IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 4516

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Reece Richard D'Antonio
Delivered on:	30 July 2020
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	19 June 2020
Assisting the Coroner:	Lindsay Spence, Principal In-House Solicitor

INTRODUCTION

1. Reece Richard D'Antonio was born on 11 June 1992.

2. He was 26 years old when he died on 7 September 2018 after falling eight stories from the 15th floor of a building.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. Mr D'Antonio's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. Mr D'Antonio's death was also reportable because he was a person in care or custody immediately before his death as he was a person whom a police officer was attempting to take into custody.

5. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the deceased was, immediately before death, a person placed in custody or care.

6. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[1] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[2]

7. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[4] or to determine disciplinary matters.

8. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

9. For coronial purposes, the phrase "*circumstances in which death occurred,*"[5] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the

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[1] Section 89(4) *Coroners Act 2008* (Vic).
[2] Preamble and section 67 *Coroners Act 2008* (Vic).
[3] *Keown v Khan* (1999) 1 VR 69.
[4] Section 69(1) *Coroners Act 2008* (Vic).
[5] Section 67(1)(c) *Coroners Act 2008* (Vic).

death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

10. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners.

11. The coronial investigation in this case was undertaken on behalf of the coroner by a member of Victoria Police who was appointed as the coroner's investigator, Detective Senior Constable Brendon Stack from the Melbourne Crime Investigation Unit. A coronial brief was prepared with witness statements taken from Mr D'Antonio's family, persons who witnessed the circumstances leading to Mr D'Antonio's death, and the forensic pathologist's medical examiners report.

12. As Mr D'Antonio's death involved 'police contact,' an active oversight of the death investigation was conducted by Professional Standards Command of Victoria Police. Detective Sergeant Roger Willems produced a report outlining the Victoria Police Oversight Investigation Framework.

13. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[6] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[7] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

14. Coroner Rosemary Carlin initially had carriage of this investigation. Following Coroner Carlin's appointment to the County Court in September 2019 I took over carriage of this matter.

15. At the conclusion of the coronial investigation I was satisfied I was able to find, as far as possible, the identity, the cause of death and the circumstances in which death occurred, so this case was listed for an inquest which was held on 19 June 2020. At the Inquest, the coroner's investigator, Detective Senior Constable Brendan Stack, was called as a witness to give evidence, and the closed-circuit television (CCTV) footage from the EQ tower on 7 September 2018 was played in court.

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[6] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[7] (1938) 60 CLR 336.

16. As the toxicology results indicated Mr D'Antonio had a high reading of methylamphetamine at the time of his death, I sought advice from an expert in toxicology, Dr Dimitri Gerostamolous, Head, Forensic Sciences & Chief Toxicologist at the Victorian Institute of Forensic Medicine.

17. I indicated I would deliver my findings electronically once I had the benefit of his report.[8]

BACKGROUND

18. During his childhood, Mr D'Antonio was diagnosed with attention deficit hyperactivity disorder. He was prescribed Ritalin, but owing to its side effects, ceased taking it.

19. Mr D'Antonio experienced some learning difficulties in high school however his mother, Debra Ellis, noted her son did very well at sports.

20. At age 15 years, Mr D'Antonio's life was touched by tragedy. His brother was involved in a car accident and suffered significant injuries, which required a lengthy hospital admission and rehabilitation. Mr D'Antonio visited his brother in hospital every day. It appears that this life-changing event triggered a change in Mr D'Antonio's personality. Ms Ellis stated that her son became angry. He subsequently left school and started working with his father.

21. Despite doing well at work and his brother eventually returning home, Mr D'Antonio remained angry. Ms Ellis stated he would lash out at small things and they had arguments.

22. In approximately 2013, Ms Ellis became suspicious that her son was using drugs due to his behaviour. At about this time, his parents requested that he take a urine drug test. This culminated in a family argument. Mr D'Antonio moved out of the family home but returned sporadically; the family came to know that Mr D'Antonio was associating with criminals. At one point, he returned to live at home for a period at which time Ms Ellis found drug paraphernalia in his room.

23. In 2016, the family was tragically affected by the sudden illness and death of Mr D'Antonio's sister.

24. Ms Ellis said that after her daughter's death, Mr D'Antonio's behaviour escalated and he ended up serving a period of imprisonment. After his release, he appeared to be getting his life back on track but then disappeared again and only had intermittent contact with his family.

[8] Report prepared by Dr Dimitri Gerostamoulos, dated 22 June 2020.

25. At the time of his death, Mr D'Antonio was a person of interest to Victoria Police for a number of incidents related to aggravated burglaries, thefts, and car-jackings. He was also subject to four outstanding bench warrants for failing to attend on bail to the Melbourne Magistrates' Court on 5 March 2018. These charges related to theft of motor vehicle offences and driving offences.

26. Police made various unsuccessful attempts to find Mr D'Antonio, who had no fixed address. On 28 May 2018, Mr D'Antonio contacted investigators and stated he wanted to hand himself in in two days. At this time, he also contacted his mother and voiced the same intention. He would go on to voice that intention to his mother several more times. However, Mr D'Antonio never handed himself in.

27. Despite their continued enquiries, police were unable to find and apprehend Mr D'Antonio.

28. Mr D'Antonio's criminal history and his estrangement from his family does not detract from the fact that he was a beloved member of his family who very much miss him, and his death was a tragedy.

IDENTITY OF THE DECEASED PURSUANT TO SECTION 67(1)(a) OF THE ACT

29. Mr D'Antonio was visually identified via fingerprint identification. Identity was not in issue and required no further investigation.

30. Identity is not in dispute and requires no further investigation.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO SECTION 67(1)(c) OF THE ACT

31. Early in the morning of 7 September 2018, Mr D'Antonio and three other persons entered an apartment on the 11th floor of the EQ Tower at 135 A'Beckett Street, Melbourne. It is unclear whether any of the group were staying in the building, but they had a keyless entry device for the apartment.

32. The actions of one member of the group, who parked a vehicle at the front of the building, raised the suspicions of the building's security guard. Another male parked another vehicle behind the first and later joined the group.

33. After making enquiries, the security guard of the EQ Tower became aware that one of the vehicles that had been parked at the front of the building had been listed as stolen. He

subsequently contacted emergency services. It later became apparent that the other vehicle was also stolen.

34. Victoria Police members arrived at the building at 6.18am. The two members of the group who had parked the vehicles were subsequently identified by the security guard and arrested in the lobby of the building.

35. After some time, one of the other group members entered the lobby and observed his associates under arrest. He thereafter returned to the remaining members of the group, which included Mr D'Antonio, in the apartment on the 11th floor. The three subsequently left the apartment and entered the stairwell and thereafter moved between the different floors of the building. The female member of the group eventually left the building. Mr D'Antonio and the remaining member of the group continued to move to different floors of the building while being tracked on CCTV by police and building staff.

36. The duo subsequently separated. Mr D'Antonio eventually gained access to the 15th floor. His associate was arrested on the ground floor.

37. On the 15th floor, Mr D'Antonio entered an unlocked apartment. At this time, the resident of the apartment was asleep. Mr D'Antonio wedged an ironing board under the front door handle in an attempt to barricade the door. He also poured a liquid, possibly oil, on the floor just inside the door.

38. At the same time, further police members, including the Critical Response Team (CIRT), arrived at the building to assist with the search for any outstanding persons associated with the group. They commenced a floor by floor search of the building.

39. In the apartment on the 15th floor, Mr D'Antonio made a number of telephone calls. About this time, the apartment's resident awoke and found Mr D'Antonio in his apartment. Due to a communication barrier, the resident did not understand what Mr D'Antonio wanted. Mr D'Antonio telephoned a friend to interpret but his intentions and wishes remained unclear.

40. The resident eventually left the apartment, leaving Mr D'Antonio alone inside. Outside his apartment he was met by police who were on the same floor. He informed them that Mr D'Antonio was inside his apartment.

41. At approximately 8.00am, Mr D'Antonio climbed over the balcony of the apartment. Although it is unclear exactly what Mr D'Antonio was attempting, it appears he was trying to

move to one of the adjacent apartments. Unable to access the other apartments, he then attempted to pull himself back up but found he could not. He began to yell *"Fuck, fuck"* or *"No, no"* before he lost his grip and fell eight storeys to the decking in the garden area on the seventh floor. Mr D'Antonio sustained multiple significant injuries.

42. Several witnesses, including a male resident of the EQ Tower who was in the seventh-floor garden at the time, saw Mr D'Antonio hanging from the building and his subsequent fall. The resident in the seventh-floor garden began screaming for help. The witness confirmed that no one else was on the balcony at the time of Mr D'Antonio's fall.

43. At the same time, a CIRT unit gathered outside the door of the apartment, however they did not attempt to enter the apartment nor announce their presence. Their intention was to wait for another CIRT unit before conducting a breach and hold, which would involve opening the door and calling Mr D'Antonio out of the apartment to minimise any risks or injury to police members or Mr D'Antonio. While waiting, the CIRT members remained as quiet as possible and turned their radio volume down.

44. There is some inconsistency in the statements about what happened during the next few moments. However, what is clear is that as the second CIRT unit travelled down to the 15th floor in the elevator, the girlfriend of the resident who had been in the garden and saw Mr D'Antonio fall entered the lift. She was visibly distressed as her boyfriend had informed her what had happened. Due to a language barrier, it was unclear what she was saying but it was clear that there was a commotion on the seventh floor.

45. As the elevator arrived on the 15th floor, the second CIRT told the first CIRT unit that they were required on the seventh floor and immediately left.

46. At the 15th floor apartment, the CIRT members slowly opened the door and entered while announcing their presence. Upon entry, they searched each room but did not find anyone. A member then moved to the balcony and looked over the edge and down into the garden area where he observed Mr D'Antonio.

47. It is clear from the CCTV footage that the CIRT team did not enter the apartment until after Mr D'Antonio had fallen.

42. Paramedics attended and declared Mr D'Antonio deceased.

MEDICAL CAUSE OF DEATH PURSUANT TO SECTION 67(1)(b) OF THE ACT

43. On 10 September 2018, Dr Heinrich Bouwer, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Mr D'Antonio's body and reviewed a post mortem computed tomography (CT) scan.

44. The autopsy revealed multiple significant injuries, including skeletal fractures and internal injuries.

45. Toxicological analysis of post mortem specimens taken from Mr D'Antonio identified methylamphetamine, including amphetamine.

46. After reviewing toxicology results, Dr Bouwer completed a report, dated 4 March 2019, in which he formulated the cause of death as "*1(a) Injuries sustained in a fall from height*". I accept Dr Bouwer's opinion as to the medical cause of death.

47. As previously noted, owing to the high level of methylamphetamine detected, I sought expert advice from Dr Dimitri Gerostamoulos.

48. Dr Gerostamoulos noted:

> *One of the main effects sought by amphetamine users is euphoria, the high experienced with the amphetamine rush in the body. This high is associated with an elevation of mood and increased alertness. Increased confidence and increased mental and physical strength become part of this effect. This high may last for several hours.*
>
> *Amphetamines stimulate the CNS* [central nervous system] *causing a person to become hyperactive and more aroused. Blood pressure and heart rate are also increased. This stimulation lasts as long as the drug is present in a person's body, with more intense effects soon after administration.*
>
> *Methylamphetamine can also result in withdrawal, fatigue and uncontrollable sleepiness; this is especially apparent after the stimulatory effects have waned or dissipated.*
>
> *Usual doses of methylamphetamine range from quite low (less than 20 mg) to quite high (up to 200 mg). At high doses the effects of methylamphetamine are quite marked and would be expected to produce high heart rates and blood*

pressure, excessive hyperactivity and marked personality changes.

49. With respect to specific comments regarding the concentration detected in Mr D'Antonio, he stated:

> *Individuals develop a tolerance to the euphoric and stimulatory effects of amphetamines following repeated use and leads to increased doses being required to have the same effects, often exceeding 500 mg daily.*
>
> *The concentration of methylamphetamine in Reece D'Antonio (5.7 mg/L) is high and consistent with chronic use. In addition, amphetamine (0.9 mg/L) was detected, in keeping with the metabolism of methylamphetamine.*

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected with the death:

50. I am cognisant that Mr D'Antonio's death occurred during a police operation in which police members were actively in pursuit of him. I am satisfied that Mr D'Antonio was attempting to avoid police and was likely afraid that he would be apprehended in connection with the stolen vehicles, which would subsequently reveal that he was also subject to outstanding bench warrants. Ms Ellis stated that her son was fearful of the police due to an earlier incident in which he had been hurt.

51. It appears that when police were conducting their search of the EQ Tower, they were unaware of Mr D'Antonio's identity and criminal history.

52. I cannot say whether Mr D'Antonio knew there were multiple police members searching the building. And, I cannot say whether Mr D'Antonio knew or suspected that police members were outside the door of the apartment when he made the decision to climb over the balcony balustrade.

53. I am satisfied that there was no one else was in the apartment when he fell from the 15th floor and I am satisfied that the CIRT unit had not commenced to enter the apartment or formally announced their presence until after Mr D'Antonio already fallen.

54. I cannot say to what proportion, if any, of Mr D'Antonio's decision-making ability was affected by the illicit drugs in his system. The report by Dr Gerostamoulos suggests the

methamphetamines likely heightened Mr D'Antonio's adrenaline levels, which may have affected his ability to think clearly and weigh the risks of his actions. It is unfortunate that he made the fateful and what came to be irreversible decision to climb over the balcony balustrade.

55. However, I am satisfied that Victoria Police members, including the CIRT members, acted within the required operational policies and procedures in performing their duties. On the evidence, I am satisfied that police members could not have predicted Mr D'Antonio's actions and subsequent death.

56. As Mr D'Antonio's use of methamphetamines was related to the circumstances of his death, it is worth noting that the study, '*Rates, characteristics and circumstances of methamphetamine-related death in Australia: a national 7-year study*', assessed the trends and mortality rates of methamphetamine-related death in Australia[9] and found that methamphetamine-related death rates doubled in Australia from 2009 to 2015. Whilst toxicity was the most frequent cause, natural disease, suicide and accident comprised more than half of deaths.[10]

57. As coroner, I have become increasingly concerned by the growing number of deaths I investigate that occur in a context of methamphetamine use. These include both deaths where methamphetamine use is a direct causal factor (for example methamphetamine-involved overdoses, and motor vehicle collisions involving methamphetamine-affected drivers), and deaths where use of the drug is a relevant stressor affecting the mental and physical health of the deceased as well as their relationships with partners and family and friends.

58. My anecdotal observations regarding methamphetamine involvement in Victorian deaths are reflected in a range of evidence showing that the burden of methamphetamine-related mortality has increased substantially over the past decade:

    (a) a 2014 Coroners Prevention Unit data summary prepared for the Parliament of Victoria's Law Reform, Drugs and Crime Prevention Committee, showed that between 2009 and 2013 the annual frequency of deaths reported to the Coroners Court of Victoria where methamphetamine was detected more than doubled, from 66 deaths in 2009 to 166 deaths in 2013;

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[9] Shane Darke, Sharlene Kaye and John Duflon (2017) 'Rates, characteristics and circumstances of methamphetamine-related death in Australia: a national 7-year study' *Addiction*, 112(12), 2191.
[10] Shane Darke, Sharlene Kaye and John Duflon (2017) 'Rates, characteristics and circumstances of methamphetamine-related death in Australia: a national 7-year study' *Addiction*, 112(12), 2191.

(b) a subsequent national study found that the rate of methamphetamine-related deaths across Australia doubled during the period 2009-2015; and

(c) Victorian Coronial data shows that between 2009 and 2016, the annual frequency of overdose deaths involving methamphetamine rose from 23 to 119. There was a subsequent decline to 93 deaths in 2017, however despite this decline methamphetamine was still the third most frequent contributing drug (after diazepam and heroin) in 2017.

59. The increase in methamphetamine-related deaths – and harms more broadly – has been accompanied by an increase in community efforts to understand and address them. Key developments have included:

(a) the Law Reform, Drugs and Crime Prevention Committee commenced its Inquiry into the Supply and Use of Methamphetamines, particularly 'Ice', in Victoria in 2013, and delivered its Final Report in September 2014. The Final Report contained 54 recommendations;

(b) these recommendations were considered by the Victorian Government's Ice Action Taskforce, which developed an Ice Action Plan (released on 5 March 2015) to coordinate the response to methamphetamine-related harms;

(c) the Ice Action Plan in turn informed the development of the Victorian Drug Rehabilitation Plan, launched in October 2017. This maintained the importance of addressing methamphetamine-related harms, while also expanding the focus to encompass other illegal drugs as well as misuse of pharmaceutical drugs;

(d) in parallel with these Victorian initiatives, the Australian Government also took steps to address methamphetamine harms, announcing its National Ice Action Taskforce in April 2015 and National Ice Action Strategy in December 2015. The National Strategy included funding for programs over a four-year period.

60. There is significant activity at both a state and federal level aimed at reducing the harms associated with methamphetamine use.

61. The decline between 2016 and 2017 in methamphetamine involvement in Victorian overdose deaths was a positive sign, though it is still too early to conclude that this was a 'turning point' as opposed to an anomaly or temporary decline.

FINDINGS AND CONCLUSION

Pursuant to section 67(1) of the Coroners Act 2008 I find as follows:

(a) the identity of the deceased was Reece Richard D'Antonio, born 11 June 1992;

(b) Mr D'Antonio died on 7 September 2018 at EQ Tower, 135 A'Beckett Street, Melbourne, Victoria, from injuries sustained in a fall from height; and

(c) the death occurred in the circumstances described above.

I convey my sincere condolences to Mr D'Antonio's family.

Pursuant to section 73(1) I direct this finding be published on the Internet.

I direct that a copy of this finding be provided to the following:

Debra Ellis, Senior Next of Kin

Richard D'Antonio, Senior Next of Kin

Professional Standards Command, Victoria Police

Detective Senior Constable Brendon Stack, Coroner's Investigator, Victoria Police

Signature:

CAITLIN ENGLISH
DEPUTY STATE CORONER
Date: 30 July 2020