CORONERS COURT
NEW SOUTH WALES

Inquest:	Inquest into the death of **Adam Douglas Southwick**
Hearing dates:	9 -11 March 2015, 6-9 October 2015
Date of findings:	3 December 2015
Place of findings:	State Coroners Court, Glebe
Findings of:	Magistrate C. Forbes, Deputy State Coroner
Catchwords:	Coronial Law-death in custody-death in police station charge dock -positional asphyxia- methyl amphetamine intoxication - implementation of police policy and procedure
File number:	2013/286184
Representation:	Mr E Cox, Counsel Assisting instructed by Mr A Mykkeltvedt, Crown Solicitors Office Mr S Callan and Ms A Rose representing the family Mr D O'Neil representing Senior Constable T Mackney Mr T Watts representing Senior Constable Osborne and Constable Herbert Mr S Beckett representing Sergeant Maria

	Mr B Haverfield representing Sergeant Walsh Mr R Hood representing the Commissioner of Police
Findings:	I find that Adam Douglas Southwick died on 20 September 2013 at Coffs Harbour Health Campus, NSW. I am satisfied the cause of his death was as a consequence of methyl amphetamine intoxication while being restrained in a confined space. Positional asphyxia as major contributory factor in the cause of death cannot be excluded. The manner of his death was misadventure.

IN THE STATE CORONER'S COURT
GLEBE
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This inquest concerns the sad death of Adam Southwick who died on 20 September 2013 while he was in custody at Coffs Harbour Police Station.

2. The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

   (a) the identity of the deceased;

   (b) the date and place of the person's death;

   (c) the physical or medical cause of death; and

   (d) the manner of death, in other words, the circumstances surrounding the death.

3. The Act also requires a Senior Coroner to conduct an inquest where the death appears to have occurred while a person is in lawful custody. (s.23, s.27).

> *"The purposes of a s.23 Inquest are to fully examine the circumstances of any death in which Police ..... have been involved, in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and*

warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."[1]

4. An inquest is an independent judicial inquiry into how a death came about. It is also a way of unearthing situations that may jeopardise lives and finding better ways of reducing those risks. This Inquest has been a close examination of the police actions on the morning of the death and pursuant to s.37 of the Coroner's Act a summary of the details of this case will be reported to Parliament.

Adam Southwick

5. Adam was 37 years of age at the time of his death. He had two children, Jayden born in 2007 and Jye James born in 2009. His family have asked for him to be referred to by his first name in these findings.

6. At the time of his death Adam was living in Gymea with his mother Dianne Veitch. He was also very close to his brother, Joshua. They have both been left bereft.

7. On 13 September 2013 Adam travelled to Coffs Harbour to visit his former de facto and his children. He travelled from Sydney by train and hired a car in Coffs Harbour.

8. On the evening of Thursday, 19 September he spoke on the phone to his brother and mother in Sydney. They said that he appeared fine and was talking about returning to Sydney the following day.

9. Later that evening he had an argument with his former de facto. He became violent toward her and threatened her with a knife

10. She said that his behaviour had changed after he had taken pills.

11. Following the argument Adam attempted to drive his hire car. At about 3.40am, Mr Jarrard Towner, a resident of Vincent St, Coffs Harbour, awoke to hear a loud thud. He

[1] Waller's Coronial Law & Practice in New South Wales 4th Edition, page 106

went out to his backyard and saw the orange flashing lights of Adam's hire car. It appeared to have crashed nose first down an embankment. When police subsequently located the vehicle, they observed that it had extensive front damage, including a cracked windscreen.

Prince Street

12. At about 4 am, just around the corner from where his car was found, he was observed by a number of local residents. He was said to be moaning and groaning. He attempted to open a front screen door. He attempted to climb a fence but fell off it backwards and then staggered into a car, hitting his head. One of the residents, Mr Ball described him as appearing drunk or on drugs. He observed him stagger and fall over a number of times. Ultimately he was seen falling over between two parked cars and then pull himself up onto the nature strip where he lay until police arrived. Another resident, Ms Menrath described him as just lying there and every now and then she could hear him like he was gasping for a bit of air and then sort of yelling at someone and then just going quiet and laying there.

13. Ms Menrath called 000 to request police and ambulance assistance at about 4.45am.

14. Senior Constable Osborne and Constable Herbert arrived at Prince St, Coffs Harbour at around 4:48am.

15. They had previously been in Vincent St where Adam's car had been left.

16. The police saw Adam lying on the ground. He was naked from the waste up. His clothing was on the ground nearby and there were $50 and $20 notes on the ground. He was making loud noises.

17. They helped him get up and assisted him to walk to the police van. One of the residents said he was barely able to walk, half walking and being dragged. Another described Adam as looking like a rag doll. He was not described or observed by any of the neighbours as resisting police in any way.

18. Ms Menrath and Mr Ball gave evidence that they heard the following conversation.

'What's your name?'

'Adam'

'Come on you can't stay here; we're going to help you'.

19. Ms Menrath gave evidence that the police were very nice to Adam.

20. It was evident that Adam was severely intoxicated. Police were not able to further identify him at this point and he could not walk without assistance.

21. Constable Osborne said that they decided to take him back to the police station for further assessment and for a decision to be made as to whether he needed medical attention. He was being detained as an intoxicated person pursuant to s.206 of the Law Enforcement Powers and Responsibility Act 2002 ("LEPRA").

22. Constable Osborne gave evidence that as they were placing Adam into the police van that Adam grabbed Constable Osborne's vest and pulled it down. In evidence, Constable Osborne said that while it may have been consistent with Adam having trouble walking that at the time he formed the view that it was aggressive and an attempt to prevent himself being put in the van. Constable Osborne formed the view it warranted handcuffs being placed on Adam.

23. The local residents that gave evidence did not see this incident or Adam being handcuffed. They were not close enough and the light was not bright enough for them to be in a position to give reliable evidence in detail as to what occurred as Adam was being placed in the police truck.

24. There is no dispute between the witnesses including the police that up to the point of being placed in the van Adam did not resist police.

25. Whether he was resisting getting into the van or was falling over when he pulled Constable Osborne's vest is not clear, certainly by all accounts once he was in the van he began to kick and yell. The residents heard that. Ms Menrath said she could hear him yell and kick once he was inside the police van. Mr Ball said that once Adam was in the van that he said "let me fucking out of here" and that he was banging and crashing in the back of the van. His reaction once in the van may be consistent with him having been reluctant to get into the van.

26. Once he was in the van the police collected Adam's personal affects, clothing and money from the street. They then commenced to drive back to the station.

27. According to police Adam continued to yell out and kick while on route to the police station. Constable Herbert and Senior Constable Osborne radioed police VKG and asked for the ambulance to be called off at approximately 4.59am while on their way back to the station and in fact passed the ambulance which was heading to Prince Street. Ambulance records indicate that the Ambulance had been called off by about 5.04am.

Coffs Harbour Police Station

28. The police vehicle arrived at Coffs Harbour police station at 5:06am. There is a CTTV camera in the garage at the police station. The footage from the camera shows the police van being reversed into the garage and parked. Both Senior Constable Osborne and Constable Herbert then go into the station leaving Adam in the back of the police van.

29. Constable Walsh was the custody manager at the station that evening. He gave evidence that there were two intoxicated persons in the cells for whom he was making arrangements to release when the van arrived. Adam was left in the van in the van dock while that was completed.

30. At 5:09am the footage shows Constable Herbert and Senior Constable Mackney going to the parked van, Senior Constable Mackney checks the inside of the van by looking through the observation window. They both then leave and head back inside the station.

31. At 5:13am, some 7 minutes after the van had arrived at the station; Senior Constable Osborne and Constable Herbert return to the van, open the door and drag Adam out on the ground. He is handcuffed and unable to walk. He appears on the footage to offer no resistance and is unable to stand or walk. They drag him along the corridors to the charge room and he is placed on the floor outside the charge dock. There is CCTV footage of the prisoner corridor and the charge room. Constable Osborne removes Adam's shoes and trousers.

32. Adam is then dragged into the charge dock at 5:15.

33. He cannot sit up. He is dragged into the dock and placed on the floor. The door is closed. He has insufficient room to lie down straight. It is not in dispute that the length of the dock is shorter than he is. At autopsy, Adam was measured to be 1.74m tall with a BMI of 30.72 and the dock was 1.488m. He is cramped and cannot stretch his legs out. A still photograph of him in the dock can be seen at Exhibit 3.

34. After the dock door was closed, at 5:15am, he can be seen moving his legs. At this point there are 5 police officers in the charge room observing him in the dock.

35. At 5:18am he appears to completely stop moving.

36. At 5:19am Senior Constable Osborne knocks on the glass door of the dock and then opens the door and together with Constable Herbert attempts to reposition Adam. Senior Constable Osborne, Constable Herbert, Sergeant Maria and Constable Prado stand near to the dock and watch Adam.

37. At 5:22 Sergeant Maria crouches down and watches Adam closely for a number of seconds.

38. At 5:23 Constable Predo claps her hands at the door as she is checking Adam. Senior Constable Walsh opens the dock door and nudges Adam's leg with his foot.

39. About 30 seconds later Constable Herbert and Senior Constable Osborne start dragging Adam out of the charge dock and Senior Constable Osborne removes Adam's handcuffs and prepares Adam for CPR. Senior Constable Osborne gave evidence that Adam's jaw was clenched tightly closed.

40. At about 5:27 CPR is commenced. Senior Constable Osborne administered mouth to mouth resuscitation while Senior Constable Walsh did chest compressions.

41. At 5:32am ambulance officers arrive.

42. Sadly, Adam was unable to be resuscitated and was taken to Coffs Harbour Health Campus and confirmed life extinct at 6:10am.

Cause of Death

43. On 26 September 2013 an autopsy was conducted by Dr I Brouwer. She determined that the cause of Adam's death was

> *"as a consequence of methyl amphetamine intoxication while being restrained in a confined space. Positional asphyxia as major contributory factor in the cause of death cannot be excluded".*[2]

44. Dr John Vinen, Emergency Physician, provided an independent expert review of this matter. He had a similar view to Dr Brouwer, though placed a greater emphasis on positional asphyxia as the primary cause of death. He was of the opinion that all of the information including the post mortem report and CCTV footage at the police station point towards positional asphyxia in association with drug related sedation as the cause of death.

45. He explained that positional asphyxia occurs when body position interferes with respiration, resulting in asphyxia and that intoxication due to drugs and or alcohol are usually sufficient to prevent the person from moving to a position that protects their airway and or respiration.

46. He said that positional asphyxial deaths tend to occur in a similar manner, with subjects initially struggling with respiratory difficulty, which may go unnoticed, then become quiet and inactive after several minutes at which stage they are noticed not to be breathing.

47. He said that people with an obstructed airway develop paradoxical breathing due to the obstruction in an attempt to breathe where the chest rises and the stomach withdraws followed by the opposite movements for a period of time which to a lay person can look like the person is breathing when in fact no air is flowing in or out, this is followed by cessation of breathing [respiratory arrest] and unless immediately corrected cardiac

[2] Ex 1 Vol 1 Tab 5

arrest.

What should have happened? What are the relevant police policy and procedures?

48. Sergeant Piet, Principal Tutor, Safe Custody, has the responsibility for the development, content and delivery of NSW Police Safe Custody Course. He gave evidence that the legislation and policies that apply to a person in a similar situation to Adam are:

    i. Part 9 LEPRA

    ii. Part 16 LEPRA

    iii. The Law Enforcement (Powers and Responsibilities) Regulation 2005

    iv. NSW Code of Practice for Custody, Rights, Investigation, Management of Evidence (Code of Practice for CRIME).

49. Sergeant Piet gave evidence that having reviewed the available material in relation to this case that the police failed to follow that legislation and policy. The primary and continued failure was failing to identify risk. He gave evidence that the Code of Practice for CRIME states at page 52

> *"Immediately call for medical assistance, (in urgent cases send the person to hospital) if someone is in custody:*
>
> - *Appears to be ill*
> - *Does not show signs of sensibility and awareness; is unconscious*
> - *Fails to respond normally to questions or conversation*
> - *Is severely affected by alcohol or other drugs (eg:inacpaable of standing from a sitting position unassisted, seen to be lapsing in and out of consciousness)*
> - *...otherwise appears to be in need of medical attention"*

50. He said that when the police arrived at Prince Street they had already received a report that Adam was falling over, falling off a fence and falling into vehicles. He noted that when police observed Adam, he was unable to walk and unable to state who he was. At that point, in his view, the risk to Adam's well-being should have been assessed and it should have been clear Adam was a person in need of medical assistance and an ambulance should have been called to attend upon him at the scene.

51. He also said that the failure to identify risk continued back at the police station. He said that the custody manager at the station failed to assess Adam while he was in the back of the van for 7 minutes in the garage at the police station. He said that if an assessment had been correctly done an ambulance should have been called to attend upon Adam at the time he was in the garage. He said Adam should have been placed in the recovery position in the garage pending the ambulance arrival.

52. The police evidence demonstrated confusion as to whether the custody manager had assumed responsibility of Adam's care before he was brought from the garage to the station. Clearly there needs to be clarification in the policy of this point. Either way his risk should have been assessed in the garage when the van arrived at the station. He should not have been left in the van for 7 minutes unaccompanied and unassessed.

53. Sergeant Piet stated that in his opinion a detainee's inability to walk indicates high risk and requires immediate inspection as to level of consciousness. A person in such a state should not be dragged anywhere by police. He says an ambulance should be summonsed to where the person is. Clearly, Adam should not have been dragged from the garage at the police station into the charge room.

54. Once Adam arrived in the charge room Sergeant Piet stated that an immediate assessment should have been undertaken. He should have been left on floor in the recovery position and an ambulance called.

55. An assessment of Adam was not done appropriately.

56. The custody manager, Senior Constable Walsh, gave evidence that in his assessment Adam was fully conscious when he was brought into the charge room. Senior Constable Walsh can be seen on the CCTV footage primarily continuing to be concerned with paper work. My assessment of the objective evidence contained in the

CCTV is that there was clearly an insufficient assessment of risk to Adam by Senior Constable Walsh.

57. Sergeant Piet said the cuffs could have been left on if there was reasonable concern that Adam was feigning and concern that he may suddenly become violent and threaten police. He said that it would have been preferable for Adam to be handcuffed in the recovery position so he could be monitored until an ambulance arrived.

58. Sergeant Piet said that while the custody manager is primarily responsible for the prisoner that every police officer in the station has authority to call for medical assistance.

59. Sergeant Piet said that all police should be aware that it is NSW Police Policy that unconscious people are not to be kept in custody and that all police, regardless of rank, are authorised to call for medical assistance.

60. Sergeant Piet was also critical of the decision to place Adam in the charge dock.

61. When Adam was placed in the dock the risk to him was not appropriately assessed or evaluated. The evidence given by the five police officers standing around the dock at the time demonstrates this;

    a. Senior Constable Walsh, the custody manager, confirmed that Adam was placed lying on the floor of the dock in a position that restricted his ability to move. He didn't believe he was in a cramped position, he didn't notice that his neck was twisted in an awkward position up against the end wall of the glass and he wasn't worried about positional asphyxia. He believed he was in the recovery position. This observation was clearly incorrect.

    b. Sergeant Maria stated that at the time he thought Adam was in a safe position in the dock and it was the most appropriate place for him to be. He said that he didn't consider Adam was at risk for asphyxia. This observation was clearly incorrect.

    c. Constable Osborne stated that that he didn't understand at the time the issues of blocking airways and didn't think Adam might not be able to breathe.

d. Constable Herbert said that he wasn't concerned about the position Adam was placed in the dock. He said that the position Adam ended up in was virtually the recovery position but obviously tight for space.

e. Constable Predo said that when Adam was in the dock, he was lying very cramped up and his head and shoulders were pressed up against the wall of the dock. His head was in a position that was pressed up against his chest. She believed he was too big for the dock lying on the ground. She was questioned on the risk of positional asphyxia and she stated she wasn't concerned about his breathing.

62. Clearly these observations and assessments were all poor. Several of the involved officers had recently completed the NSW Police Safe Custody Course. This indicates that the police training as to how to assess consciousness and the risk of positional asphyxia has not been adequate or is not being followed.

63. After observing the CCTV footage of Adam in the charge dock, Dr Vinen stated that the space on the floor into which Adam was placed was too short to allow him to lay down without compromising his airway. He said Adam was clearly unconscious when placed on the floor of the dock with the observed leg movements attributable to involuntary movements made in an attempt to breathe while his airway was obstructed due to his position in the charge dock.

64. He said that what is apparent is that Adam arrested some time prior to the police pulling him out of the dock. He said

"His head was pressed against the front corner of the dock with his neck flexed and he can (stet) moving his legs then ceasing to move at 0515 hours prior to the agonal event at 0518 hours followed by police officers repositioning him at 0519 hours then observing him for a short period then walking away then returning to observe him again followed by dragging Adam out of the charge dock commencing cardiac massage at 0527h hours

At no stage following the cessation of leg movement followed by the agonal event did he show signs of life."

65. Dr Vinen said that not only did police not appreciate that Adams airways might have been compromised and not only was there was a delay in them recognising that Adam

was not breathing but this was followed by a delay of three minutes commencing CPR after Adam was dragged out of the dock and the handcuffs removed. He said this was significant because the longer the delay in commencing cardiac massage after cardiac arrest, the less likely a successful outcome.

66. There were many days of evidence and cross examination on the issue as to when and how the ambulance that attended upon Adam at the station was arranged. The five officers in the charge room on the evening cannot all agree.

67. The objective evidence shows that the first call to NSW Ambulance was by Constable Predo via VKG at 5.19.56. (which is equivalent to 5.21.53 on CCTV Camera 19).

68. The Second call was by Constable Mackney at 5:22:43. (which is equivalent to 5.24.40 on CCTV Camera 19.)

69. If there was any discussion about calling an ambulance prior to 5:19 it is unlikely from watching the CCTV footage that officers perceived that urgent medical attention was required. Sergeant Maria gave evidence that he said that an ambulance should be called shortly after Adam was placed in the dock. Even if I accept the evidence that this conversation took place it was not acted upon in an urgent manner. The first call to the ambulance was not made until 5:19:56. It was only when the calls were actually made to the ambulance that the officers can be seen to be obviously concerned about Adam's need for urgent medical attention. At this point, in Dr Vinen's opinion, Adam had already suffered "the agonal event".

70. Both Dr Vinen and Sergeant Piet have expressed the opinion that it should have been evident to the police from the point of time of their arrival at Prince Street that Adam required medical attention. Dr Vinen gave evidence that the majority of patients with methamphetamine intoxication survive with medical treatment.

Report of Death to the Coroner

71. The police Report of Death to the Coroner (P79A) in relation to this incident was substandard. It includes the following inaccurate and apparently self-serving statements:

a) Paragraph 2 states that the police requested NSW Ambulance to attend the police station while they were on route back to the station. This was inaccurate and misleading. The NSW ambulance was in fact cancelled by the police on their way back to the station.

b) Paragraph 3 states that the deceased arrived at the station at 5:13. This was also inaccurate. The deceased arrived in the garage at the station seven minutes before that.

c) Paragraph 4 states that it was due to his aggressive behaviour that the deceased remained handcuffed whilst in the dock and that during this time the deceased continued to be agitated and aggressive. This description of Adam while he was in the dock is also inaccurate and misleading. By the time Adam was placed in the dock he was handcuffed, unable to walk and was dragged into the dock. Adam was unresponsive for the time he was in the dock. The P79A gives an inaccurate impression that the officers were dealing with an aggressive individual that needed to be forcibly restrained.

72. These apparent inaccuracies came to my attention towards the end of the inquest. Accordingly it was not possible for evidence to be called in relation to all of them. There is not sufficient evidence before me to enable me to determine how all of these inaccuracies came to be.

73. I have been handed up a copy of an amended P79A dated 25 September 2013. That document never made its way to the Coroner's file. In any event I note it still had Adam arriving at the police station at 5:13 and it too described Adam in the charge dock as continuing to yell at police. On any viewing of the CCTV footage this is clearly incorrect.

74. A report of death to a Coroner is an important document particularly in matters which involve deaths in police custody where there is a need for a transparent and independent investigation from the outset. It is of concern that in this matter the report to the Coroner was so manifestly incorrect.

75. I now move to the formal findings and recommendations.

FINDINGS

I find that Adam Douglas Southwick died on 20 September 2013 at Coffs Harbour Health Campus, NSW. I am satisfied the cause of his death was as a consequence of methyl amphetamine intoxication while being restrained in a confined space. Positional asphyxia as major contributory factor in the cause of death cannot be excluded. The manner of his death was misadventure.

RECOMMENDATIONS

To the NSW Minister for Police

1. That this matter be investigated and reviewed by the New South Wales Police Professional Standards Command.

2. That the NSW Police Force reviews the implementation of policies and training (including continuing professional development programs) dealing with ill or intoxicated detainees.

3. That the Code of Practice for Crime be revised so as to include:

    i. A clear demarcation of responsibility for persons in custody, including when and in what circumstances a custody manager assumes responsibility for a detainee from arresting police;
    ii. The importance of promptly removing persons from police vehicles upon arrival at a station so that they can be appropriately monitored and assessed;
    iii. In the event of delay in removing persons from police vehicles, the need for face to face monitoring whether by the custody manager or a delegate;

iv. The circumstances in which it is inappropriate to place an ill or intoxicated person in a dock;
v. The inappropriateness of dragging detainees who are unable to walk by reason of illness or intoxication;
vi. The appropriate procedure for the transport of ill or intoxicated detainees from public places to either a police station or hospital in circumstances where medical attention is required.

4. That the review give consideration to providing further training and/or undertaking further steps to improve the implementation of Police policies in relation to the following:

i. That if a detainee is incapable of sitting upright without assistance and communicating verbally by reason of illness or intoxication, medical assistance should be sought (including by calling an ambulance);
ii. That detainees should not be placed in the dock where, by reason of illness or intoxication, they are unable to sit upright without assistance;
iii. That detainees with a diminished level of consciousness should not be placed in a dock with their hands handcuffed behind their back;
iv. That no detainee should be placed on the floor of the dock or in a confined space that may restrict their movement and ability to breathe;
v. The need to closely monitor ill or intoxicated detainees for fluctuations in consciousness levels.

5. That consideration be given to introducing a requirement that all custody managers and shift supervisors likely to be involved in the supervision of custody arrangements complete the safe custody course;

6. That all NSW Police Stations with custody facilities should clearly display a poster or other document that provides guidance to officers in relation to:
    i. the care and assessment of detainees including in relation to levels of consciousness of detainees

ii. risk factors arising in relation to detainees suffering from intoxication or medical conditions;

iii. a reminder that all police officers, regardless of rank, are able to call an ambulance whenever they consider appropriate.

7. That NSW Police seek to develop and implement a policy or memorandum of understanding with NSW Health and NSW Ambulance regarding the transportation and care of intoxicated detainees

C.Forbes
Deputy State Coroner
3 December 2015