JURISDICTION	**:**	CORONER'S COURT OF WESTERN AUSTRALIA
ACT	**:**	CORONERS ACT 1996
CORONER	**:**	MICHAEL ANDREW GLIDDON JENKIN
HEARD	**:**	30 NOVEMBER 2020, 25 MAY - 1 JUNE 2021
DELIVERED	**:**	30 JULY 2021
FILE NO/S	**:**	CORC 658 of 2017
DECEASED	**:**	RILEY, CHAD

Catchwords:

Nil

Legislation:

Coroners Act 1996 (WA)
Criminal Code (WA)
Mental Health Act 2014 (WA)

Counsel Appearing:

Ms R Collins (30 November 2020); and Ms R Collins and Ms M James (25 May - 1 June 2021) appeared to assist the coroner.

Ms A Barter and Ms E Langoulant (30 November 2020); and Mr G McIntyre SC and Mr J Higgins (25 May - 1 June 2021), [Aboriginal Legal Service of Western Australia (Ltd.)] appeared for members of Mr Riley's family.

Ms R Panetta (30 November 2020); and Mr D Harwood and Mr L Geddes (25 May - 1 June 2021), (State Solicitor's Office) appeared on behalf of the East Metropolitan Health Service and the Western Australia Police Force.

Coroners Act 1996
(Section 26(1))

RECORD OF INVESTIGATION INTO DEATH

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Chad RILEY*** *with an inquest held at Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth, on 30 November 2020 and 25 May 2021 - 1 June 2021, find that the identity of the deceased person was* ***Chad RILEY*** *and that death occurred on 12 May 2017 at Royal Perth Hospital and was consistent with cardiac arrhythmia following violent exertion necessitating physical restraint in a man with methylamphetamine effect, known systemic hypertension and morbid obesity, in the following circumstances:*

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SUPPRESSION ORDERS

After considering applications from Mr David Harwood, counsel for the Western Australian Police Force (Police) and the East Metropolitan Health Service (EMHS), I was persuaded that it would be appropriate to make the following orders:

SUPPRESSION ORDER NO. 1

On the basis that it would be contrary to the public interest I make an Order under section 49(1)(b) of the *Coroners Act 1996* (WA) 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, including, but not limited to, firearms and/or Tasers.

Order made by: MAG Jenkin, Coroner (25.05.21)

SUPPRESSION ORDER NO. 2

On the basis that it would be contrary to the public interest I make an Order under section 49(1)(b) of the *Coroners Act 1996* (WA) that: There be no reporting or publication of the documents referred to as "Additional Information for the State Coroner - Taser X26P CEW Smart Probe Update" and "Additional Information for the State Coroner - 'Fastrap' Leg Restraints Update" respectively, or of the information contained in either of those documents.

Order made by: MAG Jenkin, Coroner (28.05.21)

INTRODUCTION

1. Chad Riley (Mr Riley) was 39-years of age when he died on 12 May 2017. His death was consistent with cardiac arrhythmia following violent exertion necessitating physical restraint in a man with methylamphetamine effect, known systemic hypertension and morbid obesity.

2. Immediately before his death, Mr Riley had been behaving strangely outside the premises of Officeworks on Lord Street in East Perth (Officeworks). He was spoken to by two members of the Police who were at Officeworks to investigate an unrelated robbery. Mr Riley appeared to be having some sort of mental health crisis and one of the officers called for an ambulance.

3. As the officers tried to engage with Mr Riley, he suddenly stood up and threatened to kill them before lunging towards them. One of the officers activated his Taser which caused Mr Riley to fall to the ground. The other officer ran forward to apply handcuffs but Mr Riley began struggling violently. At some point, Mr Riley began trying to grasp the officer's firearm and bit into the officer's arm. Despite repeated warnings, Mr Riley continued to struggle and additional Taser activations failed to subdue him.

4. One of the officers was able to call for urgent backup and other police officers attended to assist in restraining Mr Riley. Ambulance officers arrived and as they were treating Mr Riley, he suddenly stopped breathing. CPR was commenced and Mr Riley was taken to Royal Perth Hospital (RPH) by ambulance, but he could not be revived. He was declared deceased at 12.56 pm on 12 May 2017.[1]

5. Pursuant to the Coroners Act, Mr Riley's death is a "*reportable death*".[2] Further, because his death may have been caused or contributed to by a member of the Police, a coronial inquest was mandatory.[3]

6. In the coronial context the issue of causation is to be determined in a common-sense manner. Further, to have contributed to death, a factor must have made a material contribution to the death.

[1] Exhibit 1, Vol. 1, Tab 4, RPH death in hospital form (12.05.17)
[2] Section 3, *Coroners Act 1996* (WA)
[3] Section 22(1)(b), *Coroners Act 1996* (WA)

7. Members of Mr Riley's family attended the inquest into his death I held from 25 May 2021 to 1 June 2021. The documentary evidence tendered at the inquest comprised two volumes and the inquest focused on the cause of and circumstances surrounding Mr Riley's death and the causation issue I have referred to.

8. The following witnesses gave evidence at the inquest:

a. Detective Sergeant Brett Fowler (Homicide Squad);
b. First Class Constable Paul Reemeijer (attending police officer);
c. Sergeant Andrew Unsworth (attending police officer);
d. Dr Heidi Wade (East Metropolitan Health Service);
e. Mr John Barber (civilian witness);
f. First Class Constable Rory Winterburn (attending police officer);
g. First Class Constable James Wolfe (attending police officer);
h. Senior Constable Jason Savage (attending police officer);
i. First Class Constable Anton Bongers (attending police officer);
j. First Class Constable Les Turner (attending police officer);
k. First Class Constable Nikky Eather (attending police officer);
l. First Class Constable Nikolas Wakely (attending police officer);
m. Senior Constable Nathan Prendergast (attending police officer);
n. Senior Constable Mark Kimber (attending police officer);
o. First Class Constable Reece Neville (attending police officer);
p. First Class Constable Joel Grant (attending police officer);
q. First Class Constable Gregg Robson (attending police officer);
r. Sergeant Tiffany McAlinden (attending police officer);
s. Dr Clive Cooke (Forensic Pathologist);
t. Dr Jeffrey Ho (Medical Director, Axon Enterprise, Inc.);
u. Senior Constable Laura Sawyer (attending police officer);
v Detective Senior Sergeant Adrian Richards (Internal Affairs Unit);
w. Mr Chris Markham (expert on Tasers);
x. Mr Jason Van Den Esschert (expert on use of force options);
y. Dr Johan Janssen (Cardiologist); and
z. Professor David Joyce (Physician and Clinical Toxicologist).

9. The ranks of police officers shown above are the ranks held by those officers at the time of the inquest. For ease of reference, police officers (regardless of rank) are referred to in this finding using the format "*Officer Surname*". No disrespect is intended.

MR RILEY

Background[4,5,6]

10. Mr Riley was born in Perth on 7 December 1977 and was the second youngest of six children. As a young man, he was a talented volleyball player and was selected as a member of the State team. He and his ex-partner had six children and had lived in several suburbs including Balga. They also lived in Collie and Broome before moving to Victoria for 12 months in 2012. On returning to Western Australia, Mr Riley and his family lived in Merredin, but he and his partner separated in 2015.

11. Between 1999 and 2016, Mr Riley accumulated 35 convictions for various offences including assault. In March 2016, he was sentenced to a term of nine months imprisonment following convictions for assaulting a public officer.

12. Whilst Mr Riley was in custody, his ex-partner moved interstate with five of their six children. Their sixth child, a son, remained in Northam with relatives. Following his release from prison in December 2016, Mr Riley lived at Coodanup in a house owned by a family member.

13. At around this time Mr Riley was maintaining close contact with his mother. She was living in Broome and was certain that Mr Riley was abstaining from illicit drugs. In the weeks before his death, Mr Riley told his mother he was experiencing back pain and this was limiting his movements. During her phone conversations with him, she thought Mr Riley seemed lonely and depressed. She asked Mr Riley to come to Broome to live with her, but he had declined saying he didn't want to move further away from his son in Northam, who he visited on a weekly basis.

14. Mr Riley's mother spoke with him by phone on 10 May 2017. He didn't seem himself and was slurring his words as if "*he was on something*". When she spoke with him again on 11 May 2017, he was also slurring his words and he referred to an incident with his brother which had occurred some time ago. His mother thought was strange.

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[4] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), pp1-2
[5] Exhibit 1, Vol. 1, Tab 17, Statement - Ms M Ugle, paras 18.54 & 66-89
[6] Exhibit 4, Letter to the Court - Ms M Ugle (received 01.06.21)

Medical and mental health history[7,8,9]

15. Mr Riley's medical history included: high blood pressure, high cholesterol, morbid obesity (BMI = 43.7), depression and gastro-oesophageal reflux disorder. Post mortem toxicological analysis showed that at the time of his death, Mr Riley was taking amitriptyline (an anti-depressant), telmisartan (used to treat high blood pressure) and tramadol (a pain relief medication).[10] Mr Riley also had a known history of polysubstance use, including alcohol and methylamphetamine.

16. Mr Riley presented to RPH with chest pain twice in 2005 and did so again in 2007 and 2009, and on three occasions in 2010. He also presented to Broome Hospital on three occasions in 2014, Sir Charles Gairdner Hospital in 2015 and Peel Health Campus in 2017. During several of these presentations, Mr Riley disclosed using methylamphetamine before the onset of chest pain. A number of echocardiographs (ECG) showed changes which may have been related to a methylamphetamine-induced coronary spasm.

17. In 2007 and 2008, Mr Riley had multiple contacts with a community mental health service in relation to his methylamphetamine use. Identified issues included: paranoid thoughts; insomnia and anxiety; relationship issues and financial stressors. Treatment included short-term antipsychotic/anxiety medication and follow up from Mr Riley's GP. No significant suicidal or self-harm risks were identified at any of these reviews.[11]

18. On 22 December 2015, Mr Riley was taken to Fiona Stanley Hospital (FSH) from Hakea Prison and diagnosed with drug-induced psychosis. Urine testing confirmed that he was intoxicated with methylamphetamine. The St John Ambulance patient care record describes physical conflict, self-harm and the use of a Taser and it appears that Mr Riley behaved in a violent and irrational manner and had to be restrained by several security officers. Mr Riley presented to FSH again on 25 February 2017, with a further episode of methylamphetamine-induced psychiatric disorder.

[7] Mr Riley's RPH Medical records (G5357193)
[8] Exhibit 1, Vol. 2, Tab 15A, Report - Dr J Janssen (18.11.20), p1
[9] Exhibit 1, Vol. 2, Tab 17, Report - Prof. D Joyce (19.04.21), pp3-4 and ts 01.06.21 (Joyce), pp424-425
[10] Exhibit 1, Vol. 1, Tab 6, ChemCentre toxicology report (25.05.17)
[11] Exhibit 1, Vol. 1, Tab 23, Report - Dr A Jaworska (19.05.20), pp1-2

Family statements

19. At the inquest, Mr Greg McIntyre, counsel for Mr Riley's family, handed up a folder containing photographs and statements from Mr Riley's mother and one of Mr Riley's sisters. On the basis of that material, it is quite clear that Mr Riley was a dearly loved son, brother, father and uncle. His sister described him in these terms:

> He was just a big, gentle person with a gentle soul. His personality was caring, funny, outgoing, loving, considerate to all but yet as a quiet person, not a loud person. Never the kind to start trouble with anyone, he was the opposite, very respectful to everyone. He never put himself first, always his children and family.[12]

20. Mr Riley was a very community minded person who was house-proud and had a wide circle of friends. He enjoyed boxing and fishing as well as spending time with his friends and family, to whom he was devoted. As Mr Riley's sister noted:

> I would call him for some advice for anything. He would always have the right advice and make me feel better…we used to send pics of our meals we made, see who cooked the best dishes, those moments are also missed. It's been a long emotional sad four years, where he is missed every day by his children, my mother, nieces, nephews, myself and other family and friends.[13]

21. In a moving tribute to her beloved son, Mr Riley's mother made the following remarks at his funeral:

> My Baby Son: My tears are falling son as I write this eulogy. I never thought this day would come to lay another child to rest. Words can't describe how much my heart is broken. I love you forever my son, I will always miss your smiling face and hearing your voice. You are now at peace with your sister, father, aunties, uncles, nans and pops. Until we meet again, may you Rest in Peace my beautiful son.[14]

[12] Exhibit 4, Letter to the Court - Ms C Riley (received 31.05.21)
[13] Exhibit 4, Letter to the Court - Ms C Riley (received 31.05.21)
[14] Exhibit 4, Letter to the Court - Ms M Ugle (received 31.05.21)

THE EVENTS OF 11 MAY 2017[15,16,17,18,19]

Reports of erratic driving

22. At about 10.05 pm on 11 May 2017, the Police received a report that a man in a dark blue Commodore (the Commodore) was driving erratically on Mounts Bay Road in Perth. The man had also stopped his vehicle in the entrance to a carpark on Mounts Bay Road and been seen wandering around whist yelling out, crying and talking to himself.

23. Officers Unsworth, Reemeijer and Coleman (the Officers) were tasked with conducting a patrol in the area but were unable to locate the Commodore. A short time later, another police patrol saw a vehicle driving erratically on the eastbound on/off ramp for the Graham Farmer Freeway between Lord Street and East Parade in East Perth.

24. That vehicle, which matched the description of the Commodore, was apprehended and the Officers attended the scene. When Mr Riley was subsequently asked if he had been driving on Mounts Bay Road, he shrugged and shook his head "*like he didn't know if he was down there or not*".[20] Nevertheless, in my view it does appear that Mr Riley was the driver of the Commodore seen earlier on Mounts Bay Road.

25. In any event, Officer Unsworth approached the driver of the Commodore (who was later identified as Mr Riley), and tried to speak with him. Mr Riley began to shout and swear in an incoherent manner and at one stage, asked to be taken to prison. When told he had not been charged with anything and would not be going to prison, Mr Riley appeared to calm down. He was subjected to a roadside breath test for alcohol, which was negative.

26. Mr Riley began acting aggressively again and was shouting and waving his arms about. He tried to get out of his vehicle and the Officers became concerned that he may be affected by illicit drugs. Attempts were made to arrange for a police vehicle with a drug test kit to attend the scene, but no suitable vehicles were available.

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[15] Exhibit 1, Vol. 1, Tab 18, Report - Const. P Reemeijer, pp1-3 and ts 25.05.21 (Reemeijer), pp29-33 & 45-46
[16] Exhibit 1, Vol. 1, Tab 19, Report - Sgt. A Unsworth, pp1-2 and ts 25.05.21 (Unsworth), pp48-49, 57-58 & 60-61
[17] Exhibit 1, Vol. 1, Tab 20, Report - Prob. Const. Coleman, pp1-2
[18] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), pp2-4
[19] Exhibit 1, Vol. 2, Tab 19, Police Incident Report (LWP17051100348233 - 11.05.17)
[20] Exhibit 1, Vol. 1, Tab 21, Statement - SO'D (PWH nurse), para 32

27. Instead, another police vehicle arrived and Mr Riley was arrested. The plan was that he be taken to the Perth Watch House (PWH) for the purposes of a blood test for illicit drugs. Mr Riley was handcuffed before being removed from his vehicle with his hands in front of his body. In deciding to handcuff Mr Riley, the Officers considered his physical size, his erratic behaviour and the fact that his vehicle had been stopped in close proximity to the Graham Farmer Freeway.

28. The Officers were concerned that if Mr Riley exited his vehicle and ran towards traffic they would not be able to stop him. In addition, there was a warning on the police computer system in relation to Mr Riley to the effect of: "*may assault police*". In my view, based on the information that the Officers had available to them, their decision to handcuff Mr Riley was reasonable and was in accordance with relevant Police policies.

Attendance at Perth Watch House[21,22,23,24,25]

29. After his car had been moved to the East Perth train station carpark for safety Mr Riley was taken to the PWH. On the way, Officer Unsworth contacted the Mental Health Emergency Response Line (MHERL) and was advised that Mr Riley had a history of drug-induced psychosis relating to polysubstance use. During the trip to the PWH, Mr Riley was calm and compliant.

30. Mr Riley arrived at the PWH shortly after 11.00 pm and other than repeated "*heavy sighing*" he was compliant with instructions. He was taken to see the on-duty nurse and he cooperated with the taking of blood samples. Mr Riley's pulse and Glasgow Coma Score were within normal limits but after a discussion between the nurse and the Officers, and it was agreed that Mr Riley should be taken to RPH for assessment.

31. Analysis of the blood samples taken at the PWH subsequently confirmed that Mr Riley was intoxicated with methylamphetamine at the time he was apprehended by the Officers.[26,27]

[21] Exhibit 1, Vol. 1, Tab 18, Report - Const. P Reemeijer, p3 and ts 25.05.21 (Reemeijer), pp33-37 & 46
[22] Exhibit 1, Vol. 1, Tab 19, Report - Sgt. A Unsworth, pp2-3 and ts 25.05.21 (Unsworth), pp49-51 & 58-59
[23] Exhibit 1, Vol. 1, Tab 20, Report - Prob. Const. Coleman, p2
[24] Exhibit 1, Vol. 1, Tab 21, Statement - SO'D (PWH nurse), paras 4, 13-24, 30-38 & 46
[25] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), pp2-4
[26] Exhibit 1, Vol. 1, Tab 6, ChemCentre toxicology report (25.05.17)
[27] Exhibit 1, Vol. 2, Tab 17, Report - Prof. D Joyce (19.04.21), pp7-10 & 13 and ts 01.06.21 (Joyce), pp432-433

32. Shortly before leaving the PWH, Mr Riley seemed somewhat vague and had declined to give the Officers the address of a family member or friend he could be dropped off at. Officer Reemeijer asked Mr Riley if he wanted to go to hospital, and Mr Riley replied he: "*might want to speak to someone*".

33. By this stage, Mr Riley had been released unconditionally. His car keys had been returned and he had been told where his vehicle had been moved to. In any event, Mr Riley got into the passenger pod on the back of a police vehicle and shortly after midnight on 12 May 2017, was taken to RPH by the Officers.

EVENTS ON 12 MAY 2017 PRIOR TO MR RILEY'S DEATH

Attendance at RPH - 12 May 2017[28,29,30,31,32,33]

34. Mr Riley was seen by a triage nurse at 12.07 am on 12 May 2017 and given a triage score of "4", meaning he was to be seen within one hour.[34] The relevant entry in the Triage Assessment form states:

> Social/behavioural problem/psychiatric problem. Patient brought to ED by police as stated. Wanted to see psych team. Difficult to engage with AST triage. Appears to be having disordered thoughts. Not under arrest, no allergies. BAL = 0.00%.[35]

35. Observations taken at 12.15 am, show that Mr Riley's vital signs were mostly normal, although his pulse was elevated.[36] A doctor from the Psychiatric ED Liaison Team documented Mr Riley's known history of "*drug-induced behaviours*" and noted that he was not an active patient of any mental health service.[37] An entry by a nurse at 12.20 am, states that although Mr Riley said he wanted to talk to someone, he would not speak and was: "*[J]ust grunting to me an (sic) very agitated*".[38]

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[28] Exhibit 1, Vol. 1, Tab 23, Report - Dr A Jaworska (19.05.20)
[29] Exhibit 1, Vol. 1, Tab 24, Report - Dr H Wade (27.05.20)
[30] Exhibit 1, Vol. 1, Tab 18, Report - Const. P Reemeijer, pp3-4 and ts 25.05.21 (Reemeijer), pp37-43
[31] Exhibit 1, Vol. 1, Tab 19, Report - Sgt. A Unsworth, pp3-4 and ts 25.05.21 (Unsworth), pp51-56 & 61
[32] Exhibit 1, Vol. 1, Tab 20, Report - Prob. Const. Coleman, pp2-3
[33] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), pp3-6
[34] ts 25.05.21 (Wade), pp64-65
[35] Exhibit 1, Vol. 1, Tab 22B, RPH Adult Triage Nursing Assessment (12.07 am, 12.05.17)
[36] Exhibit 1, Vol. 1, Tab 22C, RPH ED Observations (12.15 am, 12.05.17)
[37] Exhibit 1, Vol. 1, Tab 22A-2, RPH PSOLIS entry (12.15 am, 12.05.17)
[38] Exhibit 1, Vol. 1, Tab 22C, RPH Secondary Assessment (12.20 am, 12.05.17)

36. Given Mr Riley's earlier request, it was decided to wait to see if he would speak with clinical staff. Although several doctors and nurses tried to engage with him, he declined to speak with them and after pushing some furniture around and "*making a lot of noise*", he walked out of the ED at about 12.47 am.

37. An entry in Mr Riley's RPH record at 12.50 am states: "*Patient polite but will not answer questions. States he would like to go home to sleep & left the department with the police"*.[39] When Mr Riley left the ED, he was listed in the RPH records as "*did not wait*", meaning that he was not assessed by a doctor in the ED.[40,41]

38. The Officers followed Mr Riley out of the ED and Officers Unsworth and Coleman spoke to him as he walked across the RPH driveway. Officer Coleman asked Mr Riley if he would like a lift anywhere or if there was anyone the Officers could call on his behalf, but Mr Riley did not reply. Meanwhile, Officer Reemeijer called Mr Riley's ex-partner's mobile and left a message and also tried calling Mr Riley's mother, but there was no response. A short time later, Mr Riley briefly returned to the ED before leaving again.

39. The Officers discussed the situation and assessed Mr Riley's risk of potential harm. They noted that he was walking calmly and steadily, was not sweating and that his breathing was calm and regular. His demeanour had not altered during the previous three hours and RPH staff had raised no immediate concerns about his welfare. Further, Mr Riley had made no threats to harm property, himself or anyone else. After considering these factors, the Officers determined that Mr Riley was at low risk of potential harm and that there was no basis to detain him under the *Mental Health Act 2014* (WA) (MHA) or otherwise.

40. The Officers again offered Mr Riley a lift but he declined and they watched him walk off in an easterly direction along Lord Street in East Perth. A short time later, Officer Reemeijer realised that Mr Riley had left his reading glasses behind and the Officers drove around to find him.

[39] Exhibit 1, Vol. 1, Tab 22A-2, RPH PSOLIS entry (12.50 am, 12.05.17)
[40] Exhibit 1, Vol. 1, Tab 22A-1, RPH PSOLIS entry (12.51 am, 12.05.17)
[41] Exhibit 1, Vol. 1, Tab 24, Report - Dr H Wade (27.05.20), pp1-2

41. The Officers eventually located Mr Riley walking south on Hill Street and gave him his glasses. Officer Reemeijer told Mr Riley that if he still wanted to talk to someone, he could return to RPH. Mr Riley's behaviour was unchanged, and this is the last time the Officers had any dealings with him.

42. CCTV footage from RPH shows Mr Riley entering the ED in the early hours of 12 May 2017,[42] on a further four occasions as follows:[43,44,45]

a. *1.52 am:* Mr Riley returns to the ED. The triage desk is not visible in this footage and it is unclear whether Mr Riley spoke to anyone before leaving the ED at 2.03 am and walking off towards Wellington Street;

b. *2.57 am:* Mr Riley returns to ED. The triage desk is not visible in this footage and it is unclear whether Mr Riley spoke to anyone before leaving the ED at 3.11 am;

c. 3.44 am: Mr Riley returns to ED. The triage desk is not visible in this footage and it is unclear whether Mr Riley spoke to anyone before leaving the ED again at 4.08 am. At 4.58 am, CCTV footage captures a male who appears to be Mr Riley, walking on a side street next to RPH; and

d. 7.17 am: Mr Riley returns to ED and sits on a chair in the Quick Assessment and Care area, which is not staffed at the time. Mr Riley is seen to leave the ED for the final time at 7.26 am.

43. Dr Heidi Wade (Dr Wade), an emergency physician at RPH, viewed the CCTV footage and stated that in her view, Mr Riley appeared to be alert, calm and cooperative (this latter comment being a reference to earlier footage that showed Mr Riley being spoken to by clinical staff). Despite Mr Riley's further attendances at the ED there is no evidence he received any treatment. At the inquest, Dr Wade noted that the triage desk in the ED was not always manned and that it was quite likely that Mr Riley's repeated attendances at the ED had gone unnoticed.[46]

[42] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), p5
[43] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), pp4-5
[44] Exhibit 1, Vol. 1, Tab 15B, Addendum Report - Det. Sgt. B Fowler (Homicide Squad), pp1-2
[45] Exhibit 1, Vol. 2, Tab 21, Report - Dr H Wade (25.05.21), pp1-2
[46] Exhibit 1, Vol. 2, Tab 21, Report - Dr H Wade (25.05.21), p2 and ts 25.05.21 (Wade), pp70-71

Observations of Mr Riley by RPH staff - 12 May 2017[47,48,49]

44. At about 6.50 am on 12 May 2017, several staff from RPH were on a break and went outside to the benches at the corner of Murray Street and Victoria Square for a cigarette. They saw a man (who they later identified from news reports as Mr Riley) walking up and down the footpath between Murray Street and the main entrance of RPH.

45. The RPH staff heard Mr Riley shout various things including:

> You know the cops are looking for me, you know they got warrants for me, and you know what it is…What did the police charge me with, what did they charge me with?...Cops are after me, why are the cops after me?

46. The RPH staff variously described Mr Riley as seemingly angry, agitated and upset and "*very paranoid and on edge*", as if *"he had mental health issues*". Two of the staff thought that Mr Riley might be affected by drugs and they did not engage with him because, as one of them put it, "*We've learnt to just ignore people like that so we don't get attacked*". Before Mr Riley walked off towards the entrance to RPH he shouted abuse at the staff and just before 7.00 am, they went back inside to resume their duties.

Observations by staff at K-Mart Tyre and Auto[50]

47. An employee of K-Mart Tyre and Auto (K-Mart Auto) was driving to work at about 8.00 am on 12 May 2017, when he noticed Mr Riley waking along Royal Street in East Perth. Mr Riley was walking as if in a trance and appeared to be either "*drug affected*" or "*mentally ill*".

48. Mr Riley was still walking up and down Royal Street at around 9.30 am. At about 10.15 am, he walked into the K-Mart Auto workshop where he was spoken to by the manager and escorted to the carpark. Mr Riley came back into the workshop a short while later and said words to the effect of "*I'm out of my mind*" or "*I'm losing my mind*". He was again escorted back to the carpark and was last seen walking off towards Officeworks which was located close-by.

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[47] Exhibit 1, Vol. 1, Tab 26, Statement - AG (RPH staff member 1), paras 4-37
[48] Exhibit 1, Vol. 1, Tab 27, Statement - RT (RPH staff member 2), paras 3-25
[49] Exhibit 1, Vol. 1, Tab 28, Statement - NG (RPH staff member 3), paras 2-16
[50] Exhibit 1, Vol. 1, Tab 16, Report - Det. Sgt. T Douglas & Det. Snr. Sgt A Richards (IAU), pp9-10

Attendance at Aboriginal Alcohol and Drug Service - 12 May 2017[51,52]

49. CCTV footage from the Aboriginal Alcohol and Drug Service (the Service), located in Royal Street in East Perth, shows Mr Riley entering the lobby area of the Service at 10.21 am on 12 May 2017. Mr Riley spoke to the receptionist and asked if he could talk to someone.

50. Mr Riley was asked to wait while the receptionist contacted the duty counsellor. However a short time later, Mr Riley walked out of the Service and did not return. The receptionist commented on his behaviour in these terms:

> I would describe his demeanour as being neutral. He was not showing any expression of any type of emotion. Just very plain. I did not notice him being intoxicated by anything like alcohol or drugs.

Observations near McIver train station - 12 May 2017

51. At about 11.10 am on 12 May 2017, a member of the public saw a man (who she later identified from news reports as Mr Riley) "*waving his arms around all over the place*" whilst sitting at the end of the tunnel that joins Lord Street in East Perth to the McIver Train Station. She thought the man was "*either drug affected or mentally ill*".[53,54]

Comments on observations of Mr Riley

52. The evidence before me establishes that Mr Riley's behaviour was essentially "*normal*" at the time he was last seen by the Officers, namely at around 12.45 am on 12 May 2017. However, by about 7.00 am that morning, Mr Riley had become agitated and appeared to several observers to be either drug affected or having some sort of mental health issue.

53. Samples of Mr Riley's blood taken at the PWH show that he was intoxicated with methylamphetamine, and samples taken after his death showed a slightly higher level of methylamphetamine. It is possible that this increased level was the result of Mr Riley consuming additional methylamphetamine after he was released from the PWH.[55,56]

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[51] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), pp5-6
[52] Exhibit 1, Vol. 1, Tab 25, Statement - FW (Receptionist at the Service), paras 2-12
[53] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), p6
[54] Exhibit 1, Vol. 1, Tab 29, Statement - HM (Member of the public), paras 3-15
[55] Exhibit 1, Vol. 1, Tab 6, ChemCentre toxicology report (25.05.17)

EVENTS LEADING TO MR RILEY'S DEATH[57,58]

Prelude[59,60,61,62,63,64]

54. At about 11.15 am on 12 May 2017, Officers Wolfe and Winterburn were directed to attend Officeworks to investigate an alleged robbery involving two females. At about 11.35 am, a member of the public saw Mr Riley banging his head against the wall of the Officeworks store. She approached Officers Wolfe and Winterburn and alerted them to the fact that Mr Riley may require medical assistance.[65]

55. When Officers Wolfe and Winterburn approached Mr Riley, he was sitting on some curbing to the left of the entrance to Officeworks rocking from side to side and back and forth whilst intermittently slapping his head with his hands. Officer Winterburn could see that Mr Riley's pupils were dilated and he seemed to be in distress. He thought Mr Riley was either "*drug affected*" or suffering from "*a cognitive impairment*".

56. Officer Winterburn called out to Mr Riley and introduced himself as a police officer and Officer Wolfe gently shook Mr Riley's left foot, but there was no response. Officer Winterburn determined that Mr Riley needed medical care and while he called emergency services for an ambulance, Officer Wolfe contacted the Police Operational Centre (VKI) to advise they had encountered a "*medical case*".

57. The operator asked Officer Winterburn to count Mr Riley's breaths, but this was difficult because Mr Riley was continually moving and making grunting noises. The operator then asked Officer Winterburn to place his head next to Mr Riley's head in order to listen for and count breaths. Understandably given Mr Riley's unusual behaviour, Officer Winterburn refused to do so. After the call ended, Officer Winterburn told Mr Riley he had called emergency services and that an ambulance was coming to help him.

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[56] Exhibit 1, Vol. 2, Tab 17, Report - Prof. D Joyce (19.04.21), pp7-10 & 13 and ts 01.06.21 (Joyce), pp427 & 432-433
[57] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), pp6-7 & 9-11
[58] Exhibit 1, Vol. 2, Tab 4, Timeline of events (12.05.17)
[59] Exhibit 1, Vol. 1, Tab 32A, Report - FC Const. R Winterburn (13.05.17), pp1-2
[60] ts 26.05.21 (Winterburn), pp97-100
[61] Exhibit 1, Vol. 1, Tab 33, Report - FC Const. J Wolfe, pp1-2 and ts 26.05.21 (Wolfe), pp128-132
[62] Exhibit 1, Vol. 2, Tab 18, Report - Mr C Markham (21.05.21), pp1-3
[63] Exhibit 1, Vol. 2, Tab 5, Mobile phone footage of police struggling to restrain Mr Riley (12.05.17)
[64] Exhibit 1, Vol. 2, Tab 19, Police Incident Report (LWP170512003349395 - 12.05.17)
[65] Exhibit 1, Vol. 1, Tab 30, Statement - SL (Officeworks customer 1), paras 2-21

Mr Riley's threats to kill police[66,67,68,69,70]

58. Officers Wolfe and Winterburn remained in Mr Riley's vicinity while they waited for the ambulance to arrive. After a few minutes, Mr Riley suddenly leaned to his right and stood up. As he did so, the officers took several steps backwards and adopted tactically appropriate positions. Officer Winterburn noted that Mr Riley's face "*appeared extremely angry and aggressive*" and Mr Riley yelled "*I'm going to kill you*" as he advanced towards the officers in what Officer Wolfe described as "*a very menacing manner*".

59. Due to his physical size and erratic behaviour, the officers considered that Mr Riley was capable of carrying out his threats to kill them. As Mr Riley continued to advance towards them, they backed away, using a parked car to put distance between themselves and Mr Riley. By this stage, the officers were directly outside the Officeworks entrance in an area where several members of the public had gathered.

60. Officers Winterburn and Wolfe each had a reasonable suspicion that there was an imminent risk of serious harm to themselves and to nearby members of the public. On that basis, and in accordance with the Police Use of Force policies (UOF policy), both officers drew their Tasers and pointed the weapons at Mr Riley.

Initial attempts to subdue Mr Riley[71,72,73,74,75]

61. The officers ordered Mr Riley to stay where he was, however, he kept repeating the words "*I'm going to kill you*", before suddenly lunging towards Officer Wolfe. Officer Winterburn was "*terrified*" that Mr Riley was about to seriously injure Officer Wolfe and in accordance with the UOF policy, he fired his Taser at Mr Riley. The Taser appeared to cause "*neuromuscular incapacity*" (NMI)[76] and Mr Riley fell to the ground.

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[66] Exhibit 1, Vol. 1, Tab 32A, Report - FC Const. R Winterburn (13.05.17), p3 and ts 26.05.21 (Winterburn), p100-101
[67] Exhibit 1, Vol. 1, Tab 33, Report - FC Const. J Wolfe, p2 and ts 26.05.21 (Wolfe), pp132-134
[68] Exhibit 1, Vol. 2, Tab 2, Statement - Mr J Barber, paras 39-51 and ts 25.05.21 (Barber), pp84-85
[69] Exhibit 1, Vol. 2, Tab 18, Report - Mr C Markham (21.05.21), p3
[70] Exhibit 1, Vol. 1, Tab 31, Statement - CB (Officeworks employee), paras 16-18
[71] Exhibit 1, Vol. 1, Tab 32A, Report - FC Const. R Winterburn (13.05.17), pp3-6 and ts 26.05.21 (Winterburn), pp100-116
[72] Exhibit 1, Vol. 1, Tab 33, Report - FC Const. J Wolfe, pp3-4 and ts 26.05.21 (Wolfe), pp133-142
[73] ts 26.05.21 (Winterburn), pp101-113, 118.120 & 122-123 and ts 26.05.21 (Wolfe), pp134-142
[74] Exhibit 1, Vol. 2, Tab 2, Statement - Mr J Barber, paras 52-96 and ts 25.05.21 (Barber), pp85-89 & 91-92
[75] Exhibit 1, Vol. 2, Tab 18, Report - Mr C Markham (21.05.21), pp3-6
[76] Involuntary stimulation of sensory and motor nerves affecting a person's ability to use the affected muscles.

62. While this was happening, Mr John Barber (who had visited Officeworks and was about to head home) began filming events on his mobile phone. Meanwhile, Officer Wolfe placed his Taser back in its holster and rushed towards Mr Riley to handcuff him before the effects of the Taser wore off.[77] Officer Winterburn shouted: "*You have been tasered, stop resisting, do not fight, do not resist*", but as the Taser finished its "*cycle*"[78] Mr Riley began to struggle. Mr Barber described the interaction between Mr Riley and the officers as "*a massive struggle*" with the officers "*having great difficulties with the big fella* (Mr Riley)" who "*kept getting up and dragging the police down*".[79]

63. Officer Winterburn was concerned that Mr Riley would overpower Officer Wolfe and pressed the trigger on his Taser to initiate another cycle. This further Taser activation had no apparent effect. Suddenly, Officer Wolfe yelled: "*He's going for my gun*" and Officer Winterburn saw Mr Riley "*fighting relentlessly*" to remove Officer Wolfe's pistol from its holster.

64. There is no doubt that Mr Riley was attempting to remove Officer Wolfe's pistol from its holster. In addition to the evidence of Officers Wolfe and Winterburn, Mr Riley's DNA was found on the pistol's handgrip.[80,81] Further, Mr Barber (an independent witness) made the following observations:

> At some point in the struggle, I could make out the man's…[i.e.: Mr Riley's]…hand at the police officer's belt where his gun was. The gun was on his hip. I could see his fingertips trying to take control of the handle of the gun. I saw this about one minute after I first heard the police officer say he…[i.e.: Mr Riley]…was going for his gun.[82]

65. A customer at Officeworks (who had previously worked as an Aboriginal Police Liaison Officer) witnessed the struggle and called emergency services. She made the following observations about Mr Riley's attempts to gain control of Officer Wolfe's pistol:

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[77] Exhibit 1, Vol. 1, Tab 31, Statement - CB (Officeworks employee), paras 19-21
[78] The Taser operates for five seconds and must then be reactivated. See later discussion on Tasers in this finding.
[79] Exhibit 1, Vol. 2, Tab 2, Statement - Mr J Barber, paras 61-62, 69 & 75-79
[80] Exhibit 1, Vol. 1, Tab 12, PathWest DNA report on swab from pistol grip of Officer Wolfe's pistol
[81] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), p14
[82] Exhibit 1, Vol. 2, Tab 2, Statement - Mr J Barber, paras 92-95 and ts 25.05.21 (Barber), p87

> I saw that the male on the ground had hold of the police officer's gun that was also laying on the ground. The male had to (*sic*) hands on the gun handle and looked like he was trying to pull the gun out of the holster.[83]

66. Two other Officeworks customers also saw Mr Riley's hand on Officer Wolfe's pistol and watched his repeated attempts to gain control of the weapon. One of these customers said he was pleased when he realised Officer Wolfe had placed his hand over Mr Riley's to stop him getting control of the pistol. The customer said he was "*a bit on edge as the gun was pointing straight in my direction*".[84,85]

67. The observations of the Officeworks customers are entirely consistent with the evidence that Officer Wolfe gave at the inquest, where he said:

> At some point he has put his hand…onto my firearm and taken hold of the…pistol grip of my firearm….I was aware that that had occurred and I immediately put my hand over to cover his hand to prevent the firearm from being withdrawn from the holster…
>
> Under no circumstances was I going to allow that firearm to be taken out of my holster. Obviously if that had occurred then things could have been drastically different. But I put my right hand to…my holster over the top of his hand and then kept that in place and tightened my grip to prevent the firearm from being withdrawn.[86]

68. Officer Wolfe was asked what might have happened had Mr Riley been able to withdraw the pistol from its holster and his response was in stark terms:

> [U]ltimately if the firearm had been withdrawn, I had a gentleman who made threats to kill me and had a firearm in his hand, potentially, which could have been critical to either myself, my colleague or members of the public...It could absolutely have turned into a life threatening situation.[87,88]

[83] Exhibit 1, Vol. 2, Tab 3, Statement - GS (Officeworks customer 2), paras 90-94
[84] Exhibit 1, Vol. 2, Tab 6, Statement - PS (Officeworks customer 4), paras 46-52
[85] Exhibit 1, Vol. 2, Tab 7 Statement - HR (Officeworks customer 5), paras 29-34
[86] ts 26.05.21 (Wolfe), p137
[87] ts 26.05.21 (Wolfe), p137
[88] See also: ts 31.05.21 (Markham), pp371 & 389

69. Officer Winterburn saw Mr Riley's hand on Officer Wolfe's pistol and that Mr Riley was "*pulling on the gun*" and that "*the holster was moving with the actions of* [Mr Riley] *trying to remove it*".[89] A Officeworks customer standing near the front entrance door was heard to say: "*He's going for their gun*" in reference to Mr Riley's attempts to grasp Officer Wolfe's pistol.[90] Meanwhile, an Officeworks employee, who was clearly aware of the gravity of the situation, called emergency services. She told the operator that police were being attacked by a male and that "*he was going for their gun*" before shepherding customers to safety away from the main front door.[91]

70. As noted, Officer Wolfe pressed his right hand firmly down on top of Mr Riley's left hand to try to prevent the pistol from moving upwards in its holster. As he did so, Officer Winterburn loaded a fresh cartridge onto his Taser and fired at Mr Riley in a further effort to cause NMI. Although the Taser electrodes hit Mr Riley's body, it appears they were too close together to cause NMI and Officer Winterburn rushed forward and pressed his Taser against Mr Riley's lower body and repeatedly discharged it. When discharged in this manner (i.e.: dive stun mode with a cartridge attached) the Taser can sometimes cause NMI.[92]

71. As the struggle continued, Officer Wolfe ended up on his left side with Mr Riley trying to free the pistol in "*a natural draw position*", meaning that Mr Riley was grasping the pistol "*in a much stronger way*". Officer Wolfe could feel his pistol rising up in its holster and genuinely thought that Mr Riley was: "*attempting to draw the firearm with the intent to kill me*" and that "*at any moment the weapon would discharge*" into his leg causing serious injury.[93]

72. At the inquest, Officer Wolfe was questioned by Mr McIntyre about whether Mr Riley could realistically have gained control of the pistol. After all, it was said, the pistol was secured in its holster by clips at all times and Officer Wolfe's hand was firmly pushing down on Mr Riley's hand to stop the pistol being removed.[94]

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[89] ts 26.05.21 (Winterburn), p108
[90] See also: Exhibit 1, Vol. 1, Tab 31, Statement - CB (Officeworks employee), paras 24-26
[91] See also: Exhibit 1, Vol. 1, Tab 31, Statement - CB (Officeworks employee), paras 24-26
[92] ts 31.05.21 (Markham), pp363-364
[93] Exhibit 1, Vol. 1, Tab 33, Report - FC Const. J Wolfe, p3 and ts 26.05.21 (Wolfe), pp140-141
[94] ts 26.05.21 (Wolfe), pp146-148

73. With respect, the difficulty with this sort of analysis is that risk assessments in the context of a violent and desperate struggle are made dynamically without the luxury of time to reflect on the myriad ways in which the situation might evolve. In this case, had Mr Riley been able to gain control of Officer Wolfe's pistol, he may have been able to inflict fatal injuries on either the officers, himself or members of the public. Whilst the risk of this occurring may have been remote, it was certainly not fanciful.

74. Having carefully considered the available evidence and taking full account of Mr Riley's physical size and erratic behaviour, it is my view that it was entirely reasonable for the officers to assess the risk posed by Mr Riley's conduct as grave and imminent. Mr Riley had made repeated threats to kill the officers, and "*was fighting relentlessly to remove PC Wolfe's firearm from his holster*".[95]

75. Officer Winterburn felt this was a struggle for his life and that he may have to draw and discharge his own pistol if Mr Riley's efforts to obtain Officer Wolfe's pistol succeeded.[96,97] In my view, the seriousness of the situation cannot be overstated and quite reasonably, both Officer Winterburn and Officer Wolfe feared for their lives during their struggle with Mr Riley.[98]

76. As the struggle continued, Mr Riley appeared to tire and Officer Winterburn was able to pin Mr Riley's arm down for the first time. Meanwhile, Officer Wolfe, managed to press the distress button on his police radio and yelled "*cuffs*" which prompted Officer Winterburn to grab his handcuffs. After a considerable and concerted effort, the officers were able to handcuff Mr Riley's hands together in front of his body.

77. Officer Wolfe managed to pull Mr Riley's hands out in front of his body so that Mr Riley was now lying on his stomach. Meanwhile, Officer Winterburn, who was on his knees next to Mr Riley, leant forward and momentarily used his torso to pin Mr Riley to the ground as Mr Riley was still thrashing about.[99]

[95] Exhibit 1, Vol. 1, Tab 32A, Report - FC Const. R Winterburn (13.05.17), p4
[96] Exhibit 1, Vol. 1, Tab 32A, Report - FC Const. R Winterburn (13.05.17), p4
[97] ts 26.05.21 (Winterburn), pp108-110 & 115
[98] ts 26.05.21 (Winterburn), p108 and ts 26.05.21 (Wolfe), pp140-142
[99] Exhibit 1, Vol. 1, Tab 32B, Report - FC Const. R Winterburn (20.11.20), p2

78. At about this time, Office Wolfe asked Mr Barber, (who as noted had been filming the struggle) to help restrain Mr Riley's legs. Mr Barber put his mobile phone in his pocket and came forward. He sat on Mr Riley's ankles and legs and was being "*bucked*" by Mr Riley as he did so.[100] By now, Mr Riley was on his right side and for the first time since the struggle began the officers felt that they had partial control, although the situation was clearly fluid and very dangerous.

79. Officer Wolfe now became very focussed on trying to retrieve the fist microphone of his police radio so he could request urgent backup. As he traced the microphone cord with his left hand, his right forearm was "*locked out*" across Mr Riley's face. Moments later Mr Riley bit into Officer Wolfe's forearm, inflicting wounds which bled profusely. Officer Wolfe was unable to move his arm out of harm's way because he was using his right hand to secure his pistol against Mr Riley's attempts to remove it.[101]

Urgent Police backup arrives[102,103,104]

80. Eventually, Officer Wolfe was able to make a desperate radio call to VKI for backup.[105] Within minutes, 12 police officers (the Backup officers) arrived and took over the task of restraining Mr Riley. Officers Winterburn and Wolfe withdrew as they were physically exhausted. The Backup officers arrived as follows:

a. *First police vehicle*: Officers Savage, Sawyer and Bongers;
b. *Second police vehicle*: Officers Kimber, Wakely and Grant;
c. *Third police vehicle*: Officers Turner and Eather;
d. *Fourth police vehicle*: Officers Neville and Prendergast; and
e. *Fifth police vehicle*: Officers McAlinden and Robson.

Mr Riley continues to struggle

81. Despite the arrival of the Backup officers, Mr Riley continued to struggle and resist efforts to subdue him. The struggle was a dynamic affair and it is neither possible nor indeed necessary to recount, on a moment by moment basis, exactly what each of the Backup officers were doing.

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[100] Exhibit 1, Vol. 2, Tab 2, Statement - Mr J Barber, paras 76-89
[101] Exhibit 1, Vol. 1, Tab 35, Series of photographs showing Officer Wolfe's wounds (photos 1-9 & 19-21)
[102] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), pp18-25
[103] Exhibit 1, Vol. 1, Tab 16, Report - Det. Sgt. T Douglas & Det. Snr. Sgt A Richards (IAU), pp17-29
[104] Exhibit 1, Vol. 2, Tab 19, Police Incident Report (LWP17051200349456 - 12.05.17)
[105] Exhibit 1, Vol. 1, Tab 33, Report - FC Const. J Wolfe, pp3-4 and ts 26.05.21 (Wolfe), pp139-140

82. However, having carefully reviewed the available evidence, including eye-witness accounts from police officers and members of the public, as well as video footage taken at the scene, I make the following observations:

a. The attempt to restrain Mr Riley on 12 May 2017, began at 11:49:10 hours when Officer Winterburn first discharged his Taser and concluded with Mr Riley's collapse about 10 minutes later (the Struggle);

b. During the Struggle, Mr Riley displayed extraordinary strength as he resisted the Backup officers and apart from brief periods when he appeared to rest, he violently and aggressively resisted their attempts to subdue him;

c. During the Struggle, Mr Riley kicked his legs, moved his arms, rolled around, lifted his thighs off the ground (despite various officers pressing down on his legs) and appeared to be trying to stand. At one stage, Mr Riley was able to dislodge officers who were attempting to restrain his legs, including one who weighed 95 kg;

d. During the Struggle various Backup officers attempted to restrain Mr Riley by kneeling around his body and pressing down on his legs, buttocks, shoulders and arms. At no stage did any of them lay on top of Mr Riley's chest, back or stomach;

e. Mr Riley was restrained in various positions during the Struggle including on his back and on his right side. However, for the majority of the Struggle, it appears that Mr Riley was lying on his stomach with his hands stretched out in front of him;

f. The prone (or face down) position is not the preferred position in which to restrain a person because of the suggestion that there may be an increased risk of positional asphyxia;

g. Although the prone position is not preferred, in this case, Mr Riley's hands were handcuffed in front of his body with his arms were above his head. Mr Riley was therefore able to use his arms to take his weight off his chest and he did so;

h. None of the Backup officers thought Mr Riley was experiencing breathing difficulties at any stage during the Struggle and several of them were monitoring his breathing (e.g.: Officers Bongers and Grant).

i. Most of the Backup officers said they were aware of the risks associated with positional asphyxia (see later discussion) and many indicated that it was for this reason that they attempted to restrain Mr Riley by holding his limbs rather than by pressing down on his chest, back or stomach;

j. On numerous occasions, various Backup officers tried to reassure Mr Riley and de-escalate the situation by saying things such as: "*calm down*", "*relax*" and "*stop struggling*";

k. When Mr Riley began "*headbutting*" the ground, Officer Bongers placed his hand on the back of Mr Riley's head to stop him from doing so and a folded police vest was subsequently placed under Mr Riley's head;[106]

l. No person struck or kicked Mr Riley at any stage during the Struggle;

m. During the Struggle Mr Riley made incoherent noises which the Backup officers variously described as growls, mumbles, grunts of exertion, shouts, screams or groans;

n. Other than Officer Prendergast who at one stage during the Struggle thought he heard Mr Riley say "*Ow, my shin*", none of the Backup officers thought Mr Riley was making noises which indicated he was in pain;

[106] Officer Winterburn had earlier prevented Mr Riley from doing this: see ts 26.05.21 (Winterburn), p125

o. At no stage during the Struggle was it possible to move Mr Riley into an alternative position (e.g.: lying on his side or sitting up) because of the level of resistance he was displaying;

p. The concern of the Backup officers was that if Mr Riley had been moved into an alternative position, he would have been much harder to control, especially as his legs were not restrained effectively;

q. If Mr Riley had managed to get up and/or break free from the Backup officers, the gravity of the situation would have significantly escalated;

r. At one stage during the Struggle, Officer Prendergast appeared to be about to place handcuffs on Mr Riley's legs but he was told not to do so as this would not have been an effective restraint;

s. Later in the Struggle, Mr Riley's legs were restrained using a "*figure 4" technique*, where one foot is placed behind the knee of the other leg in order to gain greater control of the subject's legs;

t. Most of the Backup officers considered that Mr Riley may be experiencing excited delirium and were aware that this was a medical emergency (see later discussion);

u. At one point during the Struggle, Officer Turner asked Mr Riley for his name and thought he said it was "*Alex Geoffreys/Jefferies*". Officer Turner tried to build a rapport with Mr Riley by using this name but was obviously unsuccessful;

v. Most of the Backup officers were aware that an ambulance had been called but do not appear to have been aware of the ambulance's requested priority; and

w. Mr Riley continued to resist attempts to subdue him until he suddenly stopped breathing. Several officers (e.g.: Officers Bongers, Grant and McAlinden) expressed surprise at how suddenly Mr Riley collapsed given the level of resistance he displayed.[107,108,109,110,111,112,113,114,115,116,117,118,119,120,121,122,123,124]

Arrival of ambulance officers[125,126,127,128]

83. A clinical support paramedic (CSP) happened to be driving on Lord Street in East Perth shortly before Noon on 12 May 2017. He noticed an ambulance with its lights and sirens on heading to Officeworks and decided to follow and offer assistance. On arrival at Officeworks, the CSP noticed Mr Riley was lying on his stomach being restrained by several police officers.

84. The CSP asked for a history and Officer Wolfe told him that Mr Riley had initially been non-verbal but had lunged at police before becoming physically and verbally aggressive. Mr Riley had then been tasered and had been "*face down restrained for about 10 minutes*". The CSP's initial assessment was that Mr Riley "*was unresponsive with shallow breaths*" and there was no reply when the CSP asked Mr Riley for his name.

85. At about this time, the ambulance that had been seen earlier by the CSP arrived at Officeworks and a short time later, two ambulance officers attended Mr Riley with their equipment.

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[107] Exhibit 1, Vol. 1, Tab 38, Report - Sen. Const. J Savage (13.05.17) and ts 26.05.21 (Savage), pp154-168
[108] Exhibit 1, Vol. 1, Tab 39, Report - FC. Const. A Bongers (13.05.17) and ts 26.05.21 (Bongers), pp169-176
[109] Exhibit 1, Vol. 1, Tab 46, Report - FC. Const. L Turner (13.05.17) and ts 27.05.21 (Turner), pp180-192
[110] Exhibit 1, Vol. 1, Tab 45, Report - FC. Const. N Eather (13.05.17) and ts 27.05.21 (Eather), pp192-198
[111] Exhibit 1, Vol. 1, Tab 41, Report - FC. Const. N Wakely (13.05.17) and ts 27.05.21 (Wakely), pp199-207
[112] Exhibit 1, Vol. 1, Tab 43, Report - Sen. Const. N Prendergast (13.05.17) and ts 27.05.21 (Prendergast), pp208-226
[113] Exhibit 1, Vol. 1, Tab 40, Report - Sen. Const. M Kimber (13.05.17) and ts 27.05.21 (Kimber), pp227-241
[114] Exhibit 1, Vol. 1, Tab 44, Report - Sen. Const. R Neville (13.05.17) and ts 27.05.21 (Neville), pp241-250
[115] Exhibit 1, Vol. 1, Tab 42, Report - FC. Const. J Grant (17.05.17) and ts 28.05.21 (Grant), pp253-265
[116] Exhibit 1, Vol. 1, Tab 47, Report - FC. Const. G Robson (17.05.17) and ts 28.05.21 (Robson), pp266-275
[117] Exhibit 1, Vol. 1, Tab 48, Report - Sgt. T McAlinden (15.05.17) and ts 28.05.21 (McAlinden), pp275-282
[118] Exhibit 1, Vol. 1, Tab 37, Report - Sen. Const. L Sawyer (13.05.17) and ts 31.05.21 (Sawyer), pp336-343
[119] ts 26.05.21 (Winterburn), pp118.120 & 122-123 and ts 25.05.21 (Wolfe), pp142-143
[120] Exhibit 1, Vol. 2, Tab 3, Statement - GS (Officeworks customer 2), paras 58-59, 79-82, 103-104, 114-118 & 125-127
[121] Exhibit 1, Vol. 2, Tab 1, Statement - WS (Officeworks customer 3), paras 54-55 & 59-63
[122] Exhibit 1, Vol. 2, Tab 8, Statement - Ambulance Officer K Ford, paras 28-33
[123] Exhibit 1, Vol. 1, Tab 31, Statement - CB (Officeworks employee), para 30
[124] ts 31.05.21 (Markham), pp372 and 386
[125] Exhibit 1, Vol. 2, Tab 8, Statement - Ambulance Officer K Ford, paras 16-75
[126] Exhibit 1, Vol. 2, Tab 9, Statement - Ambulance Officer P Bakowski, paras 30-59
[127] Exhibit 1, Vol. 2, Tab 10, Statement - Ambulance Officer A Barron, paras 9-63
[128] Exhibit 1, Vol. 2, Tab 11, SJA Patient Care Records (CSN01D2), p2-4 and (SPK22D2), p2-4

86. The CSP confirmed that Mr Riley was breathing by watching the rise and fall of his chest but was unable to find a pulse. To rule out a diabetic hypoglycaemic episode, the CSP tested Mr Riley's blood sugar level by means of a "prick test", where a drop of blood is obtained from the subject's finger.

87. The prick test took about 30 seconds and confirmed that Mr Riley's blood sugar levels were within the normal range. As the CSP was carrying out the prick test, Mr Riley was still moving and grunting, however moments later, Officer Bongers asked if Mr Riley was breathing.

88. The CSP checked and realised that Mr Riley had stopped breathing. He immediately rolled Mr Riley onto his back and Officer McAlinden ordered Mr Riley's handcuffs be removed. The CSP could not find a pulse and started CPR while ambulance officers inserted an airway.[129,130]

89. As this was being done, the CSP asked police to fetch a mechanical chest compression device (LUCAS machine) and attached the sensors of an electrocardiogram (ECG) to Mr Riley's chest. The ECG showed that Mr Riley's heart had no electrical activity (asystole).[131] After the LUCAS machine had been attached, the CSP inserted an intravenous line and Mr Riley was given adrenaline. Because Mr Riley was in asystole, a defibrillator device was not used.

Resuscitation attempts at RPH[132,133,134,135]

90. With the assistance of police, Mr Riley was lifted onto a stretcher and placed into an ambulance before being taken to RPH. On arrival at RPH, the CSP gave clinical staff a briefing about Mr Riley's condition and resuscitation efforts were continued for about 20 minutes.

91. Despite the efforts of the CSP, ambulance officers and RPH clinical and nursing staff, Mr Riley could not be revived.

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[129] Exhibit 1, Vol. 1, Tab 38, Report - Sen. Const. J Savage (13.05.17), p3 and ts 26.05.21 (Savage), p168
[130] Exhibit 1, Vol. 1, Tab 39, Report - FC. Const. A Bongers (13.05.17), pp3-4 and ts 26.05.21 (Bongers), pp172-174
[131] Asystole is the total cessation of electrical activity in the heart and is the most serious form of cardiac arrest.
[132] Exhibit 1, Vol. 1, Tab 4, RPH death in hospital form (12.05.17)
[133] Exhibit 1, Vol. 2, Tab 8, Statement - Ambulance Officer K Ford, paras 76-85
[134] Exhibit 1, Vol. 2, Tab 9, Statement - Ambulance Officer P Bakowski, paras 60-75
[135] Exhibit 1, Vol. 2, Tab 10, Statement - Ambulance Officer A Barron, paras 64-71

CAUSE AND MANNER OF DEATH

Post mortem examination[136]

92. On 17 and 18 May 2017, an experienced forensic pathologist, Dr Gerard Cadden (Dr Cadden), conducted a post mortem examination of Mr Riley's body. Dr Cadden also reviewed a toxicology report, a neuropathology report and an opinion from a consultant neurosurgeon.

93. Dr Cadden found no gross primary pathology such as would explain the death but noted that Mr Riley's lungs were congested and there was congestion and possible fatty change in his liver. Mr Riley's heart was enlarged (cardiomegaly) and there was an area of early coronary artery disease in one of his coronary arteries (localised arteriosclerosis).

94. Dr Cadden found numerous minor skin grazes on his limbs, consistent with Mr Riley having been involved in a scuffle. In addition, a number of marks assumed to have been made by Officer Winterburn's Taser were identified, and I will deal with this observation in more detail later in this finding.[137]

95. A colloid cyst (a benign collection of fluid) was also found in Mr Riley's brain, and Dr Cadden sought advice as to whether this could explain Mr Riley's bizarre behaviour. A consultant neurosurgeon (Mr Stephen Honeybul), felt it was highly unlikely that the cyst would have accounted from Mr Riley's behaviour. Mr Honeybul stated that when these cysts become symptomatic, they cause hydrocephalus (an abnormal build-up of fluid in the brain), and there was no evidence that this had occurred in Mr Riley's case.[138,139,140]

Toxicological analysis

96. Toxicological analysis of a sample of Mr Riley's blood taken at the PWH at about 11.35 pm on 11 May 2017 found it contained the medications amitriptyline and its metabolite nortriptyline (an anti-depressant); telmisartan (used to treat high blood pressure); and tramadol (pain relief) along with methylamphetamine at a level of 0.05 mg/L.

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[136] Exhibit 1, Vol. 1, Tab 5C, Post Mortem Report, pp1-21
[137] ts 28.05.21(Cooke), pp286-287
[138] Exhibit 1, Vol. 1, Tab 10, Neuropathology report (16.08.17)
[139] Exhibit 1, Vol. 1, Tab 11, Neuropathology report (07.06.17)
[140] Exhibit 1, Vol. 1, Tab 9A, Report - Mr S Honeybul (09.01.18)

97. Analysis of post mortem samples found therapeutic levels of the medications just referred to, along with a methylamphetamine level of 0.08 mg/L. This increased level suggests that Mr Riley used additional methylamphetamine after his release from the PWH, although it is also possible that the elevated level was due to redistribution in Mr Riley's body after death.[141]

98. Professor David Joyce, (physician and clinical pharmacologist and toxicologist), provided the Court with a report examining the possible contribution of drugs to Mr Riley's death and gave evidence at the inquest. Professor Joyce noted that the levels of methylamphetamine found in Mr Riley's system were "*not especially high*" but were concentrations commonly encountered in people with various "*methylamphetamine manifestations*".[142]

99. The antidepressant amitriptyline and its metabolite, nortriptyline, can enhance the risk of arrythmias associated with methylamphetamine use.[143] However, in Mr Riley's case, the levels of amitriptyline and nortriptyline detected were too low to have any definite effect in this regard.[144]

Cause and manner of death

100. At the conclusion of the post mortem examination, Dr Cadden expressed the opinion that the cause of Mr Riley's death was:

> Consistent with cardiac arrhythmia following violent exertion necessitating physical restraint in a man with methylamphetamine effect, known systemic hypertension and morbid obesity.[145]

101. As Dr Cadden had retired, Dr Clive Cooke (Dr Cooke), another very experienced forensic pathologist, kindly gave evidence at the inquest. Dr Cooke agreed with Dr Cadden's opinion as to the cause of Mr Riley's death.

102. I accept and adopt Dr Cadden's conclusion as to the cause of death and for the reasons set out below, I find that Mr Riley's death occurred by way of misadventure.

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[141] Exhibit 1, Vol. 1, Tab 6, ChemCentre toxicology report (25.05.17) and ts 01.06.21 (Joyce), p427
[142] ts 01.06.21 (Joyce), pp426-427
[143] See also the discussion on arrythmias later in this finding.
[144] Exhibit 1, Vol. 2, Tab 17, Report - Prof. D Joyce (19.04.21), p12 and ts 01.06.21 (Joyce), p436
[145] Exhibit 1, Vol. 1, Tab 6, Neuropathology Report & Exhibit 1, Vol. 1, Tab 5B, Post Mortem Report

FACTORS RELATED TO CAUSE OF DEATH

103. I have adopted the useful approach counsel assisting, Ms Rachel Collins employed at the inquest, and will now address each element of Dr Cadden's opinion as to the cause of Mr Riley's death. I will then address the question of whether repeated Taser activations caused or contributed to Mr Riley's death.

Cardiac arrhythmias[146,147,148]

104. Dr Johannes Janssen (Dr Janssen) is a cardiologist who provided expert reports to the Court and gave evidence at the inquest. He explained how the human heart functions and what might cause the beating rhythm of the heart to be affected so that an arrhythmia develops.

105. Dr Janssen stated that the heart has four chambers. The two at the top are called atria while the two at the bottom are called ventricles. De-oxygenated blood enters the heart through the right atrium and is pumped to the lungs by the right ventricle. After being oxygenated, blood enters the left atrium and is pumped to the body and its organs by the left ventricle.

106. The pumping action of the heart is triggered by electrical impulses initiated by a small bundle of specialised cells in the right atrium known as the sinoatrial node (SA node). The electrical activity is produced by the flow of ions (i.e.: charged particles of sodium, calcium, potassium and chloride) in and out of the cells of the heart and spreads through the walls of the atria causing them to contract, forcing blood into the ventricles.

107. A cluster of cells at the centre of the heart between the atria and the ventricles (the atrioventricular node) slows the electrical signal momentarily giving the atria a chance to contract before the ventricles do. A pathway of fibres (the His-Purkinje network) carries the electrical impulse down to the ventricles which then contract. The SA node then "*fires*" again causing the cycle to repeat. In normal circumstances, this cycle is synchronised and the heart beats normally.

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[146] See: https://my.clevelandclinic.org/health/articles/17064-heart-beat
[147] See: https://my.clevelandclinic.org/health/diseases/17183-long-q-t-syndrome-lqts
[148] ts 01.06.21 (Janssen), pp406-409

108. A measurement called the QT interval refers the a section of an ECG that represents the time it takes for the electrical system to fire an impulse through the ventricles and then recharge. This measurement translates to the time it takes for the heart to contract and then recover. When the QT interval is longer than normal, there is an increased risk of the heart developing an abnormal beating rhythm (arrhythmia).

109. One common arrhythmia is ventricular tachycardia, where the heart beats much faster than normal. This can develop into ventricular fibrillation, where the ventricles quiver uselessly and in turn, this can progress to asystole, meaning there is no electrical activity in the heart and therefore no blood flow to the body. Asystole is usually irreversible and therefore, almost always fatal.

110. In Mr Riley's case, the factors which increased his risk of developing a fatal arrhythmia included:

a. *Coronary artery disease*: Mr Riley had early coronary artery disease in one of his coronary arteries (localised arteriosclerosis);

b. *Cardiomegaly*: Mr Riley had an enlarged heart (cardiomegaly), related to his morbid obesity;

c. *Methylamphetamine*: at the time of the Struggle, Mr Riley was intoxicated with methylamphetamine which can cause the QT interval to be prolonged and thereby increase the risk of ventricular arrhythmias; and

d. *Exertion and high blood pressure*: Mr Riley had a history of high blood pressure and the methylamphetamine he had ingested would have caused his blood pressure to increase further. In addition, the intense exertion he displayed during the Struggle would have caused an acute increase in his blood pressure and this can cause arrhythmias.[149,150,151,152,153]

[149] Exhibit 1, Vol. 1, Tab 5C, Supplementary Post Mortem Report (22.01.18), p18
[150] ts 28.05.21 (Cooke), pp287, 289-291 & 301-302
[151] Exhibit 1, Vol. 1, Tab 5C, Supplementary Post Mortem Report (22.01.18), p18
[152] Exhibit 1, Vol. 2, Tab 15A, Report - Dr J Janssen (18.11.20), p2
[153] ts 01.06.21 (Janssen), pp409-410, 414 & 417-418

111. Mr Riley was in asystole when his heart was first assessed by ambulance officers using an ECG shortly after his collapse. Although it is impossible to know exactly what was going on in Mr Riley's heart prior to his collapse, it was Dr Janssen's view that it was most likely that Mr Riley developed ventricular tachycardia which progressed into ventricular fibrillation and then asystole. Given Mr Riley's poor physical condition, he would have progressed to asystole quite quickly.[154]

***Violent exertion*[155,156]**

112. Clearly, a contributor to Mr Riley's death was his violent exertion during the Struggle. I have already referred to one of the negative consequences of such intense exertion, namely a sudden rise in blood pressure creating an increased risk of developing a fatal cardiac arrhythmia.

113. A further consequence of violent exertion is a condition known as metabolic acidosis. Dr Cooke explained that in normal circumstances, the human body breaks down glucose to produce energy. This process produces acid and under intense exertion, there may be insufficient oxygen available to complete the process, causing acid to build up in the body. When acidosis develops, the heart's normal function can be affected leading to death.

114. Intense exertion can also disrupt the normal balance of electrolytes in the body, including potassium. This imbalance can affect the normal beating rhythm of the heart in a process which is separate from the acidosis process I have just referred to.

***Physical restraint including issues related to positional asphyxia*[157,158]**

115. During the Struggle, Mr Riley was restrained by various police officers over a period of about 10 minutes. At times he was on lying on his back or on his side but for the majority of time, he was restrained in the prone position with his handcuffed arms extended in front of him. At the inquest, Dr Cooke was asked what role, if any, positional asphyxia (PA) may have played in Mr Riley's death.

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[154] Exhibit 1, Vol. 2, Tab 15A, Report - Dr J Janssen (18.11.20), pp2-3 and ts 01.06.21 (Janssen), pp409-410
[155] ts 28.05.21 (Cooke), pp291-292; ts 01.06.21 (Janssen), pp410 & 416 and ts 01.06.21 (Joyce), pp431-432
[156] Exhibit 1, Vol. 2, Tab 16, Report - Dr J Ho, pp20-22 and ts 31.05.21 (Ho), pp321-322
[157] Exhibit 1, Vol. 2, Tabs 18.2 & 18.3, Report - Mr C Markham (21.05.21), Attachments 2 & 3
[158] ts 31.05.21 (Markham), pp357-358, 372 and 384

116. PA has been defined in various ways, including:

> Positional (postural) asphyxia is a form of mechanical asphyxia that occurs when a person is immobilized in a position which impairs adequate pulmonary ventilation and thus, results in a respiratory failure.[159]

117. Mr Chris Markham, an expert in the use of force options available to the Police provided the Court with a comprehensive report and gave evidence at the inquest. One of the documents attached to his report defines PA in these terms:

> 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 arrythmia and/or respiratory arrest.[160]

118. A factsheet used by the Police when training its officers notes that PA is a medical emergency and provides the following guidance:

> 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…and…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.[161]

119. The evidence before me is that none of the Backup officers thought Mr Riley was experiencing breathing difficulties at any stage during the Struggle. Several of them were monitoring his breathing and it was Officer Bongers who first noticed Mr Riley was not breathing. Further, as soon as Mr Riley collapsed his handcuffs were removed.[162,163,164,165]

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[159] See: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6023692/
[160] Exhibit 1, Vol. 2, Tab 18.2, Report - Mr C Markham (21.05.21), Attachment 2, p4
[161] Exhibit 1, Vol. 2, Tab 18.3, Report - Mr C Markham (21.05.21), Attachment 3, p1
[162] Exhibit 1, Vol. 1, Tab 39, Report - FC. Const. A Bongers (13.05.17) and ts 26.05.21 (Bongers), pp169-176
[163] Exhibit 1, Vol. 1, Tab 42, Report - FC. Const. J Grant (17.05.17) and ts 28.05.21 (Grant), pp253-265
[164] Exhibit 1, Vol. 1, Tab 48, Report - Sgt. T McAlinden (15.05.17) and ts 28.05.21 (McAlinden), pp275-282
[165] ts 28.05.21 (Markham), pp382-383

120. Dr Cooke noted that PA is a controversial topic. It appears that concerns about PA were raised in the United States in the 1980's and 1990's following a number of sudden deaths related to restraint of various types. Of particular concern seemed to be the "*hogtie position*", where the subject is restrained in the prone position with their handcuffed wrists tethered to their restrained ankles.[166]

121. With respect to the prone position used in Mr Riley's case, Dr Cooke noted that:

> 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. In this case I think, from what I have seen and what I have read, it does seem that the officers didn't place any significant strain on [Mr Riley's] back…or on the back of his chest. Most of the restraint seemed to be on the limbs…[which]…from that point of view is a very good thing.[167]

122. There is some uncertainty about just how dangerous the prone position actually is. For example, Dr Cooke noted that COVID-19 patients "*are often being nursed in ICU facedown in a prone position*" and some clinicians are starting to think that this position might be better for respiration.[168] One study noted that managing patients with acute respiratory distress syndrome in the prone position "*is known to improve mortality*" although it is noted that the impact of doing so with critically ill COVID-19 patients "*remains to be determined"*.[169]

123. As if to further illustrate the uncertainty in this area, a 2020 review of 20 studies of the effects of restraint on respiratory and/or cardiac function was unable to conclude that "*positional restraint alone is enough to cause ventilatory or cardiac compromise in healthy, adult subjects*". The key word in the above quote is "*healthy*" and the author of the literature review noted that in many cases, factors such as physical struggle, agitation, delirium, drug intoxication and pre-existing health conditions "*can all be in play in the event of a tragic outcome*".[170]

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[166] ts 28.05.21 (Cooke), p295
[167] ts 28.05.21 (Cooke), p293
[168] ts 28.05.21 (Cooke), pp294-295
[169] See: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7575418/
[170] Vilke, GM, Restraint Physiology: A review of the Literature (2020), Oct; 75 J Forensic Leg Med

124. Despite the uncertainty surrounding PA, Dr Cooke was of the view that prolonged restraint in the prone position: "*does seem to carry some risk to individuals because of the risk of cardiorespiratory impairment which may result in a cardiac arrest*"[171] and that:

> [N]otwithstanding the debate about it…I think you still have to be very cautious about restraining someone in this position…[i.e.: the prone position] in a prolonged way and without making careful observations.[172]

125. Although not an expert in this area, Professor Joyce noted that the evidence in Mr Riley's case did not describe immobilisation techniques that carried a "*special risk of respiratory compromise*".[173] For his part, Dr Cooke said that he did not think that Mr Riley's death could be directly attributed to the position in which he was restrained. Dr Cooke's conclusion was:

> He…(*Mr Riley*)…has obviously had a very sudden cardiorespiratory arrest, cardiac arrest at that time…You can't, I think, relate it exactly and only to postural asphyxia. But…I think you leave open its possible contribution to this sudden deterioration.[174]

Methylamphetamine effect and excited/agitated delirium[175,176]

126. Methylamphetamine is a powerful, highly addictive stimulant that affects 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.[177]

127. 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. The observations of RPH staff at about 7.00 am on 12 May 2017, suggest that Mr Riley was displaying signs of paranoid beliefs and bizarre behaviour. By that time, Mr Riley may well have been awake for a continuous period of at least 24-hours.

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[171] ts 28.05.21 (Cooke), p293
[172] ts 28.05.21 (Cooke), p294
[173] Exhibit 1, Vol. 2, Tab 17, Report - Prof. D Joyce (19.04.21), p7 and ts 01.06.21 (Joyce), p426
[174] ts 28.05.21 (Cooke), p295
[175] Exhibit 1, Vol. 2, Tab 17, Report - Prof. D Joyce (19.04.21), pp5-13 and ts 01.06.21 (Joyce), pp422-442
[176] Exhibit 1, Vol. 2, Tab 15A, Report - Dr J Janssen (18.11.20), p2
[177] See: https://www.drugabuse.gov/publications/research-reports/methamphetamine/what-methamphetamine

128. The term agitated or excited delirium (ED) may also be applied to this condition, although there is some controversy about what this term actually means. One definition of ED is as follows:

> Agitated or excited delirium is an acute, transient disturbance in consciousness and cognition that involves combative and/or violent behaviour…This disturbance in cognition is marked by intense paranoia, aggressive behaviour toward objects and people, hallucinations, hyperthermia, altered sensorium, and lack of willingness to yield to force…The bizarre and threatening behavior of these individuals typically leads to a police response. The subject violently resists police attempts at restraint with a surprising amount of strength, and death often occurs unexpectedly once in custody[178,179]

129. A Police document tendered into evidence suggests the signs of ED include: bizarre and/or aggressive behaviour, a very high pain tolerance, impaired thinking, paranoia and unexpected physical strength and/or endurance - all of which Mr Riley appears to have exhibited.

130. The Police document warns that:

> 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 (*therefore of being*) exposed to the application of Tactical Force Options resulting in physiological stresses which can cause cardiac and respiratory distress.[180]

131. Perhaps the position is best encapsulated in the following excerpt from Professor Joyce's report:

> There is sometimes an empty debate about whether "agitated delirium" exists. If the term is taken at its plain English meaning, which is agitation in a person who is delirious, it indubitably exists and is very familiar to everyone who has to deal with acute methylamphetamine intoxication. The debate arises because some want to attach the term to a more complicated set of characteristics that is beyond the plain English meaning of the words.[181]

[178] Dukes, GD & Davis GJ, Encyclopedia of Forensic and Legal Medicine (2nd Ed, 2016)
[179] See: https://www.sciencedirect.com/topics/neuroscience/excited-delirium
[180] Exhibit 1, Vol. 2, Tab 18.2, Report - Mr C Markham (21.05.21), Attachment 2, p5
[181] Exhibit 1, Vol. 2, Tab 17, Report - Prof. D Joyce (19.04.21), p9 - Footnote 5

132. Although the term ED is routinely used in the United States, its use in Australia is somewhat controversial, and as a diagnosis it has not been universally accepted. Although the Colleges representing pathologists and emergency physicians in Australia have accepted the term, the College representing psychiatrists has not.[182]

133. Dr Cooke said that whilst ED is clearly a medical emergency it was by no means clear whether ED could, of itself, cause sudden death. Dr Cooke said that "*most people*" are now of the view that it does not. In any event, whilst agreeing that methylamphetamine was a factor in Mr Riley's death, Dr Cooke felt that as a cause of death, Professor Joyce may have over emphasised its importance in Mr Riley's case.[183]

134. A period of sustained high-level methylamphetamine use can also cause "*amphetamine-induced delusional disorder*", a serious disorder characterised by paranoid delusions and hostility or violence towards the subjects of the paranoia. There may also be hallucinations and other signs such as facial grimacing and picking at clothing.

135. Professor Joyce observed that Mr Riley's methylamphetamine levels were consistent with any of the above conditions (i.e.: ED and/or amphetamine-induced delusional disorder), and that these states can co-exist. Further, the severity of an individual's presentation can vary over time and is related to the time since the last dose of the intoxicating drug. In this case, it is unclear whether Mr Riley took further methylamphetamine after his attendance at the ED.

136. In terms of how methylamphetamine causes sudden death, Professor Joyce explained that stimulants like methylamphetamine do not usually kill by immediate poisoning. Rather, mortality is more commonly associated with suicide, homicide or lethal risk taking. In Mr Riley's case, the levels of methylamphetamine were consistent with the ranges associated with bizarre and irrational behaviour, as well death by violence. However, Mr Riley's levels were "*much lower*" than levels which usually cause immediate death by direct drug intoxication.

[182] ts 28.05.21 (Cooke), pp292 & 297-298
[183] ts 28.05.21 (Cooke), pp298-299

137. I have already referred to the fact that methylamphetamine can cause sudden cardiac death and ventricular arrhythmias by prolonging a person's QT interval. Professor Joyce noted that some cases involving death shortly after ingestion of amphetamine had been found to be related to abnormalities in the heart that predisposed the individual to a lethal arrythmia "*under conditions of amphetamine intoxication and extreme cardiac sympathetic stimulation*".

138. Another pathway which can lead to sudden death is the rupture of an artery, but this was "*not evidenced in this case*". Further, the single temperature measurement of 38.1°C, taken from Mr Riley at 12.12 pm, was "*not enough to substantiate hyperthermia*", which is yet another pathway leading to death in the context of amphetamine intoxication.

139. A further cause of sudden death occurring hours or even days after stimulant use appears to be related to a sudden disturbance in heart rhythm, similar to the effect produced by the intravenous administration of adrenalin. Where it had been possible to observe affected patients, the rhythms seen were ventricular tachycardia or ventricular fibrillation. As Professor Joyce noted, unless circulation can be restored, ventricular fibrillation leads to asystole, which was the rhythm observed in Mr Riley's case.

140. Professor Joyce explained that this type of sudden death appears to occur primarily in association with intense physical exertion. Extra noradrenaline (a substance similar to adrenalin) is delivered to the heart to increase its performance in these circumstances. Methylamphetamine accentuates this effect and this is believed to cause a "*lethal disturbance of heart rhythm*". Methylamphetamine may also cause constriction of the coronary arteries which reduces the heart's blood supply and can predispose the individual to arrythmias.

141. Professor Joyce noted that such arrythmias had been observed in patients presenting to hospital with chest pain related to amphetamine-induced obstruction of coronary circulation. It is possible that Mr Riley's various presentations to hospital with chest pain following methylamphetamine use were examples of this condition.

142. Professor Joyce said that in the past 30 years he was aware of 11 cases where methylamphetamine users had died during intense exertion and that "*struggle against restraint has been a recurrent theme*".

143. Mr Riley's level of methylamphetamine was the second lowest in the cases Professor Joyce referred to, but he noted that:

> The state of intoxication seems to drive the user to an intensity of effort that must put extraordinary demands on the physiology to supply oxygen, supply blood flow…regulate acid base balance in the tissues and supply energy substrates. The intoxicated user does not seem to respond to cues of breathlessness, failing strength and pain that would normally bring an end to willingness to fight. How these physiological disturbances contribute to the arrythmia risk is not known.[184]

144. In terms of the combativeness exhibited by Mr Riley, Professor Joyce noted that:

> Normally, people would stop fighting when their bodies became so short of oxygen that the muscles themselves weren't working properly, and they would stop fighting when it became apparent to them that further struggle was going to be unavailing. People who are intoxicated with methylamphetamine just don't respond to either of those things, and they will just continue to fight on until the body is so metabolically disturbed that it's at risk of things going wrong, like heart rhythm disturbances.[185]

145. Professor Joyce was asked whether methylamphetamine had contributed to Mr Riley's death, and his response was:

> I believe methamphetamine has been involved in his death. I believe it's what's largely responsible for creating the psychiatric state that brought him into conflict, and I believe that it remained influential while his body underwent the metabolic disturbances that extreme protracted conflict gives and so that it was influential at that stage and through all those influences was a contributor to his death.[186]

[184] Exhibit 1, Vol. 2, Tab 17, Report - Prof. D Joyce (19.04.21), pp11-12 and 01.06.21 (Joyce), pp431-432
[185] ts 01.06.21 (Joyce), pp430-431
[186] ts 01.06.21 (Joyce), p430

146. After considering all of the available evidence, Professor Joyce expressed the view that Mr Riley was intoxicated with methylamphetamine at the time of his death and was experiencing an episode of drug-induced psychosis. Professor Joyce further concluded that the circumstances of Mr Riley's case were consistent with "*methylamphetamine-induced lethal cardiac rhythm disturbance during extreme exertion*".[187]

Systemic hypertension and morbid obesity

147. In isolation, it appears that Mr Riley's high blood pressure and morbid obesity would not necessarily have placed him at an increased risk of developing a fatal arrhythmia.

148. However, it seems plausible that as a result of Mr Riley's intense physical exertion and his methylamphetamine intoxication, he experienced an acute elevation of his blood pressure. This may therefore have meant that his pre-existing medical conditions assumed a greater importance in relation to his death, than might otherwise have been the case.[188]

[187] Exhibit 1, Vol. 2, Tab 17, Report - Prof. D Joyce (19.04.21), p13 and ts 01.06.21 (Joyce), pp432-433
[188] ts 28.05.21 (Cooke), pp290-291

TASERS

Background[189,190,191,192]

149. The weapon fired at Mr Riley was a TASER X26P Conducted Electrical Weapon (Taser), manufactured by Axon Enterprise, Inc. (Axon), a company based in Arizona in the United States. The Taser is a trigger activated, hand-held weapon that can be fitted with cartridges containing two small barbed electrodes attached to the weapon by wires. When the Taser is aimed and the trigger is pulled, the electrodes shoot out towards the subject.

150. The Taser's electrodes deliver an electrical pulse which passes through the subjects' muscles with the aim of causing NMI. To be effective, the electrodes need to be a certain distance apart and must come within a minimum distance of the subjects' skin. Where the distance between the electrodes is insufficient, or where contact between the electrodes and the subjects' skin is intermittent (e.g.: because the electrodes attach to baggy clothing), partial incapacitation (or even no incapacitation) may occur. The electrical pulses delivered by the Taser occur for a certain period of time (cycle) and further activation of the Taser's trigger causes additional cycles to be delivered.

151. The Taser may be deployed in several ways. First, if a cartridge is fitted to the Taser when the trigger is pulled, the electrodes will fire towards the subject in the manner described. Second, if one of the electrodes attached to the Taser cartridge by wires becomes detached, the Taser can be pressed against the subject's skin and NMI may occur. In this mode, two small electrodes in the Taser's muzzle take the place of the dislodged electrode.

152. Where no cartridge is fitted to the weapon, the Taser can be used in "*dive stun mode*". Because a cartridge is not fitted to the Taser, electrode wires are no longer connected to the weapon and cannot be energised. Thus in dive stun mode, the Taser is pressed against the subject and the electrodes in the muzzle of the Taser make contact with the subject's skin. Although localised pain occurs, the small electrodes in the Taser's muzzle are too close together to cause NMI.

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[189] Exhibit 1, Vol. 2, Tab 13, Report - Mr B Chiles, Technical Compliance Manager, Axon (04.08.17), pp1-4
[190] Exhibit 1, Vol. 2, Tab 18, Report - Mr C Markham (21.05.21), pp19-23 and ts 31.05.21 (Markham), pp359-365 & 380
[191] Exhibit 1, Vol. 2, Tab 18.4, Report - Mr C Markham (21.05.21), Attachment 4
[192] Exhibit 1, Vol. 2, Tab 16, Report - Dr J Ho, Med. Director, Axon (26.04.21), pp9-10 and ts 31.05.21 (Ho), pp316-317

153. The Taser contains three onboard "*logs*" which capture information about its use. The "*event log*" records the date, time and details of events such as every time the weapon is armed; its trigger is pulled; and/or its safety catch is applied. The "*pulse log*" records details of every electrical pulse generated by the Taser and the "*engineering log*" records all activity in the weapon. Analysis of these logs can provide information about when the Taser was activated and the effectiveness of each activation.

Taser use in Mr Riley's case

154. The Taser used by Officer Winterburn was sent to Axon's headquarters and was subjected to a detailed analysis which showed that:

a. the Taser was functioning within its published electrical specifications;

b. the Taser was correctly recording information in its logs; and

c. the Taser was trigger activated on 10 occasions over an 88-second period on 12 May 2017, between 11.49 am and 11.50 am.[193,194]

155. The analysis by Axon also identified that the Taser's onboard clock was running 3 minutes and 20 seconds ahead. This appears to have occurred because the weapon had not been synchronised for a period of over four months, whereas Axon's recommended synchronisation interval is three months. In any event, the activation times shown below were calculated with reference to the actual time, rather than the incorrect time recorded by the Taser's clock.[195]

156. Mr Markham's report analysed the 10 activations of the Taser used by Officer Winterburn in detail. Before dealing with that analysis, I note that Mr Markham's report confirms that although Officer Wolfe's Taser was drawn, it was not discharged.[196]

[193] Exhibit 1, Vol. 2, Tab 13, Report - Mr B Chiles, Technical Compliance Manager, Axon (04.08.17), pp1-18
[194] Exhibit 1, Vol. 2, Tab 14, Printout of Taser logs
[195] Exhibit 1, Vol. 2, Tab 13, Report - Mr B Chiles, Technical Compliance Manager, Axon (04.08.17), pp17-18
[196] Exhibit 1, Vol. 2, Tab 18, Report - Mr C Markham (21.05.21), pp64-72 and ts 31.05.21 (Markham), p369

157. In summary, Mr Markham's analysis of Officer Winterburn's Taser activations on 12 May 2017, is as follows:[197]

a. *Activation 1:* involved electrodes being fired at Mr Riley to deliver a cycle and occurred at 11:49:10 hours. The Taser's pulse log shows that this activation, which caused Mr Riley to fall to the ground, "*could have resulted in an effective deployment of the Taser*";

b. *Activation 2:* occurred at 11:49:20 hours and involved the Taser's trigger being pulled to initiate a further cycle. The pulse log shows intermittent connection for part of the cycle and the absence of any charge output for the remainder of the cycle meaning this activation "*would likely have resulted in a limited effect*". The intermittent connection may have occurred because the probe did not penetrate Mr Riley's skin due to his obesity or because one of the taser probes dislodged as he fell;

c. *Activation 3:* occurred at 11:49:26 hours and involved the Taser's trigger being pulled to initiate a further cycle. The pulse log shows that in the absence of any charge output this activation "*would likely have resulted in a limited effect*";

d. *Activation 4:* a fresh cartridge was loaded into the Taser and electrodes were fired at Mr Riley at 11:49:40 hours. The pulse log shows that this activation "*could have resulted in an effective deployment of the Taser*", however, this activation was made at close quarters meaning that the electrodes were close together. The evidence of Officer Winterburn suggests that this activation was ineffective;

e. *Activation 5:* occurred at 11:49:55 hours and involved the Taser's trigger being pulled to initiate a further cycle. Although the pulse log shows that this activation was potentially effective for about half of the cycle, the fact that the probes were discharged at close quarters (see activation 4) suggests that this activation was ineffective;

[197] Exhibit 1, Vol. 2, Tab 18, Report - Mr C Markham (21.05.21), pp32-60 and ts 31.05.21 (Markham), pp365-369

f. *Activation 6:* occurred at 11:50:03 hours and may have involved the Taser being used in dive stun mode with the cartridge still attached, although this cannot be confirmed. Again, the fact that the electrodes were discharged at close quarters (see activation 4) suggests that this activation was also ineffective;

g. *Activation 7:* occurred at 11:50:10 hours and appears to have involved the Taser being used in dive stun mode without a cartridge attached, meaning that NMI could not occur and only localised pain was possible from this activation;

h. *Activation 8:* occurred at 11:50:15 hours and was similar to activation 7;

i. *Activation 9:* occurred at 11:50:21 hours and was similar to activation 7; and

j. *Activation 10:* occurred at 11:50:27 hours and is the final activation recorded by the Taser's logs. This activation was similar to discharge 7.

Why were Taser activations 2-10 apparently ineffective?[198]

158. When coupled with the evidence of Officers Winterburn and Wolfe and the independent eyewitnesses, Mr Markham's analysis suggests that only the first of Officer Winterburn's Taser activations caused NMI.

159. There are several reasons why this appears to have been the case. In some cases an intermittent electrical pulse was delivered, and this could have been either because of Mr Riley's obesity or because the taser electrode had become dislodged during the Struggle (activations 2 and 3).

160. Several of the activations occurred in a context of a new cartridge being loaded but with the Taser being discharged at close quarters (activations 4, 5 and 6), meaning the electrodes were too close together to cause NMI. Activations 7 to 10 all appear to have been made using the Taser in dive stun mode without a cartridge attached. As noted, when used in this mode, although the Taser will cause localised pain, NMI cannot occur.

[198] Exhibit 1, Vol. 2, Tab 18, Report - Mr C Markham (21.05.21), pp32-60 and ts 31.05.21 (Markham), pp365-369

Where did the Taser probes strike Mr Riley?

161. Information about where the two sets of Taser electrodes hit Mr Riley and where the Taser was used on his body in dive stun mode, comes from the observations of eye-witnesses, the post mortem examination, forensic analysis of Mr Riley's clothing and recent analysis of post mortem photographs by Dr Cooke.

162. The available evidence appears to establish that the Taser electrodes struck Mr Riley to the left and right sides of his abdomen and possibly his right upper leg. Marks which may be consistent with the Taser being used in dive stun mode were found on Mr Riley's right shoulder and his right lower flank/upper buttock area. No marks were identified on Mr Riley's chest area or near his heart and I therefore conclude that none of the Taser activations occurred in either of these areas.[199,200,201,202,203,204,205,206,207]

Can Tasers cause adverse cardiac events?[208]

163. Dr Jeffery Ho is Axon's Medical Director and "*expert research consultant*". He provided the Court with a report and gave evidence at the inquest. Dr Ho explained that the electrical pulse delivered by the Taser has high voltage and very low amperage, which: "*is not known to be dangerous to humans from a scientific standpoint*".[209]

164. However, in a 2014 article, Dr Douglas Zipes (a highly respected electrophysiologist) concluded that in certain circumstances, Tasers can cause adverse cardiac events. Dr Zipes outlined several cases where cardiac arrest had occurred after a Taser was fired at a person's chest.[210] Dr Janssen also considered that it was possible for a Taser activation to "*cause ventricular arrythmias leading to sudden cardiac death although this might be a rare event*".[211]

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[199] Exhibit 1, Vol. 1, Tab 5C, Post Mortem Report (22.01.18), pp1-21
[200] Exhibit 1, Vol. 1, Tab 5D, Diagram prepared by Dr C Cooke after reviewing Mr Riley's post mortem photos
[201] ts 31.05.21 (Cooke), pp299-303 & 310
[202] Exhibit 1, Vol. 2, Tab 18, Report - Mr C Markham (21.05.21), pp3 & 5 and ts 31.05.21 (Markham), pp380-381
[203] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), pp14-15
[204] Exhibit 1, Vol. 2, Tab 2, Statement - Mr J Barber, para 53Winterburn's statement
[205] Exhibit 1, Vol. 1, Tab 32A, Report - FC Const. R Winterburn (13.05.17), p4 and ts 26.05.21 (Winterburn), pp101-107
[206] Exhibit 1, Vol. 1, Tab 33, Report - FC Const. J Wolfe, p3 and ts 26.05.21 (Wolfe), p135
[207] Exhibit 1, Vol. 1, Tab 40, Report - Sen. Const. M Kimber (13.05.17), pp8-9
[208] Exhibit 1, Vol. 2, Tab 16, Report - Dr J Ho, Med. Director, Axon (26.04.21), pp4-23 and ts 31.05.21 (Ho), pp320-322
[209] Exhibit 1, Vol. 2, Tab 16, Report - Dr J Ho, Med. Director, Axon (26.04.21), p12 and ts 31.05.21 (Ho), p326
[210] Zipes, D.P. *Can TASER Electronic Control Devices Cause Cardiac Arrest?*, (Jan 2014), Peer Review Journal, p106
[211] Exhibit 1, Vol. 2, Tab 15B, Supplementary Report - Dr J Janssen (25.05.21)

165. In terms of the mechanism by which an adverse cardiac event might occur, Dr Zipes referred to animal studies which had shown that:

> [T]he mechanism by which the X26 provokes cardiac arrest is by capturing the heart and increasing its rate to values too rapid for maintenance of organized electric activity, resulting in VT/VF.[212,213]

166. Dr Ho noted that although studies had demonstrated that a Taser could cause direct cardiac stimulation (causing additional cardiac contractions to occur), electrocution (where the electric current causes the heart to stop beating) had not been demonstrated.

167. Dr Ho also pointed out that external cardiac defibrillators, which are used to directly stimulate a patient's heart, typically deliver between 150 - 360 Joules of energy. By way of contrast, a Taser delivers about 0.1 Joules per pulse. Because of Mr Riley's obesity, the energy required to "*generate a physiologic change at a cellular level*" was calculated to be a minimum of 137 Joules and the Taser delivered energy that was: "*well below that minimum*".

168. Nevertheless, research by Dr Ho and his colleagues has demonstrated that direct stimulation of cardiac tissue from a Taser activation is possible. The key finding of this research was that the stimulation effect operated as a direct function of the distance from the tip of the electrode to the heart, and as Dr Ho observed:

> This work also supports the fact that the further away from the heart the CEW (*i.e.: Taser*) current application is, the lower the likelihood of direct cardiac stimulation.[214]

169. Dr Zipes also emphasised that in common with all cardiac stimulation, the distance between the electrodes delivering the electrical simulation and the heart is critical. As I have observed, there is no evidence in Mr Riley's case that any of the Taser electrodes or Taser applications in dive stun mode were in the vicinity of his chest, much less his heart.

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[212] VT/VF = ventricular tachycardia and/or ventricular fibrillation
[213] Zipes, D.P. *Can TASER Electronic Control Devices Cause Cardiac Arrest?*, (Jan 2014), Peer Review Journal, p106
[214] Exhibit 1, Vol. 2, Tab 16, Report - Dr J Ho, Med. Director, Axon (26.04.21), p12 and ts 31.05.21 (Ho), pp332-334

170. In terms of how close to the heart Taser electrodes would have to be in order to cause an adverse cardiac event, Dr Ho said:

> [I]f you look at the data that's out there, 16 to 17 millimetres dart to heart distance appears to be what's in the literature as the threshold to affect some type of cardiac activity. Not necessarily cardiac arrest but we can cause maybe an extra beat to the heart or something like that so that's what we're using as the threshold.
>
> In order to get a dart that close to the heart there's really a very, very small window on the chest where you would actually have to hit. The heart sort of is a curved structure, it drops quickly away from the outer wall chest. And so that's actually a much bigger distance than…where you kind of think the heart is so it's kind of hard to do, actually.[215]

171. In September 2009, Axon amended its guidance for law enforcement officers in recognition of possible risks associated with Taser use. According to Dr Zipes, the previous guidance from Axon had included warnings to "*aim at the target: centre of mass or legs*" and "*aiming at open front of unzipped jacket*". Dr Zipes said that guidance was amended:

> [T]o "*when possible, avoiding chest shots*…" after…(September 2009)….More recently, they noted that "*heart rate, rhythm capture*" can occur and that "*capture*" and "*cardiac arrest*" can contribute to arrest-related death in physiologically or metabolically compromised persons.[216]

172. Dr Ho confirmed that Axon no longer refers to its Tasers as "*non-lethal*" and since September 2009, has used the term "*less lethal*" instead. However Dr Ho noted that the use of the term non-lethal had been consistent with the definition of that term employed by the United States Department of Defence. Under that definition, referring to a device as non-lethal:

> [D]id not mean it was guaranteed to never cause death, it meant that the likelihood of it was very remote".[217]

[215] ts 31.05.21 (Ho), pp333-334 & 335
[216] Zipes, D.P. Can taser electronic control devices cause cardiac arrest?, (Jan 2014), Peer Review Journal, p104
[217] ts 31.05.21 (Ho), p334

173. Perhaps unsurprisingly, studies appear to establish that a subject's physical attributes and/or their level of intoxication with arrhythmogenic substances[218] are important in determining the risk of a Taser causing an adverse cardiac event. Thus, individuals with "*abnormal*" hearts and/or who are intoxicated with substances known to increase the risk of arrythmias (such as methylamphetamine), may be at an increased risk of an adverse cardiac event following Taser use.[219]

174. Quite apart from the fact that none of the Taser applications in Mr Riley's case were near his heart, it is also important to note that the last Taser activation occurred at least six minutes before his collapse.[220] Energy from the electrical pulses generated by the Taser is not stored within the body and as Dr Janssen observed:

> [I]f the taser would have caused – if the electrical current of the taser applied would have caused an arrhythmia then I would have expected the effect to be much more immediate.[221]

175. The question of whether the Taser used in dive stun mode without a cartridge could have an adverse impact on Mr Riley was raised at the inquest. The suggestion was that although a Taser used in this way cannot cause NMI, it does cause localised pain. This pain would cause the levels of stress hormones (catecholamines) in Mr Riley's body to rise and in turn, this may have contributed to his death by way of cardiovascular collapse.

176. As I have already noted, prolonged intense exertion can lead to metabolic acidosis. In Mr Riley's case, his methylamphetamine intoxication appears to have caused a delirious state in which he ignored the normal cues of exhaustion and showed little or no reaction to the painful stimulus that must have resulted from repeated dive stun Taser activations.

177. The evidence establishes that Mr Riley continued to struggle and resist the attempts of numerous officers to subdue him. In this context, Dr Janssen's view was that Mr Riley's arrythmia was more likely to be related to increased levels of stress hormones related to physical exertion.

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[218] Substances which can cause cardiac arrythmias.
[219] Zipes, D.P. *Can TASER Electronic Control Devices Cause Cardiac Arrest?*, (Jan 2014), Peer Review Journal, p108
[220] Exhibit 1, Vol. 2, Tab 4, Timeline of events (12.05.17)
[221] ts 01.06.21 (Janssen), p413

178. In this context, the question of whether the painful stimulus of the Taser activations added significantly to Mr Riley's overall level of stress hormones is clearly moot. Dr Janssen was asked whether he discounted the "*possibility of the pain affecting the arrythmia*" and his response was:

> [I]t's not black and white. I think it's part of the issue. I don't know how much pain the patient had from the repeated tasers. I don't know how he felt that.[222]

179. Dr Janssen later clarified his position in response to a question from Mr Harwood in these terms

> I already spoke to your colleague about the fact that I think…[Mr Riley]…didn't notice the taser because his catecholamines - his state was already so exaggerated he didn't notice that.[223]

180. In one research study, healthy individuals had their stress hormone levels measured immediately after they were exposed to a variety of stressors. The stressors included grappling with a person for 45 seconds, a 150-metre foot chase, grappling with a police dog, being subjected to a Taser activation and being sprayed with OC spray. The study found that the Taser activation provoked the second lowest increase in stress hormone levels and only the OC spray was lower. Significantly, grappling with someone for 45 seconds caused the highest rise in stress hormone levels.[224,225]

181. On this issue, Dr Ho noted that:

> We have actually looked at…what pain does when you apply a taser to somebody and we have measured that against the same stress hormones in somebody that is exerting themselves and we have not found that it is additive. In other words, if you have somebody exerting themselves, exhausting themselves, they get a very high level of stress hormone circulating in their body. And we have measured that and then we have applied a taser exposure to them while they are in that state and then we remeasured their circulating stress hormones and it is not higher. So in other words, adding that in (*i.e.: the Taser activation*) doesn't seem to make it higher.[226]

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[222] ts 01.06.21 (Janssen), p412
[223] ts 01.06.21 (Janssen), p417
[224] Exhibit 3, Acidosis and catecholamine evaluation following simulated law enforcement UOF encounters
[225] See also: ts 31.05.21 (Markham), pp378-379
[226] ts 31.05.21 (Ho), p324

182. In Dr Ho's view, Mr Riley's "*exertion induced acidosis*" was independent of the Taser activations he was subjected to. Dr Ho concluded that:

> [A] profound state of metabolic acidosis, due to intense physical exertion and methylamphetamine abuse, combined with [Mr Riley's] underlying health, placed him at elevated risk of sudden death. The metabolic acidosis was the most likely cause of [Mr Riley's] cardiac arrest and subsequent death.[227]

183. Dr Ho also noted that methylamphetamine had been shown to "*induce metabolic acidosis independent of any other factor*" and that Mr Riley's "*hypertensive cardiomyopathy*", his "*deconditioned obesity*" and his "*heavy physical exertion and violent resistance*" were all relevant factors in his sudden collapse and death.[228]

184. In any event, as a potential cause of death in Mr Riley's case, Dr Janssen's view was that the Taser activations were: "*on the bottom of the list*". Factors on the top of that list were: "*violent exertion, the restraint and the methamphetamine*".[229]

Comments on the use of Tasers

185. The evidence before me establishes that there is a remote possibility that Tasers can cause adverse cardiac events, but only where one of the Taser electrodes comes within about 17 mm of the subject's heart. The likelihood of an adverse cardiac event increases when the subject has risk factors for arrythmias such as an abnormal heart structure or intoxication with an arrhythmogenic substance. Notwithstanding the fact that the risk of an adverse cardiac event from Taser use may be remote, police officers should obviously avoid "*chest shots*" to minimise that risk and are trained to do so.

186. Having carefully considered the evidence in this case, I have concluded that the Taser activations Mr Riley was subjected to were very unlikely to have directly caused his adverse cardiac event. That is because none of the electrode activations were anywhere near Mr Riley's heart and the last such activation occurred approximately six minutes before his collapse.

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[227] Exhibit 1, Vol. 2, Tab 16, Report - Dr J Ho, Med. Director, Axon (26.04.21), p23
[228] Exhibit 1, Vol. 2, Tab 16, Report - Dr J Ho, Med. Director, Axon (26.04.21), p22 and ts 31.05.21 (Ho), p326
[229] ts 01.06.21 (Janssen), p419

187. Further, I have been unable to conclude that the dive stun applications in this case made any significant contribution to Mr Riley's death. It seems almost certain that as a result of Mr Riley's prolonged and extreme exertion, his stress hormone levels became dangerously high.

188. In accordance with the evidence before me, it does not seem likely that the localised pain Mr Riley would have experienced from dive stun applications of the Taser would have added much to his overall level of stress hormones. It follows that I have been unable to conclude that the use of a Taser by Officer Winterburn can be said to have caused or contributed to Mr Riley's death.

INVESTIGATIONS INTO POLICE ACTIONS

Homicide Squad investigation[230,231,232]

189. Officers from the Homicide Squad conducted an investigation into Mr Riley's death. They examined various items of physical evidence and obtained statements from police, ambulance officers and civilian witnesses. The investigation concluded that there was no criminality in relation to Mr Riley's death and that the involved officers had acted lawfully. The investigation also concluded that the level of force used against Mr Riley was "*not excessive*".

Internal Affairs Unit investigation[233,234]

190. In accordance with Police policy, officers from the Internal Affairs Unit (IAU) examined the conduct of police officers involved in the restraint of Mr Riley. The two issues under investigation were framed in these terms:

> *Issue One:* On 12 May 2017, Rory Winterburn and James Wolfe, in the execution of their duty used unnecessary force on…[Mr Riley], and in doing so breached regulation 609(b) of the *Police Force Regulations 1979.*
>
> *Issue Two:* On 12 May 2017, Mark Kimber, Joel Grant, Nikkolas Wakely, Reece Neville, Nathan Prendergast, Jason Savage, Nikki Eather, Leslie Turner, Laura Sawyer, Tiffany McAlinden, Anton Bongers and Gregg Robson, in the execution of their duty used unnecessary force on…[Mr Riley]…and in doing so breached regulation 609(b) of the *Police Force Regulations 1979.*

191. After considering the available evidence, the IAU investigation concluded that:

> The actions of the police officers in restraining…[Mr Riley]…on the ground and their attempts to control him were deemed not excessive and were justified and reasonable in the circumstances.[235]

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[230] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), p34
[231] ts 25.05.21 (Fowler), p24
[232] See also: Exhibit 1, Vol. 1, Tab 14, Report - Det. Snr. Sgt. C Taylor (Homicide Squad, 03.08.17), p9
[233] ts 31.05.21 (Richards), pp347-350
[234] Exhibit 1, Vol. 1, Tab 16, Report - Det. Sgt. T Douglas & Det. Snr. Sgt A Richards (IAU), pp4-5
[235] Exhibit 1, Vol. 1, Tab 16, Report - Det. Sgt. T Douglas & Det. Snr. Sgt A Richards (IAU), p54

COMMENTS ON THE ACTIONS OF POLICE

Hindsight bias

192. As I assess the actions of the officers in restraining Mr Riley, I must be mindful of the phenomenon known as "*hindsight bias*". Hindsight bias is the common tendency to perceive events that have occurred as having been more predictable now than they were at the time.[236]

193. One manifestation of this phenomenon, namely Mr Riley's attempts to gain control of Officer Wolfe's pistol, has already been addressed. With respect to whether there were any viable alternatives to restraining Mr Riley, I must also have regard to his threats to kill the officers and his combative behaviour, physical size and immense strength.

Criminal Code and UOF policy[237,238239,240,241]

194. After encountering Mr Riley at Officeworks, Officers Winterburn and Wolfe considered he needed to be taken to hospital for treatment of what appeared to be some form of mental health issue. However, when Mr Riley began violently struggling with the officers, it was necessary for them to arrest him for the purposes of an assessment under the MHA.

195. Given Mr Riley's apparently disordered mental state, and his unpredictable behaviour, it was clearly impossible for the officers to disengage once they had interacted with him. Put simply, Mr Riley had to be taken into custody for his own protection and for the protection of the public.

196. The *Criminal Code* permits the use force while effecting an arrest although if the amount of force is unjustified, it will be unlawful. Police are authorised to deploy any of the force options at their disposal (i.e.: open hand tactics, baton, OC spray,[242] Taser and pistol) in accordance with the UOF policy and having regard to the circumstances they are confronted with. There is no requirement to use a lesser force option before a more serious force option may be deployed.[243,244]

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[236] See for example: https://www.britannica.com/topic/hindsight-bias
[237] Criminal Code, sections 231 & 260
[238] Exhibit 1, Vol. 1, Tab 16, Report - Det. Sgt. T Douglas & Det. Snr. Sgt A Richards (IAU), pp48-55
[239] Exhibit 1, Vol. 2, Tab 12, Police UOF Policy (FR-01.01 Use of Force - Generally)
[240] Exhibit 1, Vol. 2, Tab 18, Report - Mr C Markham (21.05.21), pp82-88
[241] ts 31.05.21 (Markham), pp355-357 & pp371-372
[242] Oleoresin Capsicum is the oil derived from the stem of peppers, hence the colloquial term "pepper spray"
[243] Exhibit 1, Vol. 2, Tab 12, Police UOF Policy (FR-01.01 Use of Force - Generally)

Overview of Police interaction with Mr Riley

197. Shortly after Mr Riley was first encountered, he advanced towards Officers Wolfe and Winterburn and threatened to kill them as they backed away defensively. Although the officers considered lesser force options, they determined that it was necessary to subdue Mr Riley with a Taser. Officer Winterburn's initial Taser activation caused Mr Riley to fall to the ground, but its effects were short-lived and subsequent Taser activations were ineffective. As Officer Wolfe tried to handcuff Mr Riley, a desperate struggle ensued, and Mr Riley began a relentless attempt to gain control Officer Wolfe's pistol. Eventually, with Mr Barber's help, the officers were able to exert some level of control.

198. Mr Riley's intoxication with methylamphetamine and his consequently disordered mental state appears to explain why Mr Riley continued to resist attending police, even past the point at which he must have been exhausted. Officers Wolfe and Winterburn believed that Mr Riley posed a serious threat, not only to their own lives, but also to the lives of others. That view was reasonable given Mr Riley's erratic and combative behaviour and his physical size and strength.

199. After the Struggle, the officers were spoken to by Sergeant Vernon Elder (Officer Elder), who attended the scene after Mr Riley had been placed onto a stretcher. The officers told Officer Elder that although they feared for their lives, neither had drawn their pistol. When asked why they had not done so, the officers replied that Mr Riley was unarmed, and that lethal force in those circumstances would have been "*hard to justify*".[245]

200. After the Backup officers arrived, Officers Wolfe and Winterburn withdrew because they were physically exhausted. The Backup officers took over the task of restraining Mr Riley until Mr Riley's sudden collapse but none of them considered they could have acted differently in the circumstances, given tools they had available to them.[246,247,248,249,250,251,252,253,254,255,256]

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[244] Exhibit 1, Vol. 2, Tab 18, Report - Mr C Markham (21.05.21), pp82-88 and ts 31.05.21 (Markham), pp355-357
[245] Exhibit 1, Vol. 1, Tab 49, Report - Sgt. V Elder (26.05.17), p3
[246] Exhibit 1, Vol. 1, Tab 38, Report - Sen. Const. J Savage (13.05.17) and ts 26.05.21 (Savage), p165
[247] Exhibit 1, Vol. 1, Tab 39, Report - FC. Const. A Bongers (13.05.17) and ts 26.05.21 (Bongers), pp174 & 176
[248] Exhibit 1, Vol. 1, Tab 46, Report - FC. Const. L Turner (13.05.17) and ts 27.05.21 (Turner), p187
[249] Exhibit 1, Vol. 1, Tab 45, Report - FC. Const. N Eather (13.05.17) and ts 27.05.21 (Eather), p197
[250] Exhibit 1, Vol. 1, Tab 41, Report - FC. Const. N Wakely (13.05.17) and ts 27.05.21 (Wakely), p205
[251] Exhibit 1, Vol. 1, Tab 43, Report - Sen. Const. N Prendergast (13.05.17) and ts 27.05.21 (Prendergast), pp219-220
[252] Exhibit 1, Vol. 1, Tab 44, Report - Sen. Const. R Neville (13.05.17) and ts 27.05.21 (Neville), pp247-249

Did the actions of Police cause or contribute to Mr Riley's death?

201. The inquest into Mr Riley's death was mandatory because of the operation of section 22(1)(b) of the Act, which provides:

> (1) A coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and…
>
> (b) it appears that the death was caused, or contributed to, by any action of a member of the Police Force.

202. Section 22(1)(b) is enlivened when the issue of causation or contribution in relation to a death arises as a question of fact, irrespective of whether there is fault or error on the part of any member of the Police. In the coronial context, issues of causation and contribution are determined in a common-sense manner. Further, I have approached the issue of contribution on the basis that a factor must have made a material contribution to death in order for it to be said to have contributed to that death.

203. In this case, a cascade of events led to Mr Riley's death. The evidence appears to establish that Mr Riley developed a fatal cardiac arrythmia due to a combination of factors including his medical conditions, his prolonged exertion, and his intoxication with methylamphetamine.

204. I am satisfied that the conduct of Officers Winterburn and Wolfe during their initial interaction with Mr Riley was appropriate and that they acted in accordance with their training and relevant Police policies. Their focus at that time was Mr Riley's welfare, and by calling an ambulance shortly after they encountered him, they took timely and appropriate steps to arrange for him to receive assessment and care.

205. In relation to Officer Winterburn's use of his Taser, for the reasons explained, I have been unable to conclude that the Taser activations Mr Riley was subjected to directly or indirectly caused his death.

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[253] Exhibit 1, Vol. 1, Tab 47, Report - FC. Const. G Robson (17.05.17) and ts 28.05.21 (Robson), pp273-274
[254] Exhibit 1, Vol. 1, Tab 48, Report - Sgt. T McAlinden (15.05.17) and ts 28.05.21 (McAlinden), pp278-279
[255] Exhibit 1, Vol. 1, Tab 37, Report - Sen. Const. L Sawyer (13.05.17) and ts 31.05.21 (Sawyer), p341
[256] Exhibit 1, Vol. 2, Tab 18.1, Report - Mr C Markham (21.05.21), Attachment 1

206. As for the actions of the Backup officers during the Struggle, the evidence is that a number of them were aware of the possible risks associated with PA. Further, with the exception of a brief period at the start of the Struggle, there is no evidence that any of the Backup officers (or Mr Barber) placed any weight on Mr Riley's back, stomach or chest.[257] Instead, attempts to restrain Mr Riley focussed on controlling his arms and legs and I accept that given the circumstances they were faced with, the Backup officers had no viable alternative than to restrain Mr Riley in the manner in which they did.

207. It seems clear that PA did not directly cause Mr Riley's death. Further, given the state of expert evidence in this case, I have been unable to conclude that PA made a significant contribution to Mr Riley's death, although there is a possibility that, in combination with his intense exertion and his methylamphetamine intoxication, it may have played some role.

208. On the evidence before me, I am satisfied that the use of force by the attending police officers (including Officers Wolfe and Winterburn) was in accordance with the relevant provisions of the *Criminal Code* and the UOF Policy. I therefore agree with the conclusions reached by the Homicide Squad and the IAU in their respective reports.[258,259]

209. Finally, after carefully considering the meaning of the words used in section 22(1)(b) of the Act, other than to observe that had Mr Riley not been restrained by police his intense physical exertion would not have occurred, I have been unable to conclude, to the relevant standard, that the actions of any member of the Police caused or contributed to Mr Riley's death.

[257] Exhibit 1, Vol. 1, Tab 32B, Report - FC Const. R Winterburn (20.11.20), p2
[258] Exhibit 1, Vol. 1, Tab 15A, Report - Det. Sgt. B Fowler (Homicide Squad, 31.05.18), p34
[259] Exhibit 1, Vol. 1, Tab 16, Report - Det. Sgt. T Douglas & Det. Snr. Sgt A Richards (IAU), p54

OPPORTUNITIES FOR IMPROVEMENT

General

210. The evidence in this case identifies several opportunities for improvements which, if implemented, may reduce the risk of adverse health outcomes to people in similar positions to Mr Riley.

Dealing with patients who do not wait[260,261]

211. EMHS (which encompasses RPH), does not have a policy dealing with patients who, like Mr Riley, do not wait to be seen by clinical staff. EMHS does however have a policy dealing with patients who discharge themselves against medical advice (the DAMA policy), which provides:

> Follow up contact of the DAMA patient must be attempted as a duty of care, particularly for vulnerable and mental health patients. Contact arrangements are to be appropriately determined by the treating Medical Officer/Psychiatrist.

212. Despite the absence of a "did not wait" policy, Dr Wade stated that what *generally* happens is that if a patient leaves the ED without being seen or before an assessment is completed, a nurse will alert the treating doctors or the Emergency Physician in Charge. The relevant doctor then makes an assessment of the patient's safety.

213. Where the patient is regarded as high risk, then unless it is known that the patient is in the care of friends of family members, the Police are notified and asked to do a welfare check. If apprehended by police, the patient is asked to return to the ED voluntarily. If there are grounds to do so under the MHA, the patient might be returned to the ED (or taken to another approved hospital) for an involuntarily assessment.

214. Dr Wade noted that RPH sees large numbers of patients who are affected by illicit drugs and/or alcohol. Nevertheless, there are no specific policies to guide staff in dealing with such patients because: "*they present with a variety of complaints that may or may not relate to alcohol/drug ingestion*".

[260] Exhibit 1, Vol. 1, Tab 24, Report - Dr H Wade (27.05.20), pp2-3 and ts 25.05.21 (Wade), pp71-72
[261] WACHS Policy, pp2-5

215. In any event, when a patient presents to ED, they are assessed and allocated a "*triage score*", which is essentially an indication of how urgently the patient must be seen. There are no rules about the circumstances in which the police will stay with a patient until they are assessed by an ED doctor, although in Mr Riley's case police remained with him until he left the ED.

216. In circumstances where a patient is assessed by an ED doctor and found to have a mental health disorder which places them at high risk of harm to themselves or others, a staff member is allocated to the patient. Physical and/or chemical restraint may be employed where a high risk patient refuses to remain in the ED. Dr Wade noted that in 2019, a form had been introduced to deal with handovers from police of patients with a known history of violence.

217. In contrast, to EMHS, the WA Country Health Service does have a policy dealing with patients who do not wait to be seen by clinical staff known as the *Management and Review of 'Did Not Wait' Patients that Present to Emergency Services Policy* (Policy). Under the Policy, the "lead triage nurse" is required to make an assessment of the risk posed to the patient by not waiting to be seen. That assessment takes account of a range of factors including the assigned triage score, any observations of concern, the patient's age and ethnicity and whether there are any mental health concerns.

218. Where the patient is assessed as low risk, no further action is required. For moderate risk patients, contact attempts are initiated on the following business day. Where the patient is assessed as high risk, immediate contact is attempted. When this is unsuccessful, the matter is escalated under the *Missing or Suspected Missing Inpatient Procedure*. Where the patient is Aboriginal, follow up action may involve an Aboriginal Liaison Officer (ALO) or an Aboriginal Health Worker.

219. In my view, it would be appropriate for EMHS to introduce a policy dealing with patients who have been seen by a triage nurse and who do not wait for treatment. However, we cannot know whether the outcome in Mr Riley's case would have been any different if a "*did not wait*" policy had been in place at RPH at the relevant time. I acknowledge that police officers made several unsuccessful attempts to contact Mr Riley's family before they left RPH.

220. Perhaps all that can be said is that there is at least a possibility that if Mr Riley's next-of-kin had been contacted, he might have been persuaded to remain in the ED for assessment and have agreed to receive treatment.

Greater availability of Aboriginal Liaison Officers[262]

221. At the time Mr Riley presented to the ED, no ALOs were available. This is because ALOs are only available during business hours. It also appears that RPH does not currently employ any Aboriginal security officers. Had an ALO been available to speak with Mr Riley when he presented to the ED, there is at least the possibility that he may have been more willing to engage with that person. Of course, there is no way of knowing what might have transpired had this occurred, although Mr Riley may have been persuaded to remain in the ED for assessment.

222. Mr McIntyre suggested additional ALOs should be recruited with a view to extending their availability. This proposal undoubtedly has merit, although the challenge will be to fund the new positions and then recruit people with requisite skills. It will also be necessary to employ ALO's who are prepared to work outside normal business hours.

Mental health co-response teams[263]

223. In 2017, the Police introduced mental health co-response teams to provide support to general service officers. The teams operate between 1.00 pm and 1.00 am daily and are comprised of two police officers who have undergone specialist training and a mental health practitioner. Initially, two teams were available, but this was expanded to four in 2019, following a successful two-year trial.

224. The focus of the teams is to de-escalate situations involving mental health issues and to ensure that affected persons receives treatment and care. Clearly, the teams provide the Police with an enhanced capability to respond to subjects experiencing mental health issues. However, I am concerned that the teams are only available between 1.00 am and 1.00 pm. Outside of those hours, only phone support from MHERL or the mental health response coordinator at VKI is available.[264]

[262] ts 25.05.21 (Wade), p78
[263] ts 31.05.21 (Markham), pp386-389
[264] ts 31.05.21 (Markham), p388

225. Mr Markham said he assumed that there was "*some science*" behind the times when the teams are available. However, as I pointed out at the inquest, mental health events are unpredictable and may occur at any time.

226. For that reason, it is my view that the Police should revisit the current availability of mental health co-response teams, with a view to making at least one team available 24-hours per day.

227. In relation to communication skills training, Mr Markham also advised that as at 1 January 2021, about one quarter of all general service police officers had undergone specialist training in this area. The aim is that within two years, all officers will have completed this training.

228. Further, Mr Markham advised that guidelines from the Australia New Zealand Policing Advisory Association had been introduced to assist general service officers when dealing with people apparently affected by mental health issues.[265]

Fastrap leg restraints[266,267,268]

229. At the inquest, the officers involved in restraining Mr Riley were asked whether there were any available alternatives but none of them felt they could have acted differently, given the circumstances. The only thing which may have made a difference was a webbing strap with Velcro fasteners at the ends known as a "*fastrap leg restraint*".

230. Had this device been available at the time, it may have allowed Mr Riley's legs to have been brought under more effective control so that other positions of restraint, including the lateral position, became possible. The fastrap leg restraint is currently being trialled within the Police and it appears to offer a simple and cheap option to effectively restrain combative offenders.

[265] ts 31.05.21 (Markham), p375
[266] Exhibit 1, Vol. 2, Tab 18.5, Report - Mr C Markham (21.05.21), Attachment 5
[267] ts 31.05.21 (Markham), pp373-374, 377-378 & 381-382
[268] ts 31.05.21 (Van Den Esschert), pp392 & 400-401

Re-emphasise risks in relation to Taser use and drug-induced psychosis

231. Mr Markham noted that since September 2009, police training in relation to Taser use has been that officers should "*split the beltline*" and that activations to the subject's chest should be avoided. This is sensible and accords with research by Dr Ho and others which establishes that in limited circumstances, Tasers can cause adverse cardiac events when the electrodes come within close proximity to a subject's heart. In my view, this risk and the risks associated with repeated Taser activations should be re-emphasised in police training.[269]

232. When Officer Winterburn called emergency services and requested an ambulance, the Struggle had yet to unfold. It was therefore appropriate that the ambulance was not called on a priority one basis because at that time, it was assumed that Mr Riley was merely intoxicated with illicit substances or was having a mental health event that did not require emergency attendance.

233. In this case, an ambulance was allocated to attend Officeworks on a priority two basis. When the ambulance arrived on the scene, it was initially instructed to hold back while safety concerns at the scene were clarified. Meanwhile, as noted, the CSP had arrived at Officeworks and was attending to Mr Riley.[270] Once the Struggle had commenced at about 11.49 am, and two members of the public had separately contacted emergency services requesting an ambulance, it would have been appropriate for one of the Backup officers to have enquired about the allocated ambulance priority and to have requested an upgrade to priority one.

234. Although several of the Backup officers were aware that an ambulance had been requested, none of them appear to have been aware of the ambulance's allocated priority. Although one of the Backup officers could have contacted VKI for an update on the ambulance's arrival, this does not appear to have occurred. I accept that it is St John Ambulance and not the Police that determine an ambulance's allocated priority and that in this case, by the time any priority upgrade request would have been appropriate, the ambulance was already in the vicinity of Officeworks.[271]

[269] ts 31.05.21 (Markham), pp361, 378 & 382-384
[270] Exhibit 1, Vol. 2, Tab 11, SJA Patient Care Record (CSN01D2), pp2-4
[271] ts 31.05.21 (Markham), p358

235. Police are currently trained to treat PA and ED as medical emergencies. However, in my view it would be appropriate to re-emphasise the risks associated with these conditions and the importance of requested an ambulance on a priority one basis.[272]

236. In this case, the CSP was given a short briefing by Officer Wolfe about Mr Riley's situation. The CSP was told that when first encountered, Mr Riley had been non-verbal but had suddenly lunged at the officers and become physically and verbally aggressive. The CSP was also told that Mr Riley had been tasered at about 11.45 am and had been "*face down and restrained for about 10 minutes*".[273,274]

237. It is not entirely clear whether the relentlessness of Mr Riley's resistance and/or the number of Taser activations he had been subjected to was clearly explained during Officer Wolfe's briefing. There can be little doubt that this information would have been useful to the CSP in his assessment of Mr Riley's condition. In my view, the need for police to clearly communicate all relevant information to attending ambulance officers, especially in situations involving ED and/or PA should be emphasised during police training.

238. As for chemical restraint, I note that ambulance officers have access to midazolam for use in relation to violent or disturbed patients. However intravenous access is required to administer the medication, and this can be difficult to achieve in the context of a person who is struggling.

239. It is unclear whether sedation would have been appropriate in Mr Riley's case. There is a delicate balance between sedating a person for their own safety and not supressing breathing in a person who, like Mr Riley, appeared to be affected by ED and/or metabolic acidosis. Sedating a person in those circumstances could lead to respiratory collapse and death.[275,276]

[272] ts 31.05.21 (Markham), pp357-358
[273] Exhibit 1, Vol. 2, Tab 11, SJA Patient Care Record (CSN01D2), pp2-4
[274] Exhibit 1, Vol. 2, Tab 10, Statement - Ambulance Officer A Barron, paras 23-31
[275] ts 31.05.21 (Markham), pp357-358
[276] ts 01.06.21 (Joyce), pp433-435 & 440-441

RECOMMENDATIONS

240. In view of the observations I have made, I make the following recommendations:

Recommendation No. 1
In order to promote a patient-centred care approach, the East Metropolitan Health Service should consider introducing a policy to deal with patients who do not wait for treatment, similar to the WA Country Health Service policy entitled: *Management and Review of 'Did Not Wait' Patients that Present to Emergency Services Policy*.

Recommendation No. 2
To enhance the standard of care provided to Aboriginal people, the East Metropolitan Health Service should consider recruiting additional Aboriginal Liaison Officers (ALOs) so as to ensure that ALOs are available outside of business hours on any day of the week.

Recommendation No. 3
As soon as practicable, and assuming the trial currently underway is positive, the Western Australian Police Force should consider making fastrap leg restraints widely available to police officers and should provide training as to the appropriate use of these devices.

Recommendation No. 4
The Western Australian Police Force should consider expanding the number of Mental Health Operational Response Teams, so that these specialists can respond to situations involving mental health issues, including those caused or exacerbated by illicit drug use, (e.g.: drug induced psychosis) at any time of the day or night.

Recommendation No. 5
The Western Australian Police Force should ensure that training in relation to Tasers emphasises the importance of avoiding activations to the subject's chest and heart. Further, such training should emphasise the risks involved with repeated Taser activations and remind officers of the very real possibility that prolonged resistance and physical exertion may create an increased risk of the subject experiencing a potentially fatal health event.

Recommendation No. 6
The Western Australian Police Force should ensure that officers confronting a person exhibiting signs of drug-induced psychosis or related conditions are reminded to treat the situation as a medical emergency and ensure that an ambulance is requested on a priority one basis. Further, all relevant information about the subjects' presentation must be communicated in a timely manner to attending ambulance officers.

Comments relating to recommendations

241. After reviewing the available evidence, I determined that it would be appropriate to make six recommendations. It is my practice to forward a draft of any recommendations I intend to make to interested persons appearing at an inquest and invite comment.

242. On 22 July 2021, Ms Collins forwarded a draft of the above recommendations to counsel for the Police and the EMHS and lawyers for Mr Riley's family.[277] Lawyers for Mr Riley's family and counsel for the Police and the EMHS were broadly supportive of the proposed recommendations. With respect to recommendation 6, Mr Harwood noted that since December 2020, a St John Ambulance Western Australia (SJA) liaison officer has been based at VKI to facilitate the appropriate deployment of SJA resources.[278,279]

[277] Email - Ms R Collins (22.07.21)
[278] Email - Mr J Higgins (ALSWA) to Counsel Assisting (27.07.21)
[279] Letter - Mr D Harwood to the Coroner's Court of Western Australia (30.7.21)

CONCLUSION

243. This case illustrates the scourge of methylamphetamine addiction in our community and the tragic consequences which can flow from that use. A cascade of events which led to the death of a dearly loved 39-year old man, began with Mr Riley's decision to use illicit drugs. As a result of his intoxication with methylamphetamine, Mr Riley's mind was disordered, leading him to exhibit irrational behaviour and threaten to kill police officers who were trying to get him medical help.

244. Despite repeated Taser activations, Mr Riley engaged in a desperate struggle with police during which he repeatedly attempted to gain control of an officer's pistol. Eventually, after the arrival of 12 police officers, Mr Riley was brought under some form of control, before he suddenly collapsed. Despite the efforts of ambulance officers and clinical staff at RPH, Mr Riley could not be revived.

245. I have made six recommendations which I hope will help to improve the care and treatment provided to people in Mr Riley's situation. I take this further opportunity to express my sincere condolences to Mr Riley's family and friends on their terrible loss.

MAG Jenkin
Coroner
30 July 2021