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**JURISDICTION** : CORONER'S COURT OF WESTERN AUSTRALIA  
**ACT** : CORONERS ACT 1996  
**CORONER** : PHILIP JOHN URQUHART  
**HEARD** : 30 MAY - 2 JUNE 2022  
**DELIVERED** : 22 AUGUST 2022  
**FILE NO/S** : CORC 1512 of 2019  
**DECEASED** : NARRIER, RODERICK MALCOLM

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*Catchwords:*

Nil

*Legislation:*

Nil

**Counsel Appearing:**

Mr W Stops assisted the Coroner

Mr J Berson, with him Ms L Bultitude-Paull, (State Solicitor's Office) appeared on behalf of the Western Australian Police Force

Mr T Pontre, with him Ms A Miolin, (Moray and Agnew) appeared for St John Ambulance Western Australia

Ms A Barter, with her Ms O Roberts, (Aboriginal Legal Service) appeared for the children of the deceased and the mother of the deceased's children

Mr A Crocker, with him Ms H Drewery, (National Justice Project) appeared for the deceased's sister

**Case(s) referred to in decision(s):**

*Briginshaw v Briginshaw* (1938) 60 CLR 336

*Inquest into the death of Child JP* [2021] WACOR 42 delivered on 21 December 2021

*Inquest into the death of Levi Shane Clement Congdon* [2020] WACOR 37 delivered on 19 November 2020

*Inquest into the death of Chad Riley* [2021] WACOR 24 delivered on 30 July 2021

*Inquest into the death of Cherdeena Shaye Wynne* [2021] WACOR 21 delivered on 1 April 2022

Coroners Act 1996  
(Section 26(1))

## RECORD OF INVESTIGATION INTO DEATH

*I, Philip John Urquhart, Coroner, having investigated the death of **Roderick Malcolm NARRIER** with an inquest held at Perth Coroner’s Court, Central Law Courts, Courts 51 and 85, 501 Hay Street, Perth, on 30 May 2022 – 2 June 2022, find that the identity of the deceased person was **Roderick Malcolm NARRIER** and that death occurred on 30 October 2019 at Royal Perth Hospital, Wellington Street, Perth, from multiorgan failure following an out of hospital cardiac arrest in a man with methylamphetamine effect, restraint and focal moderate coronary artery arteriosclerosis in the following circumstances:*

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## LIST OF ABBREVIATIONS

Abbreviation	Meaning
the Act	<i>Coroners Act 1996 (WA)</i>
the Board	The WAPF Corporate Board
BWC	body worn cameras (WAPF)
CAD	computer-aided dispatch (WAPF)
cm	centimetres
CPR	cardiopulmonary resuscitation
EAM	Evidence Assessment Meeting (IAU)
FSLR	fast strap leg restraints
GABA	g-aminobutyric acid
IAU	Internal Affairs Unit
ICU	intensive care unit
kg	kilograms
LUCAS	Lund University Cardiopulmonary Assist System
the Manual	WAPF's Handcuff Manual
mg	milligrams
mg/L	milligrams per litre
ml	millilitres
the order	the inquest's suppression order
OSTTU	Operational Safety and Tactics Training Unit (WAPF)
pH	Potential of Hydrogen (a scale used to specify the acidity or basicity of an aqueous solution)
POC	Police Operations Centre (WAPF)
ROSC	return of spontaneous circulation
RPH	Royal Perth Hospital
SJA	St John Ambulance
WAPF	Western Australian Police Force

**SUPPRESSION ORDER**

**That there be no reporting or publication of any document or evidence that would reveal police policies and standard operating procedures, tactics, or training methods in relation to the use of force.**

**INTRODUCTION**

- 1 The deceased (Roderick)<sup>1</sup> died on 30 October 2019 at Royal Perth Hospital (RPH). He was 38 years old. Three days earlier, on 27 October 2019, he went into a cardiac arrest as he was restrained by police officers from the Western Australian Police Force (WAPF) and being treated by a paramedic and an ambulance officer from St John Ambulance (SJA). Roderick never regained consciousness, and he died in hospital from multiple organ failure.
- 2 Roderick’s death was a reportable death within section 3 of the *Coroners Act 1996* (WA), (the Act) because it was a death that “*appears to have been caused, or contributed to, by any action of a member of the police force*”.
- 3 By reason of section 19(1) of the Act, I have jurisdiction to investigate Roderick’s death.
- 4 Pursuant to section 22(1)(b) of the Act, an inquest into Roderick’s death was mandatory because it appears his death was caused, or contributed to, by the actions of one or more police officers.
- 5 Section 22(1)(b) of the Act is enlivened when the issue of causation or contribution in relation to the person’s death arises as a question of fact,

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<sup>1</sup> At the request of his family, the deceased will be referred to as Roderick in this finding.

irrespective of whether there is fault or error on the part of the police officers involved.

6 On the basis it would be contrary to public interest, I made a suppression order pursuant to section 49(1)(b) of the Act in respect to any reporting or publication of matters relating to WAPF policies, procedures, tactics or training methods in relation to the use of force by its officers (the order). The terms of the order are set out on the previous page. The redacted portions of this finding have been made to comply with the order.

7 I held an inquest into the death of Roderick at Perth over the course of four days, from 30 May – 2 June 2022. The following 12 witnesses gave oral evidence:<sup>2</sup>

- i. Associate Professor Paul Bailey, Medical Director, St John Ambulance Western Australia;
- ii. Constable Ahmedin Colic, one of four police officers who restrained Roderick on 27 October 2019;
- iii. Constable Jayden Bartels, one of four police officers who restrained Roderick on 27 October 2019;
- iv. Constable Kelsey Maseyk, one of four police officers who restrained Roderick on 27 October 2019;
- v. David Andrew Vincent, the ambulance officer from SJA who treated Roderick on 27 October 2019;
- vi. Simon Ball, the paramedic from SJA who treated Roderick on 27 October 2019;
- vii. Senior Constable Mark Luis, one of four police officers who restrained Roderick on 27 October 2019;
- viii. Detective Senior Constable Luke Murphy, author of the Homicide Squad report;
- ix. Detective Senior Sergeant Lloyd Van Der Schoor, the police officer who reviewed and approved the WAPF Internal Affairs Unit (IAU) report;

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<sup>2</sup> I have used the ranks of police officers as of 27 October 2019. Although Senior Constable Luis is no longer a member of WAPF, he is referred to as a WAPF police officer.

- x. Chris Markham, Capability Advisor - Use of Force, Operational Skills Faculty at the WA Police Academy;
- xi. Professor David Joyce, Clinical Pharmacologist and Toxicologist; and
- xii. Dr Nina Vagaja, Forensic Pathologist.

8 The documentary evidence at the inquest comprised of two volumes of the brief that were tendered as exhibit 1 at the commencement of the inquest. A further two documentary exhibits (exhibits 3 and 4) were tendered during the inquest, as were three audio exhibits (exhibits 2A, 2B and 2C). After the inquest, and at my request, I received a statement dated 9 June 2022 (exhibit 5) and a supplementary statement dated 29 June 2022 (exhibit 6) from the IAU investigator, Detective Senior Constable Mark Cunningham (Detective Cunningham). I also received further material from Mr Berson, counsel for the WAPF, on 14 July 2022. This material became exhibits 7A-E. Copies of the exhibits provided after the inquest were forwarded to the legal representatives of Roderick's family and SJA.

9 My primary function has been to investigate the death of Roderick. It is a fact-finding function. Pursuant to section 25(1)(b) and (c) of the Act, I must find, if possible, how the death of Roderick occurred and the cause of his death.

10 Pursuant to section 25(2) of the Act, I may comment on any matter connected to the death of Roderick, including public health or safety, or the administration of justice. This is an ancillary function of a coroner.

11 Section 25(5) of the Act prohibits me from framing a finding or comment in such a way as to appear to determine civil liability or suggest a person is guilty of an offence. It is not my role to assess the evidence for civil or criminal liability and I am not bound by the rules of evidence.

12 In making my findings, I have applied the standard of proof as set out in *Briginshaw v Briginshaw* (1938) 60 CLR 336, 361-362 (Dixon J), which requires a consideration of the nature and gravity of the conduct when deciding whether a finding adverse in nature has been proven on the balance of probabilities (the *Briginshaw* principle).

13 I am also mindful not to insert hindsight bias into my assessment of the actions taken by police in their dealings with Roderick on 27 October 2019. Hindsight bias is the tendency, after an event, to assume the event is more predictable or foreseeable than it actually was at the time.<sup>3</sup> The need to adhere to this concept is particularly relevant in this matter as police officers who are interacting with a person who is drug-affected and acting violently are often required to make quick decisions in a highly adrenalised environment.

14 The primary focus of the inquest was whether the four police officers involved in the protracted restraint of Roderick while he was in the potentially dangerous prone position was justified and appropriate in the circumstances that existed.

### THE DECEASED

15 Roderick was born on 19 December 1980. Throughout his life he remained a proud Noongar man. He had four children from two previous relationships. To his family, culture and community, Roderick was highly respected and he was known to be a caring and humble man. He was a much loved member of his family.

16 At the time of his death, Roderick was living with his partner, Natasha Forrest (Ms Forrest) and her two children, at a house on Orrong Road, Kewdale. Ms Forrest's sister and her family were also staying there at the time.

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<sup>3</sup> Dillon H and Hadley M, *The Australasian Coroner's Manual* (2015) 10

17 From the evidence before me, it is readily apparent that Roderick was using methylamphetamine for an unspecified period before his death. It is also clearly evident that he was heavily affected by methylamphetamine in the early hours of 27 October 2019. I have found it was the serious adverse effects of the methylamphetamine Roderick had used a short time earlier that caused his violent behaviour which required police attendance that morning.

18 As I stated to Roderick's family in my concluding remarks at the inquest,<sup>4</sup> I have accepted the behaviour of Roderick which the inquest heard so much about was completely at odds with his normal behaviour. I take no issue with the family's instructions that Ms Barter relayed to me in her closing submissions at the inquest:<sup>5</sup>

They say he never caused any trouble, and they saw him as a calm influence and not a violent person. They never knew him to be aggressive, and they find it difficult to believe that he was aggressive on this morning.

## THE EVENTS OF 27 OCTOBER 2019

### *Roderick injects methylamphetamine*<sup>6</sup>

19 As at the time of his death, Roderick was using methylamphetamine two or three times a week.

20 On the night of 26 October 2019, Roderick left the Orrong Road address and went into the city. At about midnight, he returned home.

21 After he arrived home, Roderick and Ms Forrest had a disagreement about him going into the city. They both then decided to go for a walk to the nearby Tomato Lake on Oats Street. At Tomato Lake, Roderick said that he wanted to get some methylamphetamine. He and Ms Forrest walked to a nearby

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<sup>4</sup> ts 2.6.22 (Coroner's concluding remarks), p.424

<sup>5</sup> ts 2.6.22 (Ms Barter), pp.399-400

<sup>6</sup> Exhibit 1, Volume 1, Tab 12, Statement of Natasha Forrest dated 27 October 2019

house where some methylamphetamine was obtained. They then walked back to their house.

- 22 Back at the house, Roderick injected the methylamphetamine into the crease of his right elbow. After that, Roderick and Ms Forrest went to bed at about 1.20 am on 27 October 2019.

***Roderick's reaction to the methylamphetamine***<sup>7</sup>

- 23 At about 4.00 am,<sup>8</sup> Ms Forrest woke up and noticed Roderick was covered in sweat and his heart beat was abnormally fast. When Roderick woke up, Ms Forrest said that she needed to go to the toilet. However, Roderick grabbed her tightly and said, "*Don't leave me baby*". He did not let go of Ms Forrest; instead, he wrapped his legs around her and held her with one arm around the top part of her body. He started to shout, "*Don't leave, don't leave*", and began growling.
- 24 The commotion woke up some of the other occupants of the house and they went to the bedroom door, which was locked. Given Roderick's irrational behaviour, Ms Forrest was very concerned for her safety. She yelled out to the others to kick the bedroom door in so that they could help her. Ms Forrest's eldest son did that, and he and Johnathan Cox (Mr Cox), the partner of Ms Forrest's sister, entered the bedroom.
- 25 Mr Cox turned the light on and saw that Roderick was on the bed with his arm around Ms Forrest's neck, choking her. Roderick was shouting, "*I don't want to go, don't leave me*". Mr Cox described Roderick as looking distressed and panicked, and he was shaking and sweating. Roderick was not responding to

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<sup>7</sup> Exhibit 1, Volume 1, Tab 12, Statement of Natasha Forrest dated 27 October 2019; Exhibit 1, Volume 1, Tab 9, Statement of Johnathan Cox dated 27 October 2019; Exhibit 1, Volume 1, Tab 13, Statement of Jaylen Muller dated 31 October 2019; Exhibit 1, Volume 1, Tab 14, Statement of Jermaine Muller dated 31 October 2019

<sup>8</sup> Ms Forrest estimated the time was 3.00 am; however, given the time of the subsequent triple zero call, the estimated time of 4.00 am given by Ms Forrest's sister is likely to be more accurate.

anything that was being said to him. As attempts were made to pull him away from Ms Forrest, he bit her on her left breast.

26 Eventually, Mr Cox and Ms Forrest's eldest son were able to force Roderick to release his hold of Ms Forrest. At this stage, Roderick was lying on his stomach on the bed and Mr Cox placed Roderick's left arm behind his back to try and prevent him from fighting. Ms Forrest's eldest son held Roderick's legs so he could not get up from the bed. Roderick continued to struggle, and ignored requests to calm down. As Roderick was being held, Ms Forrest's sister called triple zero.

27 None of the occupants of the house had ever seen Roderick act in this manner and they were very concerned for their safety.

***First attendance by police to the Orrong Road address***<sup>9</sup>

28 The triple zero call by Ms Forrest's sister was answered at 4.18 am. She reported that Roderick was "*coming down off a high*" and was choking her sister. She provided details of the address and reported that her partner was now holding Roderick down with the help of her nephew.

29 At 4.20 am, the CAD<sup>10</sup> job from this call was assigned to Constable Ahmedin Colic (Officer Colic) and Constable Jayden Bartels (Officer Bartels), who were both at Belmont Police Station. They left the police station in a marked police car under a Priority 2 status, with the car's lights and siren activated. They arrived at the Orrong Road address at about 4.23 am.

30 After getting out of their police car, both officers spoke to Ms Forrest, who was standing outside the front of the house. She showed the officers where

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<sup>9</sup> Exhibit 1, Volume 1, Tab 15, Statement of Constable Ahmedin Colic dated 28 October 2019; Exhibit 1, Volume 1, Tab 16, Statement of Constable Jayden Bartels dated 29 November 2019; Exhibit 1, Volume 1, Tab 30, WAPOL Incident Report Running Sheet - 271019 0500 14148

<sup>10</sup> Computer-Aided Dispatch

Roderick had bitten her and described his behaviour. Ms Forrest also said Roderick had injected methylamphetamine and that this was the most likely explanation for his behaviour.

31 When the two police officers entered the house, they saw Mr Cox and Ms Forrest's eldest son struggling to restrain Roderick on the bed in the front bedroom. Roderick was resisting by kicking out and attempting to push off the two males who were trying to hold him down. He was also growling and thrashing his head back and forth. Roderick was lying on his stomach and sideways across the bed, with his legs hanging off one side of the bed, and his head hanging off the other side. Attempts by the police officers to calm Roderick down failed, and he continued to struggle violently and speak incoherently.

32 With the assistance of the others in the bedroom, Officer Colic was able to place Roderick's left wrist into a handcuff. However, once that was done, Roderick had placed his right arm under his body and assistance from the others was again required before Officer Colic was able to secure Roderick's right wrist with the handcuff. Roderick was handcuffed with his hands behind his back. He continued to kick out and attempted to bite those present as he was being handcuffed. As a result of these kicks, Officer Bartels restrained Roderick's legs by crossing them together and applying weight with his right knee above Roderick's ankles [REDACTED]

33 Once Roderick was secured in the handcuffs, Officer Colic noticed Roderick's shirt was covered in sweat and his body was very hot. Given the information he had received regarding Roderick's recent injection of methylamphetamine, combined with his behaviour and body temperature, Officer Colic suspected Roderick was experiencing "excited delirium".

34 At about 4.27 am, Officer Colic used his radio attached to his police vest to call the WAPF Police Operations Centres (POC). He requested that a call be made for an ambulance to attend the address as Roderick had “*excited delirium*”.

35 At 4.27.30<sup>11</sup> am, an operator at POC called triple zero and requested that an ambulance attend the Orrong Road address.

***Second attendance by police to the Orrong Road address***<sup>12</sup>

36 At 4.25 am, Senior Constable Mark Luis (Officer Luis) and Constable Kelsey Maseyk (Officer Maseyk) from the Kensington Police Station were in a marked police vehicle when they received a radio call from POC to attend the Orrong Road address to provide assistance to police who were already there. Officer Luis activated the police car’s emergency lights and siren and drove under a Priority 2 status. They arrived at the address at about 4.27 am.

37 After briefly speaking to people in the front yard of the address, Officers Luis and Maseyk were directed to the front bedroom of the house, where they could hear Roderick yelling in a loud and aggressive manner. As they entered the bedroom, the two officers saw that Roderick was handcuffed in a prone position on the bed with his hands behind his back. Officer Colic was holding Roderick’s arms down and Officer Bartels was holding his legs down. It was obvious to Officers Luis and Maseyk that the other two officers were struggling to restrain Roderick, as he was bucking his body up and attempting to kick out with his legs in an aggressive manner whilst yelling and growling.

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<sup>11</sup> That is, 4.27 am and 30 seconds; Exhibit 2A

<sup>12</sup> Exhibit 1, Volume 1, Tab 15, Statement of Constable Ahmedin Colic dated 28 October 2019; Exhibit 1, Volume 1, Tab 16, Statement of Constable Jayden Bartels dated 29 November 2019; Exhibit 1, Volume 1, Tab 30, WAPOL Incident Report Running Sheet - 271019 0500 14148; Exhibit 1, Volume 1, Tab 17, Statement of Senior Constable Mark Luis dated 24 November 2019; Exhibit 1, Volume 1, Tab 18, Statement of Constable Kelsey Maseyk dated 27 November 2019

38 As it appeared to Officer Luis that Officer Bartels was struggling to maintain control of Roderick's legs, he took over and placed Roderick's legs into the same leg hold position that Officer Bartels had applied.

39 After Officer Luis applied the leg hold, Officer Maseyk placed her hands on Roderick's left shoulder blade and applied pressure to hold him down. As she was doing that, Roderick attempted to bite her. At one stage, Ms Forrest entered the bedroom and sat on the bed near to Roderick's head. Despite her attempts to calm him down, Roderick continued to behave in the same manner, and again attempted to bite Ms Forrest.

40 After the arrival of Officers Luis and Maseyk, and once Roderick was placed under a sufficient degree of control, the four officers were able to move him forwards so that more of his upper body was over the edge of the bed.

41 At about 4.37 am, Officer Bartels radioed POC to request an estimated time of arrival for the ambulance. Prior to the arrival of the ambulance, Roderick's behaviour remained unchanged and the four officers kept him restrained in the same prone position on the bed.

***Attendance of the ambulance to the Orrong Road address***<sup>13</sup>

42 At about 4.30 am, ambulance officer David Vincent (Mr Vincent) and paramedic Simon Ball (Mr Ball) were in a SJA ambulance on Leach Highway near Booragoon when they were allocated a Priority 2 job<sup>14</sup> to attend the Orrong Road address.

43 The ambulance arrived at the address at 4.41 am. Mr Ball and Mr Vincent immediately made their way into the house. As Mr Ball entered the front

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<sup>13</sup> Exhibit 1, Volume 1, Tab 19, Statement of David Vincent dated 8 November 2019; Exhibit 1, Volume 1, Tab 20, Statement of Simon Ball dated 8 November 2019

<sup>14</sup> A Priority 2 job means the ambulance attends the incident adhering to normal road conditions.

bedroom, he asked Mr Vincent to get the assessment bag from the ambulance. Although Roderick was being restrained by the attending police officers, Mr Ball saw that he continued to struggle and thrash his body about and was growling and rambling in an incomprehensible manner. It was evident to Mr Vincent when he attended the bedroom that the police were having difficulty restraining Roderick due to his behaviour.

44 Mr Ball conducted an initial visual examination to ascertain Roderick's airway and breathing status. He noted that Roderick's head and about 20 cm of his chest were off the edge of the bed. Although the conditions for an assessment were less than ideal, based on the noises Roderick was making and that most of his back was free from any pressure, Mr Ball concluded he was not in any respiratory distress.

45 Mr Ball received a briefing from the police officers and had Mr Vincent obtain Roderick's temperature, which was recorded at 39.2 degrees Celsius.<sup>15</sup> Although Roderick was attempting to bite him, Mr Ball was able to palpate a regular carotid pulse for Roderick that was rapid. The conclusion drawn by the SJA officers was that Roderick was experiencing a drug-induced psychosis. As a result, a decision was made to administer the sedative, midazolam, intramuscularly in order to sedate him so he could be safely taken to the ambulance.

#### *Injection of midazolam by SJA officers*<sup>16</sup>

46 Mr Vincent was tasked with drawing up the dose of midazolam. After going through the required checks and balances with Mr Ball, preparations were made to inject the standard adult dose of 10 mg of midazolam in a two ml

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<sup>15</sup> The average human body temperature is approximately 37 degrees Celsius.

<sup>16</sup> Exhibit 1, Volume 1, Tab 19, Statement of David Vincent dated 8 November 2019; Exhibit 1, Volume 1, Tab 20, Statement of Simon Ball dated 8 November 2019;

solution into Roderick's right shoulder, which was positioned by Mr Ball to make it easier for Mr Vincent to inject the drug. The injection took place at about 4.47 am.

47 Although he was still being restrained, Roderick was able to move his body away from the needle as the injection was taking place. This caused about a half, or one ml, of the solution to enter subcutaneously rather than intramuscularly. In compliance with the standard practice after administering intramuscular medications, the SJA officers began massaging the injection site.

48 About 10 seconds after the injection, Roderick suddenly went limp and stopped making any noise. As the sedating effect of midazolam is measured in minutes, rather than seconds, Mr Ball immediately became concerned as to whether Roderick was in cardiac arrest. Within a short space of time, it became apparent to Mr Ball that he was.

*The resuscitation efforts*<sup>17</sup>

49 When Mr Ball saw that Roderick was in cardiac arrest, he asked the police officers to stop restraining him, which they promptly did. As Mr Ball lifted Roderick into a more lateral position, he saw him take two agonal breaths.<sup>18</sup>

50 The handcuffs were then removed from Roderick and Mr Ball attempted to palpate a carotid pulse in Roderick's neck, but he could not locate one.

51 Roderick was then moved onto the floor. Pads from the defibrillator monitor that Mr Vincent had retrieved from the ambulance were then applied to

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<sup>17</sup> Exhibit 1, Volume 1, Tab 19, Statement of David Vincent dated 8 November 2019; Exhibit 1, Volume 1, Tab 20, Statement of Simon Ball dated 8 November 2019

<sup>18</sup> Agonal breathing refers to short, laboured breaths that occur because oxygen cannot reach the person's brain. It can be caused by a cardiac arrest.

Roderick's chest to ascertain his heart rhythm. When no heartbeat (asystole) was observed, Mr Vincent commenced cardiopulmonary resuscitation (CPR).

52 As the police officers continued CPR, the SJA officers administered oxygen to Roderick via a bag valve mask, set up an intravenous cannulation to administer adrenaline and inserted an airway device.

53 After a back-up ambulance crew arrived, Roderick had a pulse (a return of spontaneous circulation (ROSC)) at the 14 minute status check. This was at about 5.02 am. However, Roderick displayed no respiratory effort, so he continued to be ventilated. He was also noted to have low blood pressure (hypotension).

54 Roderick was placed on a stretcher and he was fitted with a LUCAS<sup>19</sup> machine in case he re-arrested on the way to hospital. At 5.20 am, the ambulance departed the address as a Priority 1 and Roderick was taken to RPH (the nearest hospital). The ambulance arrived at the emergency department of RPH at 5.27 am.

#### ***Treatment at RPH***<sup>20</sup>

55 From the emergency department, Roderick was admitted into the intensive care unit (ICU) at RPH. A search of his clothing found a syringe in one of his pockets. Scans at RPH showed that Roderick had sustained damage to multiple body organs and tissues. This damage included a hypoxic brain injury (injury due to insufficient oxygen to the brain) with swelling and herniation of the brain, myocardial insult (injury to the muscle tissue of the heart), ischaemic hepatitis (liver dysfunction), rhabdomyolysis (breakdown of

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<sup>19</sup> Lund University Cardiopulmonary Assist System

<sup>20</sup> Exhibit 1, Volume 1, Tab 3, Royal Perth Hospital Documentation for Determination of Brain Death dated 30 October 2019; Exhibit 1, Volume 1, Tab 6, Letter to the State Coroner from Dr Nina Vagaja dated 10 August 2020

muscles) and renal (kidney) failure. Roderick was placed on life support and never regained consciousness. His prognosis was regarded as extremely poor.

56 On 30 October 2019, brain death was determined by a radionucleotide scan. Following consultation with Roderick's family, his life support was stopped, which resulted in a cessation of cardiorespiratory activity. The time and date of Roderick's death was recorded as 2.28 pm on 30 October 2019.

### CAUSE AND MANNER OF DEATH <sup>21</sup>

#### *Cause of death*

57 Forensic pathologist, Dr Nina Vagaja, conducted a post mortem examination upon Roderick's body on 5 November 2019. Dr Vagaja also arranged for a number of other examinations to be performed. These examinations included microbiology, histopathology and neuropathology. A toxicological analysis was also undertaken.

58 The post mortem examination noted that Roderick was 171 cm in height and had a body weight of 73 kg. He was described by Dr Vagaja as having a slim build. There was evidence of medical intervention, including CPR. There were linear abrasions on Roderick's wrists that were consistent with being caused by handcuffs<sup>22</sup> and some minor superficial soft tissue injuries to his limbs and torso. A likely needle injection site, with associated scarring, was noted on the crease of Roderick's right elbow. No other significant injuries or evidence of natural disease were identified during the post mortem examination. Dr Vagaja also noted that the post mortem examination, "*could*

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<sup>21</sup> Exhibit 1, Volume 1, Tabs 4.1-4.3, Supplementary Post Mortem Report dated 5 November 2019 by Dr Nina Vagaja; Post Mortem Report dated 5 November 2019 by Dr Nina Vagaja, Interim Post Mortem Report dated 5 November 2019 by Dr Nina Vagaja; Exhibit 1, Volume 1, Tab 5, Neuropathology Report dated 19 November 2019 by Dr Vicki Fabian; Exhibit 1, Volume 1, Tab 6, Letter to the State Coroner from Dr Nina Vagaja dated 10 August 2020; Exhibit 1, Volume 1, Tab 7.1-7.3, Supplementary Toxicology Report dated 21 November 2019, Final Toxicology Report dated 12 December 2019, Interim Toxicology Report 18 November 2019; Exhibit 1, Volume 1, Tab 8, Report of Professor David Joyce dated 20 July 2020

<sup>22</sup> ts 1.6.22 (Dr Vagaja), p.366

*not offer further insight into whether Roderick's breathing was compromised during the restraint.*"<sup>23</sup>

59 The microscopic examination of Roderick's heart showed mild to moderate focal coronary artery atherosclerosis. Such a mild to moderate narrowing of a coronary artery does not typically show any symptoms at rest; however, it could have caused an undersupply of blood to Roderick's heart under increased demand, such as during exertion and/or with the effects of stimulant drugs.<sup>24</sup> A diminished supply of blood to the heart is a risk factor for cardiac arrhythmia (irregular heart beat).

60 Fresh haemorrhages were present in multiple tissues from Roderick's major body organs. These haemorrhages suggested the presence of a clotting disorder, as may occur in the context of multiorgan failure.

61 Macroscopic (naked eye) examination of Roderick's brain by a specialist neuropathologist confirmed the presence of cerebral swelling with transtentorial herniation (movement of brain tissue from one intracranial compartment to another).

62 Toxicological analysis was performed on hospital admission blood samples taken from Roderick before he died (antemortem samples), as well as on post mortem blood samples. The presence of methylamphetamine at the very high level of 0.82 mg/L and its metabolite, amphetamine, at 0.05 mg/L, were detected in the antemortem samples. Midazolam was also present at the therapeutic level of approximately 0.03 mg/L. Other common illicit drugs and alcohol were not present in the antemortem samples. Testing of the post mortem blood samples also detected the presence of methylamphetamine and its metabolite, amphetamine; although, as expected, at much lower levels.

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<sup>23</sup> Exhibit 1, Volume 1, Tab 6, Letter to the State Coroner from Dr Nina Vagaja dated 10 August 2020, p.2

<sup>24</sup> Methylamphetamine is a stimulant drug.

Methylamphetamine was also detected in the syringe which was found in Roderick's pocket.

63 Dr Vagaja also noted that a report prepared by Professor David Joyce, a clinical pharmacologist and toxicologist, had concluded Roderick was intoxicated with methylamphetamine at the time of his death.

64 Dr Vagaja was of the view that:<sup>25</sup>

The overall evidence was consistent with an amphetamine-induced lethal cardiac rhythm disturbance in the context of violent struggle. The presence of focal coronary artery atherosclerosis may have increased the risk of malignant cardiac arrhythmia, however methylamphetamine was an indispensable contributor to Roderick's death.

65 Dr Vagaja expressed the opinion that, given the circumstances surrounding Roderick's death, the post mortem findings and the results from the ancillary tests, the cause of death was: "*Multiorgan failure following out of hospital cardiac arrest in a man with methylamphetamine effect, restraint and focal moderate coronary artery arteriosclerosis.*"<sup>26</sup>

66 I accept and adopt this conclusion expressed by the forensic pathologist as to the cause of Roderick's death.

### ***Methylamphetamine effect and excited/agitated delirium***

67 Methylamphetamine is a powerful, highly addictive stimulant that effects the central nervous system. It usually takes the form of a white, bitter tasting crystalline powder that dissolves easily in water and alcohol. It can be smoked, snorted, injected or taken in tablet form.<sup>27</sup>

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<sup>25</sup> Exhibit 1, Volume 1, Tab 6, Letter to the State Coroner from Dr Nina Vagaja dated 10 August 2020, p.3

<sup>26</sup> Exhibit 1, Volume 1, Tabs 4.1, Supplementary Post Mortem Report dated 5 November 2019 by Dr Nina Vagaja, p.1; Exhibit 1, Volume 1, Tab 6, Letter to the State Coroner from Dr Nina Vagaja dated 10 August 2020, p.3

<sup>27</sup> See: <https://www.drugabuse.gov/publications/research-reports/methamphetamine/whatmethamphetamine>

68 Methylamphetamine intoxication can manifest in several primary forms. Acute intoxication may be characterised by agitation, increased physical activity and a propensity for aggression as well as involvement in risky, reckless or violent behaviour. Paranoid beliefs about others are common and intoxicated persons can become delirious and exhibit confusion and bizarre behaviour.

69 The term “excited/agitated delirium” may also be applied to this condition, although there is some controversy as to what this term actually means. One definition of excited delirium is as follows:<sup>28</sup>

Agitated or excited delirium is an acute, transient disturbance in consciousness and cognition that involves comparative and/or violent behaviour ... This disturbance in cognition is marked by intense paranoia, aggressive behaviour towards objects and people, hallucinations, hyperthermia, altered sensorium, and lack of willingness to yield to force ... The bizarre and threatening behaviour of these individuals typically leads to a police response.

70 WAPF officers receive training on the signs and symptoms of excited delirium from the WAPF Critical Skills training program. The risk factors associated with the condition are well documented throughout the training material, and the information is revisited and reinforced during annual in-service training.<sup>29</sup> The relevant training manual warns that:<sup>30</sup>

The condition known as ‘Excited Delirium’ is often linked to incidents of ‘Positional Asphyxia’ as subjects with the condition are at greater risk of becoming involved with members and [hence being] exposed to the application of Tactical Force Options resulting in physiological stressors which can cause cardiac and respiratory distress.

71 In his report, Professor Joyce concluded that Roderick, “*would have inevitably been intoxicated with methylamphetamine*”.<sup>31</sup> Professor Joyce also noted that Roderick’s presentation of “*elevated body temperature, accelerated*

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<sup>28</sup> Dukes, G D and Davis, G J, *Encyclopedia of Forensic and Legal Medicine* (2016); see: <https://www.sciencedirect.com/topics/neuroscience/excited-delirium>

<sup>29</sup> Exhibit 1, Volume 2, Tab 39, Report of Chris Markham dated 26 May 2022, p.36

<sup>30</sup> Exhibit 1, Volume 2, Tab 39, Annexure C.9, Excited Delirium/Positional Asphyxia Manual, p.4

<sup>31</sup> Exhibit 1, Volume 1, Tab 8, Report of Professor David Joyce dated 20 July 2020, p.7

*heart rate and profuse sweating are characteristic of people dying in circumstances of methylamphetamine-induced delirium, violent activity and restraint”.*<sup>32</sup>

72 Professor Joyce concluded that the diagnosis for Roderick was “*methylamphetamine-induced agitated delirium*”.<sup>33</sup>

73 I accept these conclusions made by Professor Joyce and find that Roderick was intoxicated by methylamphetamine and, based on all available evidence, he was also experiencing excited or agitated delirium during his interaction with police.

### ***Physical restraint and positional asphyxia***

74 Positional asphyxia has been defined in various ways, including:<sup>34</sup>

Positional Postural Asphyxia is a form of mechanical asphyxia that occurs when a person is immobilised in a position which impairs adequate pulmonary ventilation and thus, results in a respiratory failure.

75 As with excited delirium, WAPF officers are trained on an annual in-service basis regarding the dangers of positional asphyxia. The relevant training manual defines positional asphyxia in these terms:<sup>35</sup>

Positional Asphyxia arises from circumstances where there is an increased need for oxygen and the subject is unable to source sufficient amounts to sustain life, resulting in sudden death from cardiac arrhythmia and/or respiratory distress.

While the risk of Positional Asphyxia is greatly increased by placing restrained subjects in a prone position; members are advised that the condition may occur irrespective of the position in which a restrained subject is placed. The risk of death is greatest in the period immediately following the application of Tactical Force Options and physical exertion resulting from a protracted struggle with members.

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<sup>32</sup> Exhibit 1, Volume 1, Tab 8, Report of Professor David Joyce dated 20 July 2020, p.7

<sup>33</sup> Exhibit 1, Volume 1, Tab 8, Report of Professor David Joyce dated 20 July 2020, p.8

<sup>34</sup> See: <https://www.ncbi.nlm.nih.gov/pmc/articles/pmc6023692/>

<sup>35</sup> Exhibit 1, Volume 2, Tab 39, Annexure C.9, Excited Delirium/Positional Asphyxia Manual, p.4

76 I agree with the estimation by Chris Markham, the WAPF Capability Advisor - Use of Force, (Mr Markham) that Roderick was physically restrained by police in the prone position for an estimated 22 minutes. I also generally agree with his estimation that once allowance is made for the restraining of Roderick by Mr Cox and Ms Forrest's eldest son, he was continuously restrained in the prone position for at least 27 minutes.<sup>36</sup>

77 As detailed below, I have found that the four police officers involved in the restraint of Roderick were mindful to avoid placing unnecessary pressure onto his back during their restraint of him. It is clear to me that they followed their training in that regard, and paid due attention to the dangers of placing pressure on a person's back in the prone position.

78 I am also prepared to find that Roderick's considerable resistance as he was restrained in the prone position was a contributing factor in his death. I will later address the question of whether the police officers were at fault in keeping Roderick in that position. As to whether positional asphyxia was part of that contributing factor, based on all the evidence before me, and for the reasons I have outlined later in this finding, I have found that it was not.

### ***Physical exertion by Roderick***

79 Roderick had an accelerated heart rate, was sweating profusely and had an elevated body temperature even before the onset of his violent activity.<sup>37</sup> As noted by Professor Joyce, the implication from this evidence was that "*Roderick was experiencing pronounced serotonergic effects of the methylamphetamine*" before the commencement of his violent activity.<sup>38</sup> The pre-existence of these three conditions would have only increased the dangers

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<sup>36</sup> Exhibit 1, Volume 2, Tab 39, Report of Chris Markham dated 26 May 2020, p.54

<sup>37</sup> Exhibit 1, Volume 1, Tab 12, Statement of Natasha Forrest dated 27 October 2019, p.8

<sup>38</sup> Exhibit 1, Volume 1, Tab 8, Report of Professor David Joyce dated 20 July 2020, p.8

of a cardiac arrest once Roderick began his violent exertions during his restraint in the prone position by occupants of the house and then by police.

80 Roderick's mild to moderate focal coronary artery atherosclerosis may have also increased the risk of a cardiac arrest arising from the concerted resistance he was displaying during his restraint.

***Manner of death***

81 On all the evidence available, I am satisfied that Roderick died following a cardiac arrest that occurred when he was being restrained by police. The factors contributing to this cardiac arrest included Roderick's methylamphetamine intoxication, his prolonged and violent resistance when he was restrained in the prone position and, possibly, his heart disease. I also find that Roderick was experiencing excited delirium before and then during his restraint.

82 For the reasons I have outlined later in this finding, there is no evidence that the midazolam administered by the SJA officers contributed to Roderick's death. On the evidence that is available, I am satisfied that Roderick's decision to inject methylamphetamine several hours before he was restrained was the primary contributor to his death. It caused him to experience an episode of excited delirium which led him to behave in an agitated and violent manner and, in doing so, to exert himself well beyond his physiological limits after efforts were made to restrain him.

83 Accordingly, I find that death occurred by way of misadventure.

**ISSUES RAISED BY THE EVIDENCE**

***Did Officer Colic's radio call advise POC of Roderick's excited delirium?***

84 Officer Colic maintained he did advise an operator at POC (the POC operator) that Roderick had "*excited delirium*" when he made the radio call requesting an ambulance at about 4.27 am.<sup>39</sup>

85 There was a recording of this communication between Officer Colic and the POC operator.<sup>40</sup> Although the quality of this recording is poor, after listening to it a number of times, I have been able to hear the words "*showing signs of excited delirium*". Accordingly, I am satisfied that Officer Colic did convey his belief to the POC operator that Roderick had excited delirium.

***Was SJA advised by POC of Roderick's suspected excited delirium?***

86 The triple zero call made at 4.27.30 am by the POC operator to request an ambulance was also recorded.<sup>41</sup> The quality of that recording is very good. In providing the details, the POC operator advised that the person requiring an ambulance was "*having some sort of mental health issue*", that he was "*quite agitated*" and that attending police were concerned about the level of agitation. He also confirmed the person was "*violent*".

87 Unfortunately, the POC operator did not advise that the person requiring the ambulance had suspected excited delirium. The explanation for that was: "*[A]s the POC staff member was not familiar with this specific term, it appears to have been understood to be a general mental issue as opposed to a medical emergency demanding a more urgent medial [sic – medical]*"

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<sup>39</sup> Exhibit 1, Volume 1, Tab 15, Statement of Constable Ahmedin Colic dated 28 November 2019, p. 6; ts 30.5.22 (Colic), p.40

<sup>40</sup> Exhibit 2B, Constable Colic's radio call to POC

<sup>41</sup> Exhibit 2A, POC call to SJA

response.”<sup>42</sup> However, the inquest heard evidence that even if the information conveyed was that the person had excited delirium, it may not have altered the Priority 2 designation SJA allocated to the responding ambulance.<sup>43</sup> That has now changed and I will address that development later in my finding under the heading, “*Improvements since Roderick’s death*”.

88 Notwithstanding the oversight by the POC operator, I note that the ambulance still arrived within the target of 15 minutes for ambulance attendances under Priority 1 conditions. It is therefore my view that even if the ambulance had attended as a Priority 1, the time saved would have been minor and highly unlikely to have prevented Roderick’s death.

***Was it appropriate for Officer Colic to handcuff Roderick?***

89 At the inquest, Officer Colic explained that Roderick needed to be secured because Mr Cox and Mr Forrest’s eldest son were struggling with him<sup>44</sup> and he was handcuffed, “*just to secure him so he doesn’t hurt himself or he doesn’t hurt us*”.<sup>45</sup>

90 As to the use of other force options, Officer Colic discounted using spray as he did not want to cause any discomfort to Roderick or others in the house, and that he also thought, “*it just would have aggravated the situation; made the situation worse*”.<sup>46</sup> He discounted using his taser, and also his firearm “*for the obvious reason*.”<sup>47</sup>

91 Two questions arise from the decision by Officer Colic to handcuff Roderick. The first is whether it was appropriate to handcuff Roderick and the

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<sup>42</sup> Exhibit 3, Memorandum dated 30 May 2022 from Superintendent Martin Haime, State Communications Division titled: “WA Police Force and SJA Liaison Police Operations Centre”, p.1

<sup>43</sup> ts 30.5.22 (Associate Professor Bailey), p.12

<sup>44</sup> ts 30.5.22 (Colic), p.34

<sup>45</sup> ts 30.5.22 (Colic), p.34

<sup>46</sup> ts 30.5.22 (Colic), p.34

<sup>47</sup> ts 30.5.22 (Colic), p.35

second is whether it was appropriate to do so when Roderick was in the prone position. I will deal with these two questions separately.

92 Mr Markham, an expert in the use of force options available to WAPF officers, provided the court with a comprehensive report and gave evidence at the inquest. Mr Markham's report addressed the question whether the use of handcuffs by Officer Colic was justified, and if so, how it was justified.

93 As outlined by Mr Markham, the relevant WAPF manual is the Police Manual Policy, Use of Force. The Purpose Statement in this manual states: "*Any Use of Force MUST be reasonably necessary in the circumstances and officers will be individually accountable for such force.*"<sup>48</sup> (capitalisation in original)

94 The power to use and apply handcuffs is derived from section 4 of the *Police Act 1892* (WA). However, there is no specific legislative provision that governs or controls the circumstances in which police may use handcuffs. The WAPF therefore rely on sections 231 (force used in executing process or in an arrest), 233 (preventing escape from arrest) and 235 (preventing escape or rescue after arrest) of the *Criminal Code* (WA) and section 16 (use of force when exercising powers) of the *Criminal Investigation Act 2016* (WA) as the primary legislative provisions.<sup>49</sup>

95 The WAPF has a Handcuff Manual as part of its Operational Safety and Tactics Training Unit (OSTTU), (the Manual).<sup>50</sup> The Manual states that: [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] (bold type in original). The Manual further states:<sup>52</sup>

<sup>48</sup> Exhibit 1, Volume 2, Tab 39, Report of Chris Markham dated 25 May 2022, p.13

<sup>49</sup> Exhibit 1, Volume 2, Tab 39, Report of Chris Markham dated 25 May 2022, p.23

<sup>50</sup> Exhibit 1, Volume 2, Tab 39, Annexure C.2, Handcuff Manual - Version 1.0

<sup>51</sup> Exhibit 1, Volume 2, Tab 39, Annexure C.2, Handcuff Manual - Version 1.0, p.5

<sup>52</sup> Exhibit 1, Volume 2, Tab 39, Annexure C.2, Handcuff Manual - Version 1.0, p.6

[REDACTED]

...

When using Handcuffs and Other Restraints as an appropriate tactical option, members **must** ensure their use of Handcuffs and Other Restraints is in accordance with relevant legislation, WA Police Policy and the training and guidelines of the Operational Safety and Tactics Training Unit (OSTTU). (*bold type in original*)

96 Another factor identified by Mr Markham as to whether it was appropriate for Roderick to be handcuffed was that Officers Colic and Bartels were aware that Roderick had assaulted Ms Forrest by biting her, and that she had shown the officers the injury she had sustained as a result. In those circumstances, Roderick was an arrestable person for an assault causing bodily harm.<sup>53</sup> As noted by Mr Markham,<sup>54</sup>

Therefore, the provisions of this Act [the Criminal Code] and the *Criminal Investigation Act 2006*, conferred the legislative power upon PC Colic to use such force as may be reasonably necessary to overcome any force or resistance offered by Roderick, or that he reasonably suspected would be offered.

97 I agree with the following conclusion by Mr Markham:<sup>55</sup>

The application of handcuffs to Roderick by PC Colic and PC Bartels would appear to be appropriate, proportionate and reasonably necessary in the circumstances. In the circumstances as reported, their use is in accordance with relevant legislation, WA Police Force policy and the training and guidelines of OSTTU.

98 As to the second question whether it was appropriate to handcuff Roderick behind his back when he was in the prone position, Officer Colic stated:<sup>56</sup>

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<sup>53</sup> Section 317 of the *Criminal Code (WA)*

<sup>54</sup> Exhibit 1, Volume 2, Tab 39, Report of Chris Markham dated 25 May 2022, p.24

<sup>55</sup> Exhibit 1, Volume 2, Tab 39, Report of Chris Markham dated 25 May 2022, p.26

<sup>56</sup> Exhibit 1, Volume 1, Tab 15, Statement of Constable Ahmedin Colic dated 28 November 2019, p.5

I handcuffed Roderick in the back to back position as it was the only way to do so. He was being extremely aggressive and I believed that if he broke free he would seriously injure himself or someone else.

99 Although the Manual provides for the handcuffing of a person in several ways, under the heading “Handcuffing Positions”, it states:<sup>57</sup>

[REDACTED]

100 The other handcuffing positions are [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]<sup>58</sup> The relevance of these handcuffing positions is they all reduce the risk of positional asphyxia when compared to the prone position. However, given that Roderick was already in the prone position when Officers Colic and Bartels entered the bedroom, and given his aggressive behaviour and level of resistance, I am not satisfied any of these handcuffing positions were feasible options as they would have provided greater opportunities for Roderick to resist.

101 I therefore accept Officer Colic’s explanation as to why Roderick was handcuffed in the manner that he was. Accordingly, I find that it was appropriate to handcuff him in the back to back prone position. Additionally, I am satisfied that Officer Colic ensured that the handcuffs were not too tight around Roderick’s wrists.<sup>59</sup> I am also of the view that the linear abrasions observed by Dr Vagaja to Roderick’s wrists were caused by his prolonged resistance and were an unavoidable outcome of that resistance.

<sup>57</sup> Exhibit 1, Volume 2, Tab 39, Annexure C.2, WAPF Handcuff Manual - Version 1.0, p.19

<sup>58</sup> Exhibit 1, Volume 2, Tab 39, Annexure C.2, WAPF Handcuff Manual - Version 1.0, pp.20-28

<sup>59</sup> Exhibit 1, Volume 1, Tab 12, Statement of Constable Ahmedin Colic dated 28 November 2019, p.5

*Were police officers aware of the risks associated with a restraint in the prone position?*

102 A factsheet used by the WAPF for training its officers notes that positional asphyxia is a medical emergency and provides the following guidance:<sup>60</sup>

Positional Asphyxia and Excited Delirium are well documented causes of death arising from the application of force.

Careful and continuous monitoring and attention is required to support effective respiration. Where practicable, members are to closely monitor the subject's breathing and abandon any restraint at any sign of breathing difficulties or lack of pulse.

103 When handcuffing a person in the prone position, police officers are reminded: "*Remember continually monitor the subject for signs of Positional Asphyxia*".<sup>61</sup>

104 Officer Colic's evidence at the inquest was that police must be mindful of positional asphyxia when a person is experiencing excited delirium. He was aware of the importance of not placing any pressure on the back area of someone restrained in the prone position because of the risk of positional asphyxia.<sup>62</sup> Consequently, he reminded others present not to apply any pressure to Roderick's back and to only hold him by his legs and arms.<sup>63</sup> He said to be mindful of Roderick's back "*multiple times*" during the restraint.<sup>64</sup>

105 After Officer Luis took over the restraining of Roderick's legs, Officer Bartels moved and placed his hand on the back of Roderick's head and only applied

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<sup>60</sup> Exhibit 1, Volume 2, Tab 39, Annexure C.12, Positional Asphyxia and Excited Delirium – Factsheet for Instructors, p.1

<sup>61</sup> Exhibit 1, Volume 2, Tab 39, Annexure C.2, WAPF Handcuff Manual - Version 1.0, p.31

<sup>62</sup> ts 30.5.22 (Colic), p.59

<sup>63</sup> Exhibit 1, Volume 1, Tab 12, Statement of Constable Ahmedin Colic dated 28 November 2019, p.6

<sup>64</sup> ts 30.5.22 (Colic), p.64

pressure when Roderick forced his head back.<sup>65</sup> He did not continuously restrain Roderick's head due to the dangers of positional asphyxia.<sup>66</sup>

106 Officer Colic recalled that after Officers Maseyk and Luis arrived, Roderick was moved "*just a little bit more towards the edge of the bed, hoping that he would get more air*".<sup>67</sup> This was done as he and the other officers were "*mindful, obviously, of positional asphyxia*".<sup>68</sup>

107 Officer Maseyk initially positioned herself next to Roderick's left shoulder and placed her hands on his shoulder blade and applied pressure to hold him down.<sup>69</sup> She later swapped over and did the same to the right shoulder.<sup>70</sup> As it was evident to her that Roderick was experiencing excited delirium and was therefore at risk of positional asphyxia, she was mindful of the pressure she was applying and the positioning of her hands.<sup>71</sup> In her evidence at the inquest, Officer Maseyk stated that "*to negate positional asphyxia ... I positioned my body off him. There was no pressure – so to speak – from my body. It was – it was my hands.*"<sup>72</sup>

108 When Roderick attempted to bite her, Officer Maseyk had to grab the scruff of his shirt and push his body down towards the bed to avoid being bitten. She estimated she had to do this three to four times.<sup>73</sup> Once the threat of being bitten was no longer imminent, she removed her hand and returned to holding his shoulder blade.

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<sup>65</sup> Exhibit 1, Volume 1, Tab 16, Statement of Constable Jayden Bartels dated 29 November 2019, p.7

<sup>66</sup> ts 30.5.22 (Bartels), p.81

<sup>67</sup> ts 30.5.22 (Colic), p.54

<sup>68</sup> ts 30.5.22 (Colic), p.54

<sup>69</sup> Exhibit 1, Volume 1, Tab 18, Statement of Constable Kelsey Maseyk dated 27 November 2019, p.6

<sup>70</sup> ts 31.5.22 (Maseyk), p.120

<sup>71</sup> Exhibit 1, Volume 1, Tab 18, Statement of Constable Kelsey Maseyk dated 27 November 2019, p.6; ts 31.5.22 (Maseyk), p.116

<sup>72</sup> ts 31.5.22 (Maseyk), p.120

<sup>73</sup> Exhibit 1, Volume 1, Tab 18, Statement of Constable Kelsey Maseyk dated 27 November 2019, p.7

109 Once Officer Luis applied the leg lock to Roderick, he remained in that position.<sup>74</sup> The leg lock was applied by Officer Luis as per his training and he was not lying on Roderick and he was not putting any pressure onto Roderick's body.<sup>75</sup>

110 Officer Luis recalled that after he had applied the leg lock, Roderick was moved "*slightly forward ... so his chest was basically towards the left side of the bed*".<sup>76</sup> He still had control of Roderick's legs when that was done.<sup>77</sup> Later in his evidence, Officer Luis was asked the following questions by Mr Crocker:<sup>78</sup>

What do you say to the proposition that the reason he was pushed off the bed was because the officers were concerned about improving his ability to breathe?  
--- Yes. That's why we had moved him. Yes.

What was it about what he was doing that caused you at the time you decide to push him off the bed that his breathing needed assistance by being pushed off the bed? --- From my recollection, it was nothing that he was doing that made us in – put him in a position that was encouraging breathing. It's just for my understanding of positional asphyxia that we had moved him forwards just so we could give him the best care. So it was nothing that he was doing that caused me a concern in regards to his breathing. It was just a thing that you just do to look after someone, essentially, to encourage their breathing whilst we were restraining him.

111 I am satisfied from the evidence given by the four police officers involved in Roderick's restraint that they were aware of the risks associated with a restraint in the prone position. They had correctly concluded that they were dealing with someone experiencing excited delirium and they were aware of the added risk of positional asphyxia and the need to avoid pressure to Roderick's back.

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<sup>74</sup> ts 31.5.22 (Luis), p.190

<sup>75</sup> ts 31.5.22 (Luis), p.195

<sup>76</sup> ts 31.5.22 (Luis), p.194

<sup>77</sup> ts 31.5.22 (Luis), p.217

<sup>78</sup> ts 31.5.22 (Luis), p.209

112 My conclusion is supported by Mr Ball's evidence at the inquest with respect to the manner in which police were restraining Roderick when he entered the bedroom: "*It very much looked like there had been a lot of thought go into the positioning of the police officers*".<sup>79</sup> Mr Ball later provided this answer to a question from Ms Barter:<sup>80</sup>

Did you have any concerns around the pressure the police were putting on Roderick's back or chest area? --- Not at that time, no.

***Was it appropriate for police officers to keep Roderick restrained in the prone position?***

113 It is an undeniable fact that Roderick was restrained in the prone position for a considerable period of time. Even after he was handcuffed, Roderick was kept in the prone position for about another 20 minutes. Notwithstanding that, for the reasons outlined below, I find that it was necessary for him to be restrained in the prone position for that length of time.

114 When Officer Colic was asked whether there were other options open once Roderick was handcuffed, such as turning him on his side or sitting him up, he answered:<sup>81</sup>

Not at the time, not with his aggressive behaviour, the way he was behaving at the time, the fact that he was kicking out and in those handcuffs, he was still trying to bite. So at the time I was worried. Even if he was handcuffed, if he did – we could still lose control over him, and he – I just didn't want to create a bigger scenario that what it needed, because there was children in the house, and (indistinct) and there's other occupants.

115 Mr Crocker posed this question to Officer Colic:<sup>82</sup>

As you think back. If you and the other officers were all concerned about his breathing, ought there have been an attempt to get him up into a different position from which it would be easier to breathe? --- It would – it just wasn't safe. Wasn't safe. He, honestly, he was just so strong. He was just lashing out and

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<sup>79</sup> ts 31.5.22 (Ball), p.166

<sup>80</sup> ts 31.5.22 (Ball), p.173

<sup>81</sup> ts 30.5.22 (Colic), p.46

<sup>82</sup> ts 30.5.22 (Colic), p.67

he was just trying to bite. He was just kicking so hard. I've never – I've never experienced someone that was that strong.

- 116 Officer Bartels described the strength that Roderick was displaying as “*inhuman*” and “*strength I've never encountered or seen since, in my life*”.<sup>83</sup> Officer Bartels then added:<sup>84</sup>

With that amount of strength he possessed, he posed significant risks to himself if you were to leave other parts of him unrestrained. You can't just leave someone who's thrashing about like that to have their handcuffs behind them, not restrained. He would likely break his own wrist.

...

So it was a bit of a double-edged sword, because you handcuff him to stop him hurting you, but now you need to stop him from hurting himself in handcuffs.

- 117 Officer Maseyk described Roderick's strength as follows:<sup>85</sup>

He was so incredibly strong. When I first got there, I remember feeling quite fearful initially because we just – the strength – I didn't think we would be able to get him under control. He was lifting, at one point, four of us off the bed, which I – I can accept that it sounds difficult, given that he was cuffed. It – it was just an incredible strength I hadn't seen.

- 118 Officer Maseyk regarded other options, such as placing Roderick into a seated position, as being “*just completely unsafe*”, as it would not have been impossible to “*administer a leg lock in a seated or standing position*”.<sup>86</sup> Similarly, placing him in a recovery position “*wasn't practicable at the time*” as it “*would have just been really hard to manage his movements*”.<sup>87</sup>

- 119 Officer Luis had a similar view. When asked why it was not possible for Roderick to be rolled onto his side and still control him, he answered:<sup>88</sup>

I believe that if we had moved him, he – we would have lost control of him and if I had released the leg lock, I don't believe I would have been able to reapply it in a different position.

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<sup>83</sup> ts 30.5.22 (Bartels), p.98

<sup>84</sup> ts 30.5.22 (Bartels), pp.98-99

<sup>85</sup> ts 31.5.22 (Maseyk), p.118

<sup>86</sup> ts 31.5.22 (Maseyk), p.122

<sup>87</sup> ts 31.5.22 (Maseyk), p.122

<sup>88</sup> ts 31.5.22 (Luis), p.209

120 As Mr Markham pointed out, police officers are only taught in their training to apply [REDACTED].<sup>89</sup> He noted that the leg locks applied by Officers Bartels and Luis were [REDACTED].<sup>90</sup>

121 When it was suggested to Mr Markham that Roderick could have been placed in the recovery position, he answered:<sup>91</sup>

No, I – I don't agree that that was an option available to them, Mr Crocker, and the reason for that is once they – they put him into a recovery position you are then not able to control his legs, as Senior Constable Luis was doing, with the leg lock. With the – with the subject laid on their side in the recovery position there's no ability to restrain the legs. [REDACTED]

122 It is clear from all the evidence before me that the threat from Roderick did not de-escalate or diminish throughout the entire time he was restrained by police. He continued to behave aggressively and violently. As Officer Maseyk stated:<sup>92</sup>

Throughout the course of my dealings with [Roderick], I continuously considered the position in which we had him restrained.

I deemed it unsafe to attempt alternative restraints due to his increasingly erratic and aggressive behaviour.

I believe any other position would have posed a genuine risk to the safety of myself, my colleagues and the family members present.

123 I accept Officer Colic's evidence that when Roderick was in the prone position the police "*had enough control over him ... but not enough control to move him to another position or anything like that.*"<sup>93</sup>

124 Unfortunately, it is readily apparent to me that the four officers had no option other than to keep Roderick in the prone position (with the attendant risks associated with that restraint) until the arrival of the SJA officers to

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<sup>89</sup> ts 1.6.22 (Markham), p.276

<sup>90</sup> ts 1.6.22 (Markham), p.276

<sup>91</sup> ts 1.6.22 (Markham), pp.309-310

<sup>92</sup> Exhibit 1, Volume 1, Tab 18, Statement of Constable Kelsey Maseyk dated 27 November 2019, pp.9-10

<sup>93</sup> ts 30.5.22 (Colic), p.66; Similarly Officer Luis stated, "*I don't believe the situation would have been able to be controlled if I or if – if we had moved him to a different position.*": ts 31.5.22 (Luis), p.211

administer the necessary sedative drug to treat his drug-induced psychosis. There was another option of “*tactical disengagement*” i.e. leaving Roderick alone in the bedroom “*to his own devices and the injuries he could have sustained or possibly inflicted on others because he’s not being restrained*”.<sup>94</sup> However, I agree with Mr Markham’s opinion that this option was simply not open. Nor do I think it was viable for the police officers to have moved Roderick from the bedroom and place him in the secure police pod until the SJA officers arrived. As Mr Markham said in his evidence:<sup>95</sup>

But in doing that, they would have exposed themselves to risk of injury because he would have been kicking, biting. They [would] have had to carry him, lift him off the ground physically, because that’s his demeanour and level of aggression, which we refer to as active physical aggression because he’s actually trying to assault the officers. He’s not just trying to break free and resist their efforts to restrain him. He’s actually trying to assault them, kick them and bite them. So in moving him to the pod and then putting him into the back of a police pod handcuffed, shutting the door and monitoring from the outside, and then leaving him again to his own devices. They’ve then got to – on the arrival of the ambulance, they’ve then got to get him out of the pod, which then exposes them to more risk because of the kicking and the biting and the fact that his legs aren’t restrained.

125 Mr Markham described the unenviable position the police officers were in:<sup>96</sup>

They’re aware that he has been restrained for an extended period of time, but what are their options? And obviously it’s an impossible situation. They know it’s a medical emergency but the person they’re trying to restrain, because of the excited delirium, because of the drugs, he’s relentless, he’s tireless and he’s actually resisting beyond the point of exhaustion.

126 Apart from when positional asphyxia is evident, police are trained to only place a person into the recovery position from the prone position [REDACTED]

[REDACTED]<sup>97</sup> If the police officers had attempted to restrain or control Roderick in a way other than the prone position before the effects of his excited delirium had subsided, there

<sup>94</sup> ts 1.6.22 (Markham), p.291

<sup>95</sup> ts 1.6.22 (Markham), pp.291-292

<sup>96</sup> ts 1.6.22 (Markham), p.292

<sup>97</sup> Exhibit 1, Volume 2, Tab 39, Annexure D.5, Use of Force – Contemporary Issues and Trends PowerPoint, p.245; ts 1.6.22 (Markham), p.287

was a very real risk of injury to the police officers present, the occupants of the house, the SJA officers once they had arrived and/or Roderick himself.

127 In the circumstances that existed during the restraint of Roderick, I am satisfied the police followed their training and that their ongoing risk assessments were correct in determining it was unsafe to restrain or control Roderick in any other way other than in the prone position until he stopped resisting, either voluntarily or from the effects of a sedative drug.

***Did police officers adequately monitor Roderick's breathing?***

128 As already outlined above, police officers are trained "*to closely monitor*" a person's breathing who is restrained in the prone position. The four officers involved in the restraint of Roderick gave the following evidence regarding their efforts to monitor his breathing.

129 Officer Colic checked Roderick's breathing by observing his body movements and trying to touch his wrist for a pulse.<sup>98</sup> As Roderick "*was throwing his whole body around*", Officer Colic "*thought he was breathing fine, because he was able to do all of that.*"<sup>99</sup> Officer Colic's evidence at the inquest was that every police officer present was ensuring Roderick could breathe and that, "*we were just communicating about his breathing and we were just relaying to each other what we were seeing about his breathing and we were just relaying that SJ [St John Ambulance] were coming and obviously we were just waiting for them*".<sup>100</sup>

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<sup>98</sup> ts 30.5.22 (Colic), p.43

<sup>99</sup> ts 30.5.22 (Colic), p.43

<sup>100</sup> ts 30.5.22 (Colic), p.66

130 When Officer Bartels had been replaced by Officer Luis in applying the leg lock to Roderick, he moved towards Roderick's upper body. In that position, he monitored Roderick's breathing in the following manner:<sup>101</sup>

I can see his mouth, I can see the back of his back raising up and down, suggesting deep, you know inhalation of oxygen. I was – I was right there in close proximity to observe that and hear it.

131 Officer Bartels also gave evidence that once he had moved to the top half of Roderick, "*I didn't see any changes in breathing*"<sup>102</sup> and that it was "*distinct rise and falling of breathing, not gasping*".<sup>103</sup>

132 From where Officer Maseyk was positioned near Roderick's head, she was able to see Roderick's face. Her evidence at the inquest was:<sup>104</sup>

I monitored his breathing – at that point, when I was on the left, my job was to look at his face. I was looking for things like, you know, change in colour, weakening. He never weakened for the entire 10 minutes I was – I was holding him. He never changed in his strength. He – he didn't weaken. He was still – as I said, he was still verbalising – although I didn't understand a lot of what he was saying, he was still communicating in some sense. He was – a lot of it wasn't English, I don't think. So I didn't see anything to suggest that – that he was struggling to breathe. His – I was watching his face, watching his lips – that's another thing we're taught with positional asphyxia, is that the lips might start to [turn] blue if someone's lacking oxygen. That wasn't the case. I had a fairly good view to his face, where I was on both shoulders, because I eventually moved to the right side and I – I monitored that as best as I could ... I did what I could in terms of positioning and looking for other signs that he couldn't breathe, as in, you know, verbalising it.

133 Officer Maseyk also recalled saying to the other police officers a few times, "*I'm looking at his face*" and that other officers would say when there was any repositioning taking place, "*Make sure his back's free*".<sup>105</sup>

134 Officer Luis stated that he and Officer Maseyk were communicating to Roderick, encouraging him to breathe.<sup>106</sup> From his position at Roderick's legs,

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<sup>101</sup> ts 30.5.22 (Bartels), p.81

<sup>102</sup> ts 30.5.22 (Bartels), p.96

<sup>103</sup> ts 30.5.22 (Bartels), p.97

<sup>104</sup> ts 31.5.22 (Maseyk), p.120

<sup>105</sup> ts 31.5.22 (Maseyk), p.127

he “*monitored his back to ensure that it was rising and falling*”.<sup>107</sup> From those observations, Officer Luis believed that Roderick’s breathing was “*sufficient*”.<sup>108</sup>

135 None of the police officers observed that Roderick was encountering difficulties with his breathing or heard him say he was not able to breathe. That evidence is consistent with the accounts given by the occupants of the house when they were in the bedroom. It is also consistent with what the SJA officers observed when they attended.

136 When asked whether he saw any signs from Roderick that suggested he was having any difficulty breathing before the midazolam injection, Mr Vincent said: “*So from what I remember, there was incomprehensible sounds*<sup>109</sup> *coming from him, which in my mind, meant that there was air going in and out of his lungs, so no*”.<sup>110</sup>

137 When it was put to Mr Ball that Roderick was not displaying any obvious respiratory difficulty when he observed him, he answered:<sup>111</sup>

Yes. I – I think that would be fair to say. I – I would feel more comfortable saying that I wasn’t able to assess it properly. But it was based on my – based on the – I guess, the visual and auditory cues was that he was – he was able to take breath and out – in and out if he was able to make those sounds. There was a lot of sort of growling and – and mumbling going on.

...

So with that sort of – the effort to make those sounds, I had assumed at that time that he had adequate respiratory effort.

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<sup>106</sup> ts 31.5.22 (Luis), p.194

<sup>107</sup> ts 31.5.22 (Luis), p.194

<sup>108</sup> ts 31.5.22 (Luis), p.194

<sup>109</sup> Mr Vincent later explained that what he meant by “incomprehensible sounds” was he could not make out the words Roderick was saying.

<sup>110</sup> ts 31.5.22 (Vincent), p.145

<sup>111</sup> ts 31.5.22 (Ball), p.163

138 At the inquest, Mr Markham agreed there were practical difficulties for police to be able to effectively monitor a person's breathing who is restrained in the prone position and experiencing excited delirium:<sup>112</sup>

There is. Because they're dealing with somebody who is violently struggling. So their concern is to – is to maintain that control and restraint but, at the same time, try and monitor the person's vital signs and their breathing and then react appropriately and then the question is: well, what could they do if they do identify an issue? It's not going to stop until that person actually – and that's why we've got in the training they will fight and fight and fight and then you will suddenly stop.

But by then it could be too late; yes? --- Yes.

139 Notwithstanding those practical difficulties, I am satisfied that the four police officers did adequately monitor Roderick's breathing as he was being restrained in the prone position. That monitoring did not detect any indication that Roderick was experiencing respiratory difficulties before his cardiac arrest. For the reasons I have outlined later in this finding, I am satisfied that the medical evidence before me supports the observations made by the police officers that Roderick was not having difficulties breathing, and did not stop breathing, prior to his cardiac arrest.

***Did the injection of midazolam cause or contribute to Roderick's death?***

140 As already outlined, Roderick went into cardiac arrest shortly after he had been administered 2 mg of the sedative, midazolam, by SJA officers. The question arises as to whether this dosage of midazolam caused, or contributed to, this cardiac arrest. Based upon all the information available, I am able to find that it did not.

141 Midazolam is a water-soluble benzodiazepine that has anxiolytic, sedative and anticonvulsive characteristics. This is due to its bonding with receptors in the central nervous system, its action to increase the inhibitory effect of the

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<sup>112</sup> ts 1.6.22 (Markham), p.317

g-aminobutyric acid (GABA) neurotransmitter on the GABA receptors and subsequent membrane threshold. Midazolam is lipid-soluble<sup>113</sup> in physiological pH which means it reaches the central nervous system quickly, allowing for rapid sedation of short duration. It is therefore appropriate for brief symptom control and it is commonly used for short term sedation of patients with profound behavioural disturbances.<sup>114</sup>

142 When administered intramuscularly, midazolam takes about 10 minutes from administration to initiate a sedative effect. As it can cause respiratory depression and hypotension, monitoring of the patient's vital signs is therefore recommended, although that can be difficult in an agitated patient.<sup>115</sup>

143 As of 27 October 2019, SJA Clinical Practice Guidelines recommended an intramuscular dosage of 10 mg of midazolam for an adult experiencing drug-induced psychosis.<sup>116</sup> This was the intended amount of midazolam for Roderick. However, about half of the dose was administered subcutaneously (instead of intramuscularly as intended) which meant that it would have had reduced effectiveness.<sup>117</sup>

144 SJA conducted an internal clinical review of the incident involving Roderick, which included the administering of midazolam. The finding of the internal review was that, "*medications were administered in accordance with SJWA Clinical Practice Guidelines*".<sup>118</sup>

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<sup>113</sup> Capable of dissolving in fats, oils or fatty tissues.

<sup>114</sup> Exhibit 1, Volume 1, Tab 37, Report of Associate Professor Paul Bailey dated 23 May 2022, p.2

<sup>115</sup> Exhibit 1, Volume 1, Tab 37, Report of Associate Professor Paul Bailey dated 23 May 2022, p.2

<sup>116</sup> Exhibit 1, Volume 1, Tab 37, Report of Associate Professor Paul Bailey dated 23 May 2022, Clinical Practice Guidelines for Ambulance Care in Western Australia, Version 34.2, p.2

<sup>117</sup> Exhibit 1, Volume 1, Tab 37, Report of Associate Professor Paul Bailey dated 23 May 2022, pp.2-3

<sup>118</sup> Exhibit 1, Volume 1, Tab 37, Report of Associate Professor Paul Bailey dated 23 May 2022, p.2

145 Professor Joyce addressed the question whether the midazolam dosage contributed to Roderick's death. In his opinion:<sup>119</sup>

If the midazolam was deposited in muscle and subcutaneous fat, as the ambulance officer (David Vincent) perceived, very little could have entered the circulation in the short time that elapsed between administration and the first perception that Roderick had become limp.

The measured concentration [approx. 0.03 mg/L], at around 43 minutes from administration, is lower than effective concentrations usually encountered during conventional intravenous or intramuscular use. It is also lower than any concentration reported from cases where midazolam overdose has been the cause of death (Baselt, 2017).

...

Midazolam is appropriate for the purpose of gaining some control over a patient with dangerous methylamphetamine-induced agitated delirium. The dose of midazolam would be regarded as appropriate and safe, subject to monitoring of breathing and support of respiration if needed. Care for breathing is part of the protocol for administering any drug that might put it at risk, such as midazolam. A 10 mg dose of midazolam, even given intravenously, may be insufficient to gain control in a patient with severe methylamphetamine-induced agitated delirium.

Patients with severe methylamphetamine-induced agitation (agitated delirium) may require repeated dosing.

Midazolam very likely failed to enter the circulation in effective concentrations in this case. There is little reason to suspect that it contributed to death.

146 This part of his report was confirmed by Professor Joyce at the inquest: "*I concluded that there wasn't much reason to suspect that midazolam had made any contribution to death*" and that the administration of midazolam "*didn't have any of the hallmarks of potential danger.*"<sup>120</sup>

147 I accept the conclusion of the internal clinical review by SJA and the opinion of Professor Joyce as outlined above, regarding the midazolam administered to Roderick. Accordingly, I find that the injection of 10 mg of midazolam was appropriate given Roderick was experiencing a methylamphetamine-induced psychosis (or excited/agitated delirium) and that it did not cause, or contribute to, Roderick's death.

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<sup>119</sup> Exhibit 1, Volume 1, Tab 8, Report of Professor David Joyce dated 20 July 2020, pp.10-11

<sup>120</sup> ts 1.6.22 (Professor Joyce), p.338

*Did Roderick experience respiratory difficulties before his cardiac arrest?*

148 In answers to questions from Mr Crocker, Associate Professor Bailey described the two ways relevant to Roderick's death in which a person can stop breathing. One is when the person's ability to breathe is obstructed, causing the blood being pumped from the heart to not be oxygenated, which ultimately leads to a loss of heart function. In that instance, the respiratory arrest is first, followed by the cardiac arrest.<sup>121</sup>

149 The second way is when the ability to breathe is compromised following the loss of the heart's function to pump blood effectively.<sup>122</sup>

150 After agreeing that these two processes are different in terms of a respiratory arrest and a cardiac arrest, Associate Professor Bailey provided this answer with respect to what happened to Roderick:<sup>123</sup>

I think the risk predominantly relates to malignant cardiac arrhythmias, so a heart cause of cardiac arrest. Notwithstanding our discussion on positional asphyxia, I think a primary respiratory arrest would be a less likely cause of a cardiac arrest in a patient with agitated delirium.

On the material that you've seen in preparation for giving evidence at this inquest, do you have a view about the mechanics of what caused the cessation of breathing here? --- It would only be a view, and I think the most probable cause would be a primary cardiac arrest with subsequent respiratory arrest.

151 That view was shared by other medically-qualified witnesses who gave evidence at the inquest.

152 As Professor Joyce observed in his report at [44]:<sup>124</sup>

The ambulance officer's very early appreciation (within about 30 seconds, according to the estimate of David Vincent) of a lost carotid pulse suggests strongly that cardiac arrest was the first event, because it typically takes minutes for circulation to be lost when consequent on failure of breathing.

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<sup>121</sup> ts 30.5.22 (Associate Professor Bailey), p.26

<sup>122</sup> ts 30.5.22 (Associate Professor Bailey), p.26

<sup>123</sup> ts 30.5.22 (Associate Professor Bailey), p.26

<sup>124</sup> Exhibit 1, Volume 1, Tab 8, Report of Professor David Joyce dated 20 July 2020, p.10

153 Professor Joyce also pointed out that although the evidence from a toxicology position does not offer further insight into whether Roderick's breathing was compromised during the restraint, he noted that, "*sudden cardiac death during methylamphetamine-induced violent physical activity does not require the simultaneous presence of compromised breathing*".<sup>125</sup>

154 In his evidence before the inquest, Professor Joyce gave the following explanation for this conclusion in answers to questions from Mr Crocker:<sup>126</sup>

In essence, is what you're saying that the problem that Roderick had was that his heart stopped working properly because of the disturbance – amongst other things, the electrical disturbance within the heart stopped or caused it to stop pumping as it is meant to pump? That's part of it? --- Yes.

And as a result of that, blood is not being pumped around the body as well as it should and one of the important destinations for that blood is the brain and therefore the brain suffers a problem. So far so good? --- Yes.

And one of the problems that flow from the brain experiencing difficulty is that the brain stops telling the lungs that they've got work to do and the result is the person stops breathing? --- Yes.

The other way someone could get into great difficulty is if the person stops breathing because they can't get air in, their airway is obstructed, they're being asphyxiated in a circumstance where the heart keeps pumping normally but what the heart is doing is pumping blood which is not getting replenished with oxygen? --- Yes.

And what you've told his Honour is that you think what happened to Roderick is the first example, namely, his heart got into difficulty because, amongst other things, of the exertion and the meth rather than the heart was working okay but it was pumping blood that didn't get oxygen into it? --- Yes.

Now, I understand that's a very simplistic way but the way I've described it, they're really the two big alternatives. There's a cardiac problem that creates – that's the first stage or there is a respiratory breathing problem and you've come down on the side of, "I think this is a cardiac problem at the start"? --- Yes.

Right. And one of the strong reasons that you conclude that it's the cardiac arrest which is the first event is that you say it typically takes minutes for circulation to be lost if it is lost as a result of failure of breathing? --- Yes.

And that is the observation you make at the end of paragraph 44 [of your report] in the context of the paramedic who says that when Roderick collapsed the

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<sup>125</sup> Exhibit 1, Volume 1, Tab 8, Report of Professor David Joyce dated 20 July 2020, p.10

<sup>126</sup> ts 1.6.22 (Professor Joyce), pp.352-353

paramedic felt for the pulse on the side of his neck and there wasn't anything there? --- Yes.

155 In her evidence at the inquest, Dr Vagaja, although not being able to completely exclude the respiratory arrest as the first event, expressed the view that: “*Overall, I feel more comfortable saying that cardiac was in front of the – any potential respiratory in order of importance. So I would say that was more likely...*”.<sup>127</sup>

156 Dr Vagaja was later asked this question by Mr Crocker:<sup>128</sup>

And although you say there is no scientific way you can exclude asphyxiation or a problem breathing as being the event that sets in train the fatal end, you think the more likely cause is as Professor Joyce [stated], that what set up the problem was the heart failed? --- Yes. The heart failed, although aided by the restraint and the struggle.

157 During the restraint of Roderick, there were 11 persons present in the bedroom at various stages.<sup>129</sup> There is no evidence before me that any of those witnesses observed Roderick having difficulty breathing or heard him say anything to suggest he was having trouble breathing.

158 The only evidence that might point to Roderick having difficulty breathing before his cardiac arrest is something that can be heard in the background during the recorded radio call by Officer Colic to the POC operator at about 4.27 am. To put the timing of that call in context, this was about nine minutes after Roderick had been restrained in the prone position, initially by occupants of the house and then by Officers Colic and Bartels, and about 20 minutes before he went into a cardiac arrest.<sup>130</sup>

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<sup>127</sup> ts 1.6.22 (Dr Vagaja), p.364

<sup>128</sup> ts 1.6.22 (Dr Vagaja), p.370

<sup>129</sup> This group comprised of the five occupants from the house, the four police officers and the two SJA officers.

<sup>130</sup> Officers Luis and Maseyk had not yet attended the bedroom when the radio call was made.

159 When the recording of the radio call<sup>131</sup> was first played at the inquest, family members who were in attendance not only recognised the voice of Roderick in the background, but also believed they heard him say, just before the recording ended, “*I can’t breathe*”. Based on his family’s recognition of the voice, I am prepared to accept that the voice heard is Roderick’s.

160 When questioned as to whether they heard Roderick say, “*I can’t breathe*”, when he was being restrained, each of the four attending police officers said that they either did not remember, did not recall, or did not hear him say that.<sup>132</sup>

161 I have now listened to exhibit 2B many times. I have listened to it again in the courtroom, and wearing earphones as it was played on my desktop computer. I have also listened to the enhanced recordings supplied by the WAPF (exhibit 7D) and the Australian Federal Police (exhibit 7E) through these two formats.

162 Unfortunately, even with the enhancements, the recording remains poor and it remains difficult to precisely determine what is being said by Roderick. Another problem is that although a voice can be heard in the background (which may also have been Roderick) before the relevant words are said, this takes place when Officer Colic is speaking and it is impossible to hear what is being said. Hence no context is available when attempting to determine what is being said by Roderick at the critical time.

163 The significance of potential evidence from Roderick stating, “*I can’t breathe*”, in the presence of two police officers who are restraining him in the prone position, is obvious. That significance requires me to adhere to the

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<sup>131</sup> Exhibit 2B

<sup>132</sup> ts 30.5.22 (Colic), p.54; ts 30.5.22 (Bartels), p.85; ts 31.5.22 (Maseyk), p.125; ts 31.5.22 (Luis), p.198

*Briginshaw* principle which is neatly summarised in the following passage from the High Court's decision:<sup>133</sup>

The serious of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences.

164 The poor quality of the recording does not permit me to find, to the required standard, that the actual words spoken by Roderick were, "*I can't breathe*". Had there been some corroborating or circumstantial evidence, either from an eye witness or medical evidence, to support a finding that these were the words said then it may have been open for me to make that conclusion. As there is not, there is some force to the contention that in the absence of such supporting evidence and the existence of eye witness and medical evidence that is inconsistent with Roderick having any difficulty breathing before he went into cardiac arrest, means that it is likely something other than, and sounding similar to, "*I can't breathe*" was said.

### *Adequacy of the IAU investigation*

165 As with all matters involving the death of a person in police custody, the IAU conducted an investigation into Roderick's death. Detective Cunningham was the police officer responsible for that investigation and his findings were contained in a report.<sup>134</sup>

166 The purpose of an IAU investigation where a death has occurred in police custody or police presence is to examine whether the actions of police officers involved complied with WAPF policy. A parallel investigation by the WAPF

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<sup>133</sup> *Briginshaw v Briginshaw* (1938) 60 CLR 336, 362 (Dixon J)

<sup>134</sup> Exhibit 1, Volume 1, Tab 33, IAU Report dated 14 April 2020

Homicide Squad is to investigate whether there are criminal aspects in the matter.<sup>135</sup>

167 With respect to the death of Roderick, the IAU investigated whether the four attending police officers complied with WAPF policies with respect to the use of force and their duty of care towards Roderick.<sup>136</sup> Although I agree with the outcome of the IAU investigation, which found there was compliance by the officers with respect to their use of force and duty of care obligations, questions were raised at the inquest regarding the adequacy of the investigation.

168 One of those questions related to the failure to interview the four subject officers in compulsory interviews. It is my understanding it was a common practice of IAU investigations prior to 2021 not to conduct such interviews, particularly when officers had already provided typewritten statements to Homicide Squad (as had occurred here).

169 This practice has now changed following the implementation of a recommendation I made in *Inquest into the death of Child JP* [2021] WACOR 42 delivered on 21 December 2021. This recommendation stated:<sup>137</sup>

That for IAU investigations involving a fatality that may be the subject of a mandatory inquest under section 22(1)(b) of the *Coroners Act 1996* (WA), all subject officers are to be compulsorily interviewed (whether or not they have already provided statements to another section of the WA Police Force), unless there are exceptional reasons not to do so.

170 In light of the common practice that existed prior to 2021 to not conduct compulsory interviews with subject officers in IAU investigations, I will not be critical of the failure by Detective Cunningham to conduct interviews in this matter.

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<sup>135</sup> ts 31.5.22 (Van Der Schoor), p.233

<sup>136</sup> Exhibit 1, Volume 1, Tab 33, IAU Report dated 14 April 2020, pp.4-5

<sup>137</sup> *Inquest into the death of Child JP* [2021] WACOR 42 delivered on 21 December 2021, p.84

171 Another question was whether Detective Cunningham had listened to the audio recordings of police radio communications and triple zero calls and, if he had, whether he properly documented (i) that he had and (ii) the conclusions he had made. More precisely, this question was directed to the radio call made by Officer Colic to the POC operator at about 4.17 am on 27 October 2019.<sup>138</sup>

172 Detective Cunningham was not called as a witness at the inquest as he was on extended personal leave. Instead, Detective Senior Sergeant Lloyd Van Der Schoor (Detective Van Der Schoor), whose signature appeared on the IAU report alongside Detective Cunningham's, was called. It emerged during the course of Detective Van Der Schoor's evidence that he did not take an active role in the IAU investigation, nor did he read or examine all of the material that Detective Cunningham had considered.<sup>139</sup>

173 Regrettably, the contents of the IAU report shed no light on whether Detective Cunningham had investigated what could be heard at the very end of Officer Colic's radio call to POC. In fact, the wording used in the report suggested the POC voice extracts may not have even been considered.<sup>140</sup> I therefore requested that Detective Cunningham prepare a statement with respect to this matter after the inquest was completed.

174 A statement dated 9 June 2022 from Detective Cunningham was provided to the court.<sup>141</sup> Unfortunately, that statement also shed little light on the matter. Detective Cunningham stated:<sup>142</sup>

I cannot specifically recall whether I listened to the POC recordings as part of the investigation concerning [Roderick], but it was my usual practice to listen to such recordings with POC as I did that with every job.

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<sup>138</sup> Exhibit 2B

<sup>139</sup> ts 31.5.22 (Van Der Schoor), pp.240-241

<sup>140</sup> Exhibit 1, Volume 1, Tab 33, IAU Report dated 14 April 2020, p.23

<sup>141</sup> Exhibit 5A

<sup>142</sup> Exhibit 5A, Statement of Detective Senior Constable Mark Cunningham dated 9 June 2022, p.2

175 For the preparation of his statement, Detective Cunningham had listened to exhibit 2B. He stated: *“I could not pick anything up from that recording, as in, it sounds like a jumble to me. I am 63 years of age and have some difficulty hearing things”*.<sup>143</sup>

176 When Detective Cunningham was advised of what Roderick’s family heard during the inquest, he stated:<sup>144</sup>

If, during my investigation, I had evidence of [Roderick] saying that, I would have investigated it further as it is a critical point in the investigation if a subject was being restrained.

177 The only reference in the IAU report to this audio recording is under the heading: “Police Operations Centre (POC) Voice Extracts”. Curiously, underneath that heading, it simply reads: *“The POC voice extracts do not form part of this report”*.<sup>145</sup>

178 In his statement, Detective Cunningham explained: *“I believe this comment relates to my view that the calls did not contain anything which could be considered controversial or would progress the investigation”*.<sup>146</sup>

179 I was not satisfied with the explanations provided by Detective Cunningham in this statement. I requested a supplementary statement to address the following:<sup>147</sup>

- That Detective Cunningham had examined the IAU file to check if any contemporaneous records had been made of IAU having obtained the recording in question and of him listening to it. If those records exist, they should be attached to his supplementary statement.
- If there were no contemporaneous records detailing the above, an explanation as to why that is the case. And did that suggest this recording (and other recordings referred to in the inquest) were not obtained by the IAU?

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<sup>143</sup> Exhibit 5A, Statement of Detective Senior Constable Mark Cunningham dated 9 June 2022, p.3

<sup>144</sup> Exhibit 5A, Statement of Detective Senior Constable Mark Cunningham dated 9 June 2022, p.3

<sup>145</sup> Exhibit 1, Volume 1, Tab 33, IAU Report dated 14 April 2020, p.23

<sup>146</sup> Exhibit 5A, Statement of Detective Senior Constable Mark Cunningham dated 9 June 2022, p.2

<sup>147</sup> Email from Anna MacDonald (court support officer) to Mr Berson dated 17 June 2022

- An explanation as to why the IAU report had described the POC recordings as: “*The POC voice extracts do not form part of this report*” when that same description had been used with respect to material that was clearly not relevant to this IAU investigation.<sup>148</sup>
- If Detective Cunningham had listened to the recording and found no issue or controversy with its contents, why did he not give the type of explanation he gave under the heading ‘Use of Force’ at page 23 of the IAU report?<sup>149</sup> For example: “*The POC voice extracts at [specified time] are consistent with the statement provided by [the subject officer].*”

180 A supplementary statement from Detective Cunningham was provided to the court dated 29 June 2022.<sup>150</sup>

181 In the preparation of this supplementary statement, Detective Cunningham attended the offices of the Coronial Inquest Coordination Division on 27 June 2022 and reviewed his investigation file.<sup>151</sup> However, after doing that, Detective Cunningham stated, “*my memory is not refreshed as to whether I did in fact listen to the POC voice extracts at the time*”.<sup>152</sup>

182 It would therefore appear that Detective Cunningham did not review his investigation file for the preparation of his first statement dated 9 June 2022. If this is correct, I am troubled by that. Notwithstanding the fact he was on leave at the time, Detective Cunningham should have reviewed the IAU investigation file for the preparation of his first statement.

183 Detective Cunningham was able to say that the POC voice extracts were received by the IAU as they had been saved in the “P drive” folder concerning Roderick under “Homicide Squad Case File”.<sup>153</sup>

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<sup>148</sup> Examples of this other material that were not relevant included “*Custody Records*” and “*Automated Resource Locator (ARL)*”.

<sup>149</sup> This explanation read: “*UOF2019-1602 was submitted by Colic on 28 October 2019, and is consistent with the statements provided by the subject officers.*”

<sup>150</sup> Exhibit 5B, Supplementary statement of Detective Senior Constable Mark Cunningham dated 29 June 2022

<sup>151</sup> Exhibit 5B, Supplementary statement of Detective Senior Constable Mark Cunningham dated 29 June 2022, p.1

<sup>152</sup> Exhibit 5B, Supplementary statement of Detective Senior Constable Mark Cunningham dated 29 June 2022, p.1

<sup>153</sup> Exhibit 5B, Supplementary statement of Detective Senior Constable Mark Cunningham dated 29 June 2022, p.2

184 Although Detective Cunningham stated that it was his usual practice to record the collection of evidence (such as statements and audio files) in the running sheet, the running sheet for this investigation did not record when he received the Homicide Squad file. As Detective Cunningham explained, “*I am not sure why it is not recorded in the running sheet, but it was likely an oversight on my part*”.<sup>154</sup>

185 As to his explanation as to why the IAU report stated: “*The POC voice extracts do not form part of this report*”, Detective Cunningham stated:<sup>155</sup>

This was the first investigation of this kind that I had conducted. As a result, in preparing the report, I relied on an investigation report of a similar nature as a template for my investigation report.

The POC Voice Extracts are described in my report in the manner that they are because I used the previous investigation report as a template for my investigation report. I have borrowed that language from that similar report.

...

I did not include an explanation under POC Voice Extracts to the effect that the POC Voice Extracts are consistent with the statements provided by the subject officers because of my reliance on the previous investigation report as a template.

...

In hindsight, I could have included, at a minimum, a description of the POC Voice Extracts and the result of my view of the Extracts.

186 This would appear to be a different explanation to the one he provided in his first statement.<sup>156</sup>

187 Whatever explanation given by Detective Cunningham is the correct one, the description given in the IAU report as to use made of the POC voice extracts in the investigation was not only inadequate but also potentially misleading. One reading of the description they “*do not form part of this report*” is that they were not considered. I am of the view that the benefit of hindsight (as

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<sup>154</sup> Exhibit 5B, Supplementary statement of Detective Senior Constable Mark Cunningham dated 29 June 2022, p.3

<sup>155</sup> Exhibit 5B, Supplementary statement of Detective Senior Constable Mark Cunningham dated 29 June 2022, pp.3-4

<sup>156</sup> “*I believe this comment relates to my view that the calls did not contain anything which could be considered controversial or would progress the investigation*”: Exhibit 5A, Statement of Detective Senior Constable Mark Cunningham dated 9 June 2022, p.2

cited by Detective Cunningham) is not required for the conclusion to be drawn that he should have (not “*could have*”) included, at the very minimum, a description of the POC voice extracts and the outcome of his review of them.

188 I have also concluded that had Detective Cunningham listened to the POC voice extracts, then he did so far too late in his investigation. I am prepared to find, for the reasons outlined by Mr Berson in exhibit 7A, that the file containing the POC voice extracts was accessed at 10.38 am on 1 April 2020.<sup>157</sup> Logically, it would have been Detective Cunningham accessing the file, as he was the sole investigating officer. However, this was the same day as the IAU Evidence Assessment Meeting (EAM). It is my understanding an EAM is held for senior IAU officers to review the proposed outcomes of the investigation. With respect to this investigation, Detective Cunningham’s proposed outcomes were accepted.<sup>158</sup>

189 Mr Berson has submitted to the court: “*Accordingly, at least, the extract that is captured in exhibit 2B was accessed prior to the EAM and prior to the conclusion of the IAU investigation*”.<sup>159</sup> However, what this demonstrates is that exhibit 2B was only accessed a matter of hours before the EAM<sup>160</sup> and, as the proposed outcomes were accepted at the EAM meeting, very shortly before the conclusion of the IAU investigation.

190 It would seem that with respect to exhibit 2B, it is a matter of good fortune for the IAU investigation that I have not been able to determine the recorded words spoken by Roderick were, “*I can’t breathe*”.

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<sup>157</sup> Exhibit 7A, Letter from Mr Berson to Counsel Assisting dated 14 July 2022, p.2

<sup>158</sup> Exhibit 1, Volume 1, Tab 33, IAU Report dated 14 April 2020, p.29

<sup>159</sup> Exhibit 7A, Letter from Mr Berson to Counsel Assisting dated 14 July 2022, p.2

<sup>160</sup> The EAM meeting commenced at 2.22 pm and concluded 12 mins later at 2.34 pm: Exhibit 7A, Letter from Mr Berson to Counsel Assisting dated 14 July 2022, p.2

191 I am also concerned that Detective Cunningham was allocated this matter to investigate. Detective Cunningham has advised the court that this was “*the first investigation of this kind that I had conducted*”.<sup>161</sup> He had only been stationed at IAU since May 2019.<sup>162</sup> Given his relative inexperience, it would have been more suitable for Detective Cunningham to be partnered with an experienced IAU investigator. Instead, it appears he may have only been supplied with the report from a previous IAU investigation to use as a template for his own report.

192 I have identified some shortcomings with respect to this IAU investigation. Those shortcomings did not have a bearing on the ultimate outcomes of the investigation which, in my view, were correctly made. Nevertheless, I agree with the following submission by Mr Crocker:<sup>163</sup>

Any IAU investigation is a very important exercise, even more so when it involves the death of a person in police custody. It should be undertaken by appropriately trained and skilled persons. All stages of the investigation should be documented.

### IMPROVEMENTS SINCE RODERICK’S DEATH

#### *Communications between WAPF and SJA regarding persons with excited delirium*

193 I have already identified the failure of the POC operator to treat the request of Officer Colic for an ambulance as a medical emergency. However, I am satisfied changes have been made that should lead to improvements in communications between the WAPF and SJA regarding the response to a person with a suspected drug-induced psychosis.

194 Superintendent Martin Haime, from WAPF State Communications Division, advised the oversight that occurred in Roderick’s case has been addressed.

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<sup>161</sup> Exhibit 5B, Supplementary statement of Detective Senior Constable Mark Cunningham dated 29 June 2022, p.3

<sup>162</sup> Exhibit 5A, Statement of Detective Senior Constable Mark Cunningham dated 9 June 2022, p.1

<sup>163</sup> Additional Submissions by Counsel for Monica Narrier dated 22 July 2022, p.3

Presently, every case where the subject person has suspected excited delirium is to be regarded as a medical emergency.<sup>164</sup> A policy section has been added to the POC knowledge base that states: *“Any assessment that a person is suffering from ‘excited delirium’ should be accompanied by supporting observations surrounding their condition and symptoms and must be treated as a medical emergency”*.<sup>165</sup>

195 Superintendent Haime has also provided a copy of the written direction to all police officers and staff at POC dated 27 May 2022 that contains the following passage:<sup>166</sup>

In all cases where officers indicate they are dealing with a person who is or may be suffering from ‘excited delirium’ and request attendance by St John Ambulance, it must be treated as a medical emergency that requires a priority response. When requesting assistance from St John Ambulance, the use of the term ‘Excited Delirium’ should be avoided and where possible, it must be accompanied by observations of the person’s behaviour, symptoms and demeanour. Plain speak should be used to accurately describe the situation and/or the behaviour of the person in need.

196 Notwithstanding Superintendent Haime’s observation regarding the non-use of the term “excited delirium” when requesting assistance from SJA, Associate Professor Bailey’s evidence was that SJA call takers and paramedics are aware of the phrase “agitated or excited delirium”. Associate Professor Bailey provided these answers to questions from Counsel Assisting at the inquest:<sup>167</sup>

If VKI had communicated to police [sic - SJA] and used the term “excited delirium” accompanied with the other information, would that have changed the allocation of the priority, perhaps from Priority 2 to Priority 1? Would that have changed the allocation? --- At that time, it may not; today it would.

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<sup>164</sup> Exhibit 3, Memorandum dated 30 May 2022 from Superintendent Martin Haime, State Communications Divisions, p.1

<sup>165</sup> Exhibit 3, Memorandum dated 30 May 2022 from Superintendent Martin Haime, State Communications Divisions, Annexure A, p.3

<sup>166</sup> Exhibit 3, Memorandum dated 30 May 2022 from Superintendent Martin Haime, State Communications Divisions, Annexure B, p.6

<sup>167</sup> ts 30.5.22 (Associate Professor Bailey), p.12

Right. And what would be the reason for that? --- There's a previous coronial recommendation relating to the use of the term "agitated delirium" that we've informed our call takers and paramedics of and that, regardless of the outcome of the prioritisation of a case, when we hear those words, we should have a very low threshold for upgrading that call to Priority 1.

197 Associate Professor Bailey further explained:<sup>168</sup>

What I can say is that our people are now very aware of "excited delirium" as a term that members of the police calling us may use, and regardless of which call determinant the conversation triggers, when those words are used to us, that call is brought to the attention of the clinical support paramedic who is a paramedic contained within the State Operation Centre and they have a brief to have a low threshold to upgrade that call if, in fact, it had not been allocated Priority 1 in the first instance.

198 I am satisfied there have been improvements made by the WAPF and SJA in response to a communication from an operational police officer that a person is experiencing "*excited delirium*". I am also satisfied both agencies have taken steps to alert their personnel as to what is the appropriate response to a person experiencing excited/agitated delirium (i.e. a drug-induced psychosis).

199 These improvements have already been undertaken following two earlier inquests in which recommendations were made that are relevant to this inquest. One was *Inquest into the death of Levi Shane Clement Congdon* [2020] WACOR 37 delivered on 19 November 2020. The recommendation made by Coroner King was:

That the WAPF and SJA implement a liaison process with respect to the training each agency provides to their officers about medical emergency terminology and protocols.

200 The other was a recommendation made by Coroner Jenkin in *Inquest into the death of Chad Riley* [2021] WACOR 24 delivered on 30 July 2021 which said:

The Western Australian Police Force should ensure that officers confronting a person exhibiting signs of a drug-induced psychosis or related conditions are reminded to treat the situation as a medical emergency and ensure that an

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<sup>168</sup> ts 30.5.22 (Associate Professor Bailey), p.29

ambulance is requested on a Priority 1 basis. Further, all relevant information about the subject's presentation must be communicated in a timely manner to attending ambulance officers.

201 In those circumstances, I do not find it necessary to make any further recommendations with respect to these aspects of the inquest into Roderick's death.

### ***Rostering of two SJA paramedics at POC***

202 In January 2021, SJA commenced a trial of rostering two paramedics at POC to develop greater coordination between the two agencies. As outlined by Associate Professor Bailey in his report: "*Results from the trial showed safety benefits in agencies sharing information in respect of arrival times and improved situation awareness*".<sup>169</sup>

203 Superintendent Haime expressed a similar view stating: "*The physical co-location of SJA and POC staff is optimal in terms of ensuring agile and accurate communication between agencies in managing a response to operational incidents*".<sup>170</sup>

204 Unfortunately, this arrangement was discontinued in December 2021, "*as the necessity for paramedics to be carrying on-road duties is currently of a higher priority*".<sup>171</sup>

### ***IAU investigations***

205 There is considerable merit in having subject police officers compulsorily interviewed by the IAU for investigations involving a death that may be the subject of an inquest under section 22(1)(c) of the Act.

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<sup>169</sup> Exhibit 1, Volume 1, Tab 37, Report of Associate Professor Paul Bailey dated 23 May 2022, p.5

<sup>170</sup> Exhibit 3, Memorandum dated 30 May 2022 from Superintendent Martin Haime, State Communications Divisions, p.2

<sup>171</sup> Exhibit 1, Volume 1, Tab 37, Report of Associate Professor Paul Bailey dated 23 May 2022, p.5

206 As already outlined above, the current policy, which was adopted by the IAU since Roderick's death, is that such interviews will take place, unless there are exceptional reasons not to do so.<sup>172</sup>

207 The practice of IAU reports being co-signed by a more senior investigating officer caused some difficulty with respect to this inquest. Should that officer be called to give evidence at an inquest, they would find it difficult to answer many questions regarding the investigation. That is because they are not involved with the actual investigation. Detective Van Der Schoor experienced precisely that when he was called as a witness instead of Detective Cunningham, who was the investigator and author of the report.

208 It would seem that as a result of this inquest, the practice of a senior investigating officer co-signing IAU reports "*has ceased with immediate effect*".<sup>173</sup> Above the signature block of the senior investigating officer, the words, "*Reviewed and Approved by:*" will now be inserted.<sup>174</sup>

209 I endorse this change as it now clarifies that the role of the senior investigating officer is to review and approve the IAU report in a supervisory and oversight capacity, in contrast to the responsibilities of the investigating officer who is the actual author of the report.<sup>175</sup>

### ***Introduction of body worn cameras***

210 The WAPF commenced the introduction of body worn cameras (BWC) in June 2019. They were made available to all frontline officers, as well as selected specialist units. Deployment was completed in June 2020.<sup>176</sup> None of

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<sup>172</sup> Exhibit 7A, Letter from Mr Berson to Counsel Assisting dated 14 July 2022, p.2; ts 31.5.22 (Van Der Schoor), p.240

<sup>173</sup> Exhibit 7A, Letter from Mr Berson to Counsel Assisting dated 14 July 2022, p.3

<sup>174</sup> Exhibit 7A, Letter from Mr Berson to Counsel Assisting dated 14 July 2022, p.3

<sup>175</sup> Exhibit 7A, Letter from Mr Berson to Counsel Assisting dated 14 July 2022, p.3

<sup>176</sup> Exhibit 1, Volume 2, Tab 39, Annexure D.1, p.217

the four police officers involved in the restraint of Roderick had been equipped with BWC at the time.<sup>177</sup>

211 Standard operating procedures for BWC include the use of a buffering mode that enables the recording and caching of 30 seconds of video prior to deliberate camera activation.<sup>178</sup> I fully agree with the observation that the use of BWC will “*assist in providing transparency and accountability*”.<sup>179</sup>

212 The vision and audio from BWC will become invaluable at inquests as it will provide independent evidence of the incident. BWC has already being used to enhance WAPF training.<sup>180</sup>

### POTENTIAL RECOMMENDATIONS

213 I extend my thanks to Mr Crocker, counsel for Roderick’s sister, for providing a written list of suggested recommendations at the conclusion of the inquest. I have carefully considered those and, as outlined below, I have incorporated several of those suggestions into the recommendations I have made.<sup>181</sup> As to the balance, one of these suggestions has been the subject of a recommendation in another inquest and has already been put into effect by the WAPF<sup>182</sup> and with respect to the remaining suggestions,<sup>183</sup> I am satisfied that the measures currently in place are sufficiently adequate to address the matters they raised.

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<sup>177</sup> ts 30.5.22 (Colic), p.57

<sup>178</sup> Exhibit 1, Volume 2, Tab 39, Annexure D.1, p.217

<sup>179</sup> Exhibit 1, Volume 2, Tab 39, Annexure D.1, p.217

<sup>180</sup> ts 1.6.22 (Markham), p.284

<sup>181</sup> Suggested recommendations 2, 4.3, 4.6 and 6

<sup>182</sup> Suggested recommendation 1

<sup>183</sup> Suggested recommendations 3, 4.1, 4.2, 4.4, 4.5 and 5

*Returning the rostering of two SJA paramedics at POC*

214 I have already referred to the rostering of two paramedics from SJA at POC in 2021 (the POC roster). This arrangement was continued until the end of that year. From all accounts, that trial was very successful.

215 I have carefully considered whether I should make a recommendation that the POC roster be reintroduced. Notwithstanding its benefits, I have decided not to. In doing so, I have had regard to the submissions of Mr Pontre, counsel for SJA, at the inquest. He outlined that there were two reasons why SJA did not support a recommendation for the reintroduction of the POC roster.

216 The first reason was the need for developing the liaison process between the WAPF and SJA that led to the introduction of the POC roster had already led to improvements. Since the discontinuing of the POC roster, the liaison process was being continued by other means; such as high level meetings between the two agencies, further material being distributed through the agencies and each agency's ongoing specific training.<sup>184</sup> I am satisfied that the WAPF and SJA are committed to an ongoing liaison process.

217 The second reason was resourcing considerations. As submitted by Mr Pontre, the evidence from Associate Professor Bailey was that "*other operational matters take a higher institutional priority at present, and that is particularly so in light of paramedic shortages due to the COVID pandemic*".<sup>185</sup> There is merit to Mr Pontre's submission that there is now "*a question as to whether or not at a certain point the benefits that run from such a project are outweighed by the costs of it in other areas*".<sup>186</sup>

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<sup>184</sup> ts 2.6.22 (Mr Pontre), p.404

<sup>185</sup> ts 2.6.22 (Mr Pontre), p.404

<sup>186</sup> ts 2.6.22 (Mr Pontre), p.405

*WAPF training with respect to positional asphyxia*

218 The manner in which the four police officers in this matter restrained Roderick was appropriate at all times. They ensured minimal pressure was applied to his back area, and they monitored his breathing. Their restraint of Roderick contrasts sharply with the restraint of another person by four police officers six months earlier, and which was the subject of an inquest before me in 2021.

219 That other person was Ms Wynne. She was restrained in the prone position by one officer applying a leg hold across her upper back and with no officer monitoring her breathing.<sup>187</sup> The first part of my recommendation from that inquest was that WAPF training needed to reinforce the increased risk of a fatal health event occurring to a person in the prone position and the need for officers to effectively monitor the person's breathing.<sup>188</sup>

220 I accept Mr Markham's evidence that there now is, "*specific reference to excited delirium and positional asphyxia over and above the training that we had prior to [the inquests into the deaths of] Riley and Wynne*".<sup>189</sup>

221 Nevertheless, I remain concerned that training with respect to the restraint of a person in the prone position still provides that: [REDACTED]

[REDACTED]

.<sup>190</sup>

222 It therefore appears that the second part of my recommendation in *Inquest into the death of Cherdeena Shaye Wynne* [2022] WACOR 21 has not been implemented. That part of the recommendation read:<sup>191</sup>

<sup>187</sup> *Inquest into the death of Cherdeena Shaye Wynne* [2021] WACOR 21 delivered on 1 April 2022

<sup>188</sup> *Inquest into the death of Cherdeena Shaye Wynne* [2021] WACOR 21 delivered on 1 April 2022, p.95

<sup>189</sup> ts 1.6.22 (Markham), p.284

<sup>190</sup> Exhibit 1, Volume 2, Tab 39, Annexure D.5, Use of Force – Contemporary Issues and Trends, p.245

<sup>191</sup> *Inquest into the death of Cherdeena Shaye Wynne* [2022] WACOR 21 delivered on 1 April 2022, p.95

Further, such training should emphasise that any physical restraint by pressing down on the chest, back or stomach of the subject person in the prone position should only be used in exceptional circumstances.

223 When I raised this at Roderick’s inquest, Mr Markham gave the following explanation as to why WAPF training continues to include a reference to a restraint in this manner of someone in the prone position:<sup>192</sup>

The reason that’s in there, your Honour, is that in the initial physical restraint to apply handcuffs, that rolling around on the floor, which is what will happen in a dynamic use of force situation, it’s unavoidable that the officers will at some point potentially use – put downward pressure on a subject’s back, chest, abdomen.

224 By his use of the word “*potentially*”, Mr Markham’s evidence is not that it would always be the case that an application of downward force to the back, chest or stomach would be required to place handcuffs on a person in the prone position. Nevertheless, I am troubled by the present wording in WAPF training manuals that [REDACTED]

[REDACTED]

225 Unlike Mr Markham’s example of when a downward force to the back, chest or stomach may potentially be necessary, the restraint of Ms Wynne involving a police officer’s leg hold across her upper back was maintained after she had been handcuffed. I found this to be unnecessary and inappropriate once Ms Wynne had dropped a suspected dangerous item she was holding.<sup>193</sup>

226 Although the restraint of Roderick by police to his upper body was appropriately confined to the temporary pressure by one officer to Roderick’s

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<sup>192</sup> ts 1.6.22 (Markham), p.288

<sup>193</sup> *Inquest into the death of Cherdeena Shaye Wynne* [2021] WACOR 21 delivered on 1 April 2022, p.75

shoulder blades only, the restraint of Ms Wynne is a clear example of the dangerous practice of applying downward force to a person's back when it was not necessary. It is my firm view that police officers should be trained that this application of force to someone in the prone position ought to be strictly limited.

***Indicators that are identical for excited delirium and positional asphyxia***

227 One difficulty police officers face when restraining a person with excited delirium in the prone position is the indicators that the person may be exhibiting due to positional asphyxia may also apply to excited delirium. One indicator of positional asphyxia is jerking limbs, and resistance is a common indicator for excited delirium.<sup>194</sup> After raising this at the inquest, Mr Berson, counsel for the WAPF, asked Mr Markham:<sup>195</sup>

How are police officers to determine the difference between the two? --- That's [a] very good question, and that's going to be down to the individual officer at the time and their interpretation of the actions of the subject and whether they perceive that to be a physical threat and an assaultive action as opposed to limbs just flailing, because of the manic behaviour associated with ED and PA.

228 Mr Markham then agreed the same problem exists with increased body temperature, as that is an indicator for positional asphyxia as well as for excited delirium.<sup>196</sup> Mr Markham also agreed the officers involved in the restraint of Roderick attributed the fact he was sweating to excited delirium, rather than positional asphyxia.<sup>197</sup> Mr Markham then volunteered this was something that could be, "*reinforced in the training going forward*".<sup>198</sup>

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<sup>194</sup> Exhibit 1, Volume 2, Tab 39, Annexure C.12, Positional Asphyxia and Excited Delirium – Factsheet for Instructors, p.1

<sup>195</sup> ts 1.6.22 (Markham), p.328

<sup>196</sup> ts 1.6.22 (Markham), p.328

<sup>197</sup> ts 1.6.22 (Markham), p.328

<sup>198</sup> ts 1.6.22 (Markham), p.328

229 I agree with Mr Markham and am therefore of the view that a recommendation regarding the reinforcing of these matters in police training is appropriate.

*Fast strap leg restraints*

230 In October 2019, the only way WAPF officers had been trained to restrain a person's legs was [REDACTED]

231 Since Roderick's death, the WAPF has trialled the use of fast strap leg restraints (FSLR). Such a restraint involves the use of webbing straps with Velcro fasteners that are applied above the knees and above the ankles of the person being restrained. As explained by Mr Markham at the inquest:<sup>199</sup>

The use of fast straps: they're fast; they're effective; they're safe.

...

They involve the use of two straps, two restraints, one goes around the top of the leg, one goes around the lower legs, so they compromise the mobility of a subject, prevent them from kicking, and prevent them from standing up. They're very quickly applied because they work on a Velcro hook and loop system. They're 1.2 metres long, and it's basically a case of just wrapping them around the subject's legs.

[REDACTED]

...

[REDACTED]

...

And, similarly, they can be quickly removed in a case of a medical emergency. But the trial that has been conducted has indicated that they are successful. We've – as a result of their use, we've not had any injuries to the subjects that they've been applied to, or to the officers that have actually used the fast strap leg restraints as an application of force.

<sup>199</sup> ts 1.6.22 (Markham), pp.277-278

232 Had FSLR been available to the police officers who restrained Roderick, the likelihood of him being in the prone position for the length of time that he was may have lessened. As Mr Markham explained:<sup>200</sup>

And certainly once the other officers have arrived and we've got four officers, then there is the potential that with Roderick's legs restrained in fast strap leg restraints, thereby negating or mitigating the risk of him being able to kick out at the officers, he could have been turned on his side and actually restrained in the recovery position. And obviously in doing that, that would have optimised his breathing and would have assisted with mitigating the risks of positional asphyxia.

233 A recommendation that the WAPF make FSLR available to its officers, and provide the necessary training to use them, has already been made by Coroner Jenkin in an inquest last year which involved the death of a man who had been restrained by police in the prone position.<sup>201</sup> I fully agree with that recommendation. In the words of Coroner Jenkin, this device "*appears to offer a simple and cheap option to effectively restrain combative offenders*".<sup>202</sup>

234 The court was advised that the availability for all operational police officers to be provided with FSLR was to be considered by the WAPF Corporate Board (the Board) on 27 July 2022. The court asked counsel for the WAPF to advise the court of the Board's decision.

235 By email dated 5 August 2022, counsel for the WAPF advised that there was "*a change of process*" following the appointment of the new Commissioner of Police and that matters ordinarily presented to the Board's monthly meetings "*are still being progressed out of sessions*".<sup>203</sup> Nevertheless, the email stated

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<sup>200</sup> ts 1.6.22 (Markham), p.278

<sup>201</sup> Recommendation No. 3 in *Inquest into the death of Chad Riley* [2021] WACOR 24 delivered on 30 July 2021:

"As soon as practicable, and assuming the trial currently underway is positive, the Western Australian Police Force should consider making fast strap leg restraints widely available to police officers and should provide training as to the appropriate use of these devices."

<sup>202</sup> *Inquest into the death of Chad Riley* [2021] WACOR 24 delivered on 30 July 2021, p.61

<sup>203</sup> Email from Ms Bultitude-Paull to Ms MacDonald dated 5 August 2022

that the counsel's instructors anticipated an outcome "*on or by 10 August 2022*".<sup>204</sup>

236 However, by email dated 15 August 2022, counsel for the WAPF advised that a decision "*has not been finalised*" and the WAPF would now not be able to provide a timeframe for the decision.<sup>205</sup>

### COMMENTS RELATING TO THE RECOMMENDATIONS

237 It is my practice to forward a draft of any recommendations I intend making to an interested party affected by the recommendations and invite comment.

238 The draft of my proposed recommendations relating to WAPF training and positional asphyxia were forwarded by email to counsel for the WAPF on 2 August 2022. The WAPF was invited to provide a response to those proposed recommendations by 16 August 2022.<sup>206</sup>

239 That response was provided by Ms Bultitude-Paull, counsel for the WAPF, in an email dated 15 August 2022.

#### *WAPF training with respect to positional asphyxia*

240 My proposed recommendation regarding the application of downward force to a person's back, chest or stomach who is in the prone position, required amendments to WAPF training materials with respect to Empty Hand Tactics and Handcuffing. Those amendments included the insertion of the following paragraph:

The restraint of a subject in the prone position should always avoid the application of downward force directly to the subject's back, chest or stomach. A restraint in that manner should only be used in exceptional circumstances by one officer, and only for the purpose of applying handcuffs. It should immediately cease once police have gained control of the subject.

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<sup>204</sup> Email from Ms Bultitude-Paull to Ms MacDonald dated 5 August 2022

<sup>205</sup> Email from Ms Bultitude-Paull to Ms MacDonald dated 15 August 2022, p.1

<sup>206</sup> Legal representatives for the other interested parties were also provided with the draft recommendations.

241 Ms Bultitude-Paull advised that the WAPF did not endorse this recommendation for two reasons. First, the WAPF cannot use prescriptive language for the use of Empty Hand Tactics in dynamic and unpredictable situations. Consequently, the WAPF was of the view that, “*directing officers to have only one officer able to apply downward force is too prescriptive to be appropriate in all the circumstances that may arise*”.<sup>207</sup>

242 Second, the phrase “exceptional circumstances” was intentionally removed from Use of Force policy and training in 2013 as it was “*too subjective and did not provide clear guidance to officers who were needing to make, on occasion, instantaneous decisions in circumstances which were, by their nature, almost always exceptional*”.<sup>208</sup>

243 The reasons the WAPF have put forward as to why it does not support this proposed recommendation are confined to discrete parts of it. I remain firm in my view that WAPF training for its cadets and operational officers must emphasise that the application of downward force upon the back, chest or stomach of a person in the prone position should only be used very sparingly. Although the four police officers who restrained Roderick were aware of that, one of the police officers involved in the restraint of Ms Wynne was not, having testified at that inquest that he had applied the leg hold he had on the upper back of Ms Wynne “*many times*” on males and females.<sup>209</sup>

244 I remain far from convinced that the present wording in WAPF training materials adequately addresses the need to avoid this application of downward force, which is medically recognised as increasing the risk of positional asphyxia. As Dr Clive Cooke, the most experienced forensic pathologist in

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<sup>207</sup> Email from Ms Bultitude-Paull to Ms MacDonald dated 15 August 2022, p.1

<sup>208</sup> Email from Ms Bultitude-Paull to Ms MacDonald dated 15 August 2022, p.1

<sup>209</sup> *Inquest into the death of Cherdeena Shaye Wynne* [2021] WACOR 21 delivered on 1 April 2022, p.95

Western Australia, testified last year at the *Inquest into the death of Chad Riley* [2021] WACOR 24.<sup>210</sup>

One of the really important things with the prone position seems to be avoiding any weight on the back of the chest and the back of the abdomen because that will make a risk of harm such as sudden death much worse.

245 I have amended the original version of my recommendation to take into account the two matters raised by the WAPF. I have subsequently (i) deleted the reference that only one police officer should apply the downward application of force upon the back, chest or stomach and (ii) deleted the reference that this application of force is only to be used in “exceptional circumstances”.

246 Notwithstanding these changes, if the recommendation is still considered to be overly prescriptive by the WAPF, then I sincerely hope the bigger picture is taken into account; namely, this recommendation is designed to reduce the risk of persons dying from positional asphyxia when restrained by police.

***Indicators that are identical for excited delirium and positional asphyxia***

247 My second intended recommendation related to the reinforcing of WAPF training concerning two indicators for positional asphyxia that are the same for excited delirium. The draft wording of this recommendation read:

The WAPF should ensure that training in relation to the indicators of positional asphyxia reinforces that evidence of struggling and/or sweating by the restrained person may be due to positional asphyxia and not excited delirium.

248 Ms Bultitude-Paull’s instructions from the WAPF was that it did not oppose the recommendation as it related to “struggling”.<sup>211</sup> However, that part relating to “sweating” was not endorsed. It was submitted WAPF training materials already include a reference to “*rapidly escalating body*

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<sup>210</sup> *Inquest into the death of Chad Riley* [2021] WACOR 24 delivered on 30 July 2021, p.35

<sup>211</sup> Email from Ms Bultitude-Paull to Ms MacDonald dated 15 August 2022, p.1

*temperature*” as an indicator of positional asphyxia and that the WAPF “*is unaware of any medical reference which indicates that sweating, of itself, is a symptom of positional asphyxia*”.<sup>212</sup>

249 My use of the word “sweating” in my intended recommendation was in the context that it is a well-recognised symptom of an escalating body temperature, and that “*increased body temperature*” is also cited as an indicator of excited delirium in WAPF training materials.<sup>213</sup>

250 I remain concerned that the police who restrained Roderick assumed his high body temperature was due to his excited delirium, and that no consideration was apparently given to it being due to positional asphyxia. Although it would appear this assumption was correctly made in Roderick’s case, there may be other occasions when a person’s high body temperature during their restraint is due to positional asphyxia or a combination of positional asphyxia and excited delirium.

251 I will delete the reference to “sweating” in my recommendation and, to maintain consistency, replace it with the phrase used in current WAPF training materials. I should also emphasise that I accept current training does correctly identify the various indicators of positional asphyxia and excited delirium. The purpose of this recommendation is for training to reinforce there are two indicators for positional asphyxia that are also common indicators for excited delirium.

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<sup>212</sup> Email from Ms Bultitude-Paull to Ms MacDonald dated 15 August 2022, p.1

<sup>213</sup> Exhibit 1, Volume 2, Tab 39, Annexure C.10, Excited Delirium and Positional Asphyxia CS1 and CS2 Theory PowerPoints – June 2013, p.171

*Fast strap leg restraints*

252 As outlined above, the WAPF has not reached a final decision regarding the introduction of FSLR for its operational officers. On behalf of the WAPF, Ms Bultitude-Paull submitted:<sup>214</sup>

In lieu of a decision, WAPF appreciates Coroner Urquhart may be minded to make a recommendation in relation to fast strap leg restraints. If he proposes to do so, WAPF would appreciate the opportunity to consider any such recommendation before it is finalised.

253 I am minded to make such a recommendation. However, I am not minded to delay the handing down of this finding so that the WAPF can further consider the recommendation.

254 The main reason for that is because I am going to make a very similar recommendation to the one Coroner Jenkin has already made in *Inquest into the death of Chad Riley* [2021] WACOR 24 delivered on 30 July 2021.

255 Before that inquest's finding was delivered, the WAPF and other interested parties were invited by Coroner Jenkin to comment with respect to that recommendation (together with five other recommendations).<sup>215</sup> The responses from counsel for WAPF and lawyers for the other interested parties were "*broadly supportive of the proposed recommendations.*"<sup>216</sup>

256 Another reason is the strong endorsement for the introduction of FSLR by Mr Markham at the inquest.

257 Accordingly, I do not regard it is necessary to hear further submissions from the WAPF regarding this recommendation.

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<sup>214</sup> Email from Ms Bultitude-Paull to Ms MacDonald dated 15 August 2022, p.1

<sup>215</sup> *Inquest into the death of Chad Riley* [2021] WACOR 24 delivered on 30 July 2021, p.65

<sup>216</sup> *Inquest into the death of Chad Riley* [2021] WACOR 24 delivered on 30 July 2021, p.65

## RECOMMENDATIONS

### Recommendation No. 1

The following sentence currently appears in the WAPF Operational Safety and Tactics Training Unit Empty Hand Tactics and Handcuffing Training Manuals with respect to the use of a restraint of a subject in the prone position by police:



To reduce the danger of positional asphyxia to a subject in the prone position, that sentence should be replaced with the following:

*“The restraint of a subject in the prone position should always avoid the application of downward force directly to the subject’s back, chest or stomach. If such an application of downward force is required, it should only be used for the purpose of applying handcuffs. It should immediately cease once police have gained control of the subject.”*

### Recommendation No. 2

The WAPF should ensure that training in relation to the indicators of positional asphyxia reinforces that evidence of struggling and/or rapidly escalating body temperature by the restrained person may be due to positional asphyxia and not excited delirium.

### Recommendation No. 3

As soon as practicable, the WAPF should consider making fast strap leg restraints available to operational police officers and should provide training as to the appropriate use of these devices.

## CONCLUSION

258 After injecting a quantity of methylamphetamine at his home in Kewdale in the early hours of 27 October 2019, Roderick experienced an episode of excited/agitated delirium that was caused by his methylamphetamine intoxication. On the evidence before me, this was the first time he had had such an episode after using methylamphetamine.

259 The effects of excited delirium caused Roderick to become violent towards his partner, who had to be assisted by other occupants of the house to escape him. Due to Roderick's behaviour, police were called at 4.18 am.

260 When two police officers attended the address, they saw Roderick being restrained on his bed by two other occupants of the house. He was displaying great strength and refused calls to calm down. He was eventually handcuffed behind his back; however, he continued to resist. The two police officers kept Roderick restrained on his stomach on the bed and after correctly suspecting he was experiencing excited delirium, one of the officers placed a radio call for an ambulance to attend. The two officers were then assisted by another two police officers and the ambulance arrived at the address at 4.41 am.

261 Given his high temperature and ongoing erratic and violent behaviour, the two SJA officers concluded Roderick was experiencing a drug-induced psychosis. In accordance with SJA guidelines, 10 mg of midazolam was injected into Roderick's upper arm to sedate him so that he could be safely taken to hospital.

262 Within about 10 seconds after the injection, Roderick suddenly became limp due to a cardiac arrest. The handcuffs were removed and resuscitation efforts were commenced by the SJA officers and police. A back-up ambulance crew attended, and after 14 minutes of resuscitation, a pulse (ROSC) was detected.

263 At 5.27 am, an ambulance took Roderick to RPH. However, he was in a critical condition, having sustained severe damage to his brain and major body organs. Roderick never regained consciousness and remained on life support before it was ceased after consultation with his family. Roderick died on 30 October 2019 from multiple organ failure.

264 Although Roderick was restrained in the prone position for a considerable period of time, I have found this restraint was necessary to prevent him from committing further acts of violence due to his excited delirium, and to ensure that the safety of police, the occupants of the house, the SJA officers and Roderick himself was maintained.

265 I have also found that the four attending police officers complied with WAPF policy and procedures, their training and their duty of care towards Roderick at all times; particularly with respect to the calling of an ambulance, the monitoring of Roderick's breathing and avoiding unnecessary downward pressure on his back, chest and abdomen whilst he was restrained in the prone position. I am also satisfied the attending SJA officers complied with their training and their duty of care towards Roderick, and that the injection of midazolam did not cause or contribute to his cardiac arrest.

266 Unfortunately, it was Roderick's decision to inject methylamphetamine several hours before he was restrained that primarily contributed to his death. It led to an episode of excited delirium that caused him to behave in a violent and very physical manner for an extended period of time after he was restrained. His methylamphetamine intoxication led him to exert himself well beyond his physiological limits and those exertions only ceased when he went into cardiac arrest.

267 Although the four police officers involved in the restraint of Roderick complied with their training with respect to the risk of positional asphyxia when restraining someone, I am of the view that WAPF training can be further improved in this area. I have therefore made two recommendations which I believe will further enhance the training of police in this important area.

268 I have also made a recommendation for the introduction of FSLR for operational police officers. The inquest heard evidence that a trial regarding their use has recently been completed and had been deemed a success.

269 I commend Roderick's family for the dignified manner in which they have conducted themselves since Roderick's death and at the inquest. In doing so, they have honoured his memory. I also thank the family for the letter I received, and which was read out by one of their counsel on the last day of the inquest. Included in that letter was the following:<sup>217</sup>

Roderick was a proud Noongar man; proud of himself, and happy to be who he was.

Our lives will never be the same without him.

As a family, we believe that Roderick Narrier stands for PEACE, no racism and for all to get along for the future.

270 I extend my condolences to the family of Roderick, particularly his four children, for their sad loss.

PJ Urquhart  
Coroner  
22 August 2022

<sup>217</sup> Exhibit 4, Statement of Roderick's family