenced, being the article by Krexi et al titled *Sudden cardiac death with stress and restraint: The association with sudden adult death syndrome, cardiomyopathy and coronary artery disease*.[67] This was also tendered in a previous Inquest where restraint was raised as a

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[61] Transcript, page 23
[62] Transcript, page 33
[63] Transcript, page 35
[64] Exhibit C58, page 30
[65] (2021) 61(3) *Med Sci Law* 215
[66] (2019) 39 *Aterioscler Thromb Vasc Biol* 1739
[67] (2016) 56(2) *Medicine, Science and the Law* 85

possible cause of death. This article discusses the nexus between physical and emotional stress and sudden cardiac death. It found that death often occurs in these circumstances with no structural heart disease and raises a potential involvement of channelopathies.

95 Having considered all of the evidence and the articles which guided that evidence, I am satisfied that it is not possible to determine Mr Shepley's cause of death. The predominant factor I am left with is a complete absence of specific evidence which makes any one contributing factor more likely than any other. I am therefore left in a situation where there is no single cause that I am able to determine was the operative cause. I consider that the most likely mechanism of Mr Shepley's death was of a cardiac nature. This was potentially contributed to by an arrythmia brought about by a predisposition to prolonged QT, exacerbated by methadone use. It was also possible that the acute on chronic effects of methamphetamine use was contributory. I am not satisfied that that either mechanism is established on the evidence in a clear enough way to reach a finding to the standard of certainty I consider would be required. While I recognise that it is unfortunate to do so, I enter a finding that Mr Shepley's death was as a result of an unascertained cause.

Preventability

96 The evidence from Professor Kelly was very clear in her assessment of the prospects of survivability of an out of hospital cardiac arrest. She provided oral evidence on this topic (as she has in many other Inquests) which was consistent with the evidence in her written opinion.[68]

97 When giving evidence, Professor Kelly was also provided with a number of hypotheticals about what might have been done for Mr Shepley's care had appropriate action been taken by Mr Timmins. These included what treatment might have been available to treat various arrhythmias had they been detected if Mr Timmins had placed a cardiac monitor onto Mr Shepley, as he ought to have done. These hypotheticals were also dependent on other assumptions, such as the availability of the right medication, and Mr Shepley's ability to receive and tolerate the medication if it were available. Considering these hypothetical situations, Professor Kelly said that she was not able to elevate Mr Shepley's chances to where it would have been more likely than not that he would have survived.[69]

98 Given the clear evidence of Professor Kelly, I am not satisfied that there is sufficient evidence to base a finding of preventability on. I consider that it has not been proved that Mr Shepley's death could have been prevented with any particular intervention.

99 I pause to observe that a person in a critical condition, having had medical assistance sought on his behalf, did not deserve the level of care provided by Mr Timmins. While it is unlikely that Mr Timmins could have saved Mr Shepley, that is far from certain and what Mr Timmins' lack of action did do was deny Mr Shepley any chance of survival.

Custody

100 Given the manner of Mr Shepley's behaviour in the lead up to his fall, it was clearly appropriate for police to apprehend and arrest him. Given his behaviour, notwithstanding that he was potentially injured, his restraint was called for and, as I have assessed, was

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[68] Exhibit C58, pages 26-28
[69] Transcript, pages 614-615

appropriately conducted. I am satisfied that Mr Shepley was in lawful custody at the time of his death.

Conclusions

101 I find the failing in Mr Shepley's care was that of Mr Timmins alone, and not a result of systemic issues within SAPOL or SAAS. Consequently, I consider that there are limited recommendations that I can make which would prevent a recurrence of the same or similar circumstances, or that would improve public health and safety. In that light, I make only a recommendation to the Minister for Health and Wellbeing:

One That a general publication be made to all members of SAAS reminding them to consider the possibility of sudden post-agitation restraint cardiac issues and to swiftly examine and monitor such patients upon arrival.

102 As I touched on at the beginning of these Findings, the detection of someone's diminishing responsiveness in situations such as these is the key to preventing death.

103 I wish to make it very clear that the SAPOL members who were in direct contact with Mr Shepley after he was restrained escalated their concerns on numerous occasions. This was appropriate care. The escalation of their concerns do not appear to have been reported in the usual way to the SAAS paramedics, due to a systems failure. The casual demeanour of Mr Timmins upon entering the yard of the premises may be explained to a degree by this issue. However, there can be no reasonable explanation for a paramedic not examining an unconscious person who had fallen from a height, and who was potentially under the influence of illicit substances.

Condolences

104 Mr Shepley struggled with the torment of illicit substance abuse during his life. Notwithstanding that, he had potential and his untimely death meant that he was not able to realise that potential. I offer my condolences to Mr Shepley's family for their loss.

Keywords: *Death in Custody; Police; Restraint; Unascertained Cause*