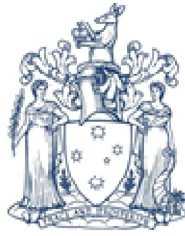

Rule 63(1) Court Reference: COR 2015 0833

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the ***Coroners Act 2008***

Inquest into the death of: ROBERT THOMAS LOVE

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	6 November 2020
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank Victoria 3006
Hearing Dates:	August 2018, 8 August 2018, 27 August 2018, 31 August 2018 & 15 May 2020.
Appearances:	Rachel Walsh of Counsel (instructed by Jeanne Gorman Barrister & Solicitor) on behalf of Christopher Love.
Counsel Assisting the Coroner:	Catherine Fitzgerald of Counsel instructed by In-House Legal Service lawyers.

TABLE OF CONTENTS

FINDING INTO DEATH WITH INQUEST 1

TABLE OF CONTENTS 2

JURISDICTION 5

PURPOSE OF THE CORONIAL INVESTIGATION 5

STANDARD OF PROOF 6

BACKGROUND 7

CIRCIMSTANCES IMMEDIATELY PROXIMATE TO DEATH 10

INVESTIGATIONS PRECEDING THE INQUEST 12

Police Investigation 12

Application for an Inquest 14

Medical Cause of Death 14

Forensic pathology opinion 16

Family concerns 17

Coroners Prevention Unit Review 17

Clinical rationale for prescribing Baclofen in alcohol abuse 19

Clinical rationale for prescribing Baclofen to treat anxiety 20

Contraindications and cautions in prescribing Clofen (“Baclofen”) with other drugs 21

Documented signs and symptoms of Baclofen overdose 22

Reasonableness of Baclofen prescribing 24

Determination not to hold an Inquest 24

Additional Family concerns 25

In-house Legal Services Review 26

Police Contact with Robert 26

Review of Family concerns 29

Directions Hearing 31

INQUEST 32

The cause of Robert’s death 32

Toxicological Analysis 38
Locating Robert and the Victoria Police Investigation 40
FURTHER INVESTIGATIONS 42
RESUMPTION OF THE INQUEST 43
COMMENTS 44
FINDINGS 47

I, AUDREY JAMIESON, Coroner having investigated the death of ROBERT THOMAS LOVE

AND having held an Inquest in relation to this death on 7 August 2018, 8 August 2018, 27 August 2018, 31 August 2018 and 15 May 2020 (via Cisco WebEx)

at Southbank

find that the identity of the deceased was ROBERT THOMAS LOVE

born on 19 April 1981

and the death occurred between 14 and 18 February 2015

at Unit 1 of 40 Railway Road, Briar Hill, Victoria 3088

from:

1 (a) UNDETERMINED

SUMMARY

1. Robert Thomas Love[1] was 33 years of age at the time of his death. He lived alone in Briar Hill and was self-employed as a landscaper and builder.

2. Robert had a medical history of alcohol abuse and illicit drug use, including the use of heroin, and had experienced mental ill-health. He had attempted to end his own life on a number of occasions.

3. Robert and his former partner, Linda Hunter, had two children together. In 2012, Robert had been imprisoned for family violence-related offences. Ms Hunter was granted a Family Violence Intervention Order to protect her from Robert proximate to his death, however, the pair maintained regular contact.

4. On 18 February 2015, Robert was found deceased, of undetermined causes, in the main living area of his home by Victoria Police members ("Police") who had attended to perform a welfare check at the request of a friend.

[1] With the consent of Mr Christopher Love, Robert Thomas Love was referred to as "Robert" during the course of the Inquest. Save where I have determined formality requires the use of his full name, I have endeavoured to refer to him only as "Robert" throughout the Finding.

JURISDICTION

5. Robert's death was reportable under section 4 of the *Coroners Act 2008* (Vic) [**the Act**], because it occurred in Victoria, and was considered unexpected, unnatural and to have resulted, directly or indirectly, from an accident or injury.

PURPOSE OF THE CORONIAL INVESTIGATION

6. The Coroners Court of Victoria is an inquisitorial jurisdiction.[2] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3] The cause of death refers to the medical cause of death, incorporating, where possible, the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[4]

7. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and any recommendations made by coroners; this is generally referred to as the "prevention" role.[5] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with a death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected

[2] *Coroners Act 2008* (Vic) [the Act] s 89(4).

[3] Section 67(1) of the Act.

[4] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[5] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

with the death, including public health or safety or the administration of justice.[6] These are effectively the vehicles by which the prevention role may be advanced.[7]

8. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation.[8]

9. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was the result of homicide, or the deceased was, immediately before death, a person placed in custody or care,[9] or if the identity of the deceased is unknown.

10. In all other circumstances, pursuant to section 52(1) of the Act, a Coroner's power to hold an Inquest is discretionary. This broad discretion must be exercised in a manner consistent with the preamble and purposes of the Act. In deciding whether to conduct an Inquest, a Coroner should consider factors such as whether there is such uncertainty or conflict of evidence justifying the use of the judicial forensic process; whether there is a likelihood that an Inquest will uncover important systemic defects or risks not already known and, the likelihood that an Inquest will assist to maintain public confidence in the administration of justice, health services or public agencies.

STANDARD OF PROOF

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, coroners should give effect to the principles enunciated in *Briginshaw v Briginshaw*. [10] These principles state that in deciding whether a matter is proven on the balance of

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[6] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[7] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[8] Section 69(1) of the Act.

[9] Section 52(3A) of the Act provides an exception to the requirement of a mandatory inquest into the death of an individual in custody or care immediately before death if the death is due to natural causes.
[10] (1938) 60 CLR 336.

probabilities, in considering the weight of the evidence, the deicison-maker should bear in mind:

- the nature and consequence of the facts to be proved;
- the seriousness of any allegations made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and
- if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.[11]

12. The effect of the 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.

13. This finding draws on the totality of the material obtained in the coronial investigation of Robert's death. That is, the court file, the Coronial Brief prepared by Senior Constable Simon Webber and further material obtained by the Court, together with the transcript of the evidence adduced at Inquest and the closing submissions of counsel.

14. In writing this finding, I do not purport to summarise all the material evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any particular aspect of the evidence that it has not been considered.

BACKGROUND[12]

15. Robert was the third child and only son born to Marijke and Christopher Love. He was a 'good kid', who struggled in school with literacy and numeracy and grew up, along with

[11] *Briginshaw v Briginshaw* (1938) 60 C.L.R. 336.

[12] This section is a summary of background and personal and/or uncontentious circumstances that provide a context for those circumstances in which death occurred.

his older sisters Michelle and Catherine, in a household where there was conflict between his parents.[13]

16. Robert's parents separated when he was about 18 years of age; he went to live with his mother[14] and his behaviour became volatile and abusive on a background of increasing drug and alcohol abuse.[15]

17. During his early 20s, during a relationship breakdown, Robert attempted to end his own life by means of carbon monoxide poisoning. Some months later, he made another suicide attempt in similar circumstances. On both occasions, Police conveyed Robert to the Austin Hospital. By late 2002, it was apparent to Robert's family that his drug and alcohol issues were significant.[16]

18. In 2005, Robert formed a relationship with Linda Hunter, and they started living together before the birth of their first child the following year.[17]

19. Michelle Love reported that her brother's drug use escalated following the death of his mother in 2006, and the death of a good friend in 2007.[18]

20. In 2009, Robert bought his first house, in Railway Road, Briar Hill, and lived there with Ms Hunter and their child. In 2010, the couple had a second child.[19] According to Ms Hunter, their relationship, particularly after the birth of their first child, was 'on and off' due to Robert's volatility and aggressive outbursts.[20]

21. In January 2012, an intervention order was granted allowing Robert and Ms Hunter to live together but prohibiting him from committing family violence.[21]

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[13] Statement of Christopher Love.

[14] I note that Robert's mother, Marijke Love died from cancer in December of 2006.

[15] Statement of Christopher Love.

[16] Ibid.

[17] Statement of Linda Hunter.

[18] Statement of Michelle Love.

[19] Statement of Linda Hunter.

[20] Ibid.

[21] Ibid.

22. Members of Robert's family were aware of the conflict between him and Ms Hunter and attributed it to a combination of work and life stressors[22] and heavy drug use.[23] Christopher Love observed that his son's mental health deteriorated in early 2012.[24]

23. In March 2012, Robert consumed heroin, methylphenidate (Ritalin), alcohol and a large amount of sodium valproate and was taken by ambulance to the Austin Hospital.

24. In mid-2012, Robert was involved in a siege; he held Ms Hunter and their children hostage at their home.[25] Christopher Love stated that his son wielded a knife at Police and wanted them to shoot him.[26] Police eventually overpowered Robert by shooting him with a 'bean bag gun'.[27] He was arrested and charged with offences including contravention of the intervention order protecting Ms Hunter; Robert was imprisoned for approximately eight months and was released in February 2013.[28]

25. Ms Hunter reported that the couple remained in contact so that Robert could see their children. According to Ms Hunter, Robert would often threaten to end his own life.[29]

26. Dr Tony Michaelson of North Eltham Medical Centre was Robert's general practitioner (GP). Robert attended appointments with his GP fortnightly for opiate replacement therapy; he was stable on a low dose of Suboxone,[30] which reduced his cravings for opiates and the need to use them regularly.[31] However, Dr Michaelson observed a recurring pattern of binge drinking leading to aggressive behaviour.[32] Robert was availed

[22] Statement of Michelle Love.

[23] Statements of Michelle Love and Christopher Love.

[24] Statement of Christopher Love.

[25] Statement of Linda Hunter.

[26] Statement of Christopher Love.

[27] Statement of Michelle Love.

[28] Statement of Linda Hunter.

[29] Ibid.

[30] Suboxone contains both buprenorphine and naloxone.

[31] Statement of Dr Tony Michaelson.

[32] Ibid.

of antidepressants, counselling and rehabilitation options, but did not follow-through consistently.[33]

27. In November 2014, Dr Michaelson referred Robert to A/Prof Alan Gijsbers, a specialist physician in addiction medicine. At their first and only an appointment on 9 January 2015, Robert acknowledged that he used alcohol to deal with his emotions – from three to a dozen stubbies of beer daily – and disclosed suffering severe anxiety, particularly in social situations, since childhood.[34] A/Prof Alan Gijsbers prescribed a 'low dose' of Baclofen,[35] 10mg twice per day, to assist with Robert's alcohol addiction and anxiety. The addiction specialist considered that as well as being a muscle relaxant, Baclofen was a 'very useful drug to decrease anxiety and decrease cravings for alcohol'.[36] A/Prof Gijsbers planned to see Robert for review a month later.[37]

28. In January 2015, Christopher Love visited his son. He found Robert to be relaxed and, uncharacteristically, 'opened up' to him about referrals to an addiction specialist and for anger management therapy.[38] His 'behaviour seemed good' and the two men had a couple of beers together, but 'nothing excessive'.[39]

CIRCIMSTANCES IMMEDIATELY PROXIMATE TO DEATH

29. Ms Hunter reported that over the New Year period, she had seen more of Robert, and they were 'more of a family'.[40] They had a heated argument on the night of Thursday, 12 February 2015 but by the following morning, tensions had abated.[41]

30. The following night, Friday 13 February 2015, Robert and Ms Hunter went to Brunswick Street in Fitzroy. While out, they argued for about two-hours and Ms Hunter

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[33] Ibid.

[34] Statement of A/Prof Alan Gijsbers.

[35] Sold under brand-names, including Lioresal, Liofen and Gablofen.

[36] Statement of A/Prof Alan Gijsbers.

[37] Ibid.

[38] Statement of Christopher Love.

[39] Ibid.

[40] Statement of Linda Hunter.

[41] Ibid.

considered that Robert knew this was the end of their relationship. She contacted Police because Robert was 'following her around' after the argument.[42] Robert was arrested and for being drunk in public, not for breaching the intervention order.[43]

31. After Robert was released from police custody, he went by taxi to Ms Hunter's home to collect his car. Robert pleaded with Ms Hunter to let him in, but she did not, and Robert drove off. Immediately afterward, she received two texts which read, '*please don't leave me*' and '*please you're my one and only*'.[44] Ms Hunter did not reply to these messages.

32. On Sunday 15 February 2015, Ms Hunter sent Robert text messages, enquiring whether he wanted to see the children but received no response.[45]

33. On Monday 16 February 2015, Ms Hunter attended Robert's residence to collect some possessions from the carport and heard him singing and moaning from inside. Ms Hunter assumed he was drug affected and left without initiating contact.[46]

34. On Tuesday 17 February 2015, a neighbour rang Ms Hunter to ask her to check on Robert, as neither he nor his dogs had been seen for a while. Ms Hunter told the neighbour she had been to the premises and heard him inside.[47]

35. At around 3.30pm on Wednesday 18 February 2015, Brandon Pearse attended Robert's home, concerned that he had not heard from his friend for five days and a report that Robert had not gone to work the day before. Mr Pearse felt uneasy because Robert's dogs were inside, and he had not answered the door. Mr Pearse contacted Police.[48]

36. At 6.35pm, Victoria Police members Senior Constable (SC) Simon Webber, SC Simon Gregory and Constable James Delianis attended Robert's home to conduct a welfare check. They knocked on the front door, which was slightly open, and called out, but

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[42] Statement of Linda Hunter.

[43] Ibid.

[44] Ibid.

[45] Ibid.

[46] Ibid.

[47] Statement of Gillian Chwialkowski.

[48] Statement of Brandon Pearse.

received no response. They could hear dogs barking inside. SC Gregory lifted a canvas awning covering the front window and saw Robert lying on the floor of the east side of the living room. It was apparent that he was deceased.[49]

37. Police entered the house through the unlocked front doors which led into a small hallway. To their right, an internal door to the living room was closed. Upon opening this door, two dogs rushed out and police saw a room in disarray and Robert, clothed in only a pair of jeans, lying on his back with arms splayed out on either side of his body and his fists clenched. There was dried blood on Robert's face and a small amount of blood beneath his navel.[50]

INVESTIGATIONS PRECEDING THE INQUEST

Police Investigation

38. SC Webber of Eltham Police Station commenced an investigation of Robert's death and was later appointed my Coronial Investigator.[51] During an examination of the open-plan kitchen-living room of Robert's house where his body was located, police observed three chairs lying on their sides on the kitchen floor and that the refrigerator had been pushed against a door leading outside. Smears of what appeared to be blood and several clumps of hair were found on the kitchen and lounge room floors; police noticed that there appeared to be hair missing from the top of Robert's head.[52]

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[49] Statement of Senior Constable Simon Webber.

[50] Statement of Constable James Dalianis.

[51] A coroner's investigator is a Police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions from a coroner and carries out the role subject in accordance with the Coroner's direction. One of the tasks completed by the Coronial Investigator is the preparation of a brief of evidence. The coronial brief prepared by SC Webber contained, *inter alia*, statements made by Robert's father Christopher Love; sisters Michelle and Catherine Love; ex-partner Linda Hunter; friend Brandon Pearse; a neighbour; General Practitioner at North Eltham Medical Centre Dr Tony Michaelson; Specialist Physician in Addiction Medicine A/Prof Alan Gijsbers along with photographs taken at the scene of Robert's death and other documents.

[52] Statement of Constable James Dalianis. In a photograph taken on 14 February 2015, Robert had a full head of hair.

39. No ‘suicide notes’ or illicit drug paraphernalia were located, however, an empty tablet container was found on the kitchen bench.[53] The container was labelled as containing 100 ‘Baclofen 10mg’ tablets, which had been prescribed by A/Prof Gijsbers and dispensed on 8 February 2015 with dosing instructions to take two tablets daily. Several empty beer bottles were found in the kitchen and, outside, the recycling bin was almost full of similar bottles.[54]

40. Given the displacement of furniture, apparent wounds to Robert’s body and no discernible cause of death, police were concerned that Robert’s death was suspicious. SC Webber notified Police communications of the situation which, in turn, notified Darebin Crime Investigation Unit (CIU). After photographs were taken of the scene, the area was cordoned pending the arrival of detectives.[55]

41. At about 6.45pm, Detective Leading Senior Constable (DLSC) David Breer and two colleagues from Darebin CIU attended Robert’s home. DLSC Breer tasked the general duties police to perform a witness canvass of neighbouring properties and maintain a crime scene log before examining the scene.[56] He observed that the front door had sustained minor damage to the frame, jamb and snib consistent with being forced open,[57] and noted the displacement of furniture and the medication bottle seen by the first responders. DLSC Breer viewed Robert’s body: facial injuries were evident and a third of the hair appeared to be missing from the top of his head; blood was observed on Robert’s stomach, but no injury was apparent.[58]

42. The detectives liaised with the Serious Crime Response Team and the Homicide Squad and arranged for the premises to be forensically examined by the Major Crime Scene Unit (MCSU) and a Fingerprint Branch officer. The MCSU seized several exhibits

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[53] Statement of Constable James Dalianis.

[54] Ibid.

[55] Statement of SC Simon Webber.

[56] Statement of DLSC David Breer.

[57] Ibid.

[58] Ibid.

including a sample of the hair and a swab of apparent blood from the kitchen floor and the empty medication container.[59]

43. Following receipt of the forensic pathology report, and liaison with the Homicide Squad, DLSC Breer determined that there was insufficient evidence to suggest that Robert's death was suspicious.[60]

Identity

44. Robert Thomas Love was identified through fingerprint analysis and comparison with records held by Victoria Police.

45. On 23 February 2015, Coroner Caitlin English completed a Form 8 (Rule 32)[61] *Determination by Coroner of Identity of Deceased* pursuant to section 24 of the Act.

46. Robert's identity was never in dispute and required no further investigation.

Application for an Inquest

47. In a Form 26 *Application for an Inquest*, dated 15 May 2015, Robert's father raised concerns that there were suspicious circumstances surrounding his son's death.

48. A Form 28 dated 10 July 2015 was provided to Christopher Love in which I indicated that I was not in a position to decide whether or not to hold an inquest into Robert's death as I was awaiting the forensic pathologist's report and coronial brief of evidence, both of which would assist me to determine the issue.

Medical Cause of Death

Post-mortem examination

49. Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), reviewed a post-mortem computed tomography (CT) scan of the whole body and the Victoria Police Report of Death, Form 83, and performed a full post-mortem examination.

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[59] Statement of LSC Scott Ellis.

[60] Statement of DLSC David Breer.

[61] The contemporaneous provision; the current provision is Rule 35(5).

50. A ‘blow out’ fracture of the right eye socket was evident on the post-mortem CT scan.[62]

51. During his external examination of Robert’s body, Dr Lynch identified four injuries to the face and neck involving bilateral periorbital bruising and a one centimetre laceration over the left eye, abrasions to the forehead and bruising over the right cheek which extend to the right side of the neck.[63] Although dried blood was evident on the backs of both hands, no injuries were identified.[64] Bruising and abrasions were evident over both of Robert’s lower limbs.[65]

52. Dr Lynch’s chief anatomical findings following autopsy were extensive bruising and abrasions to the face with subcutaneous haemorrhage on the scalp, mild cerebral swelling but no intracranial haemorrhage with immunohistolochemical evidence of grade 1 diffuse traumatic axonal injury.[66] There was haemorrhage in the strap muscles of the neck involving the sternomastoid and sternohyoid muscles and subcutaneous haemorrhage on the back of the right hand and forearm. Although focal proximal left anterior descending coronary artery disease was noted, this was considered an incidental finding; no natural disease process that might be invoked as the cause of Robert’s death was identified.[67]

Toxicology

53. Toxicological analysis of post-mortem blood detected norbuprenorphine,[68] while morphine,[69] buprenorphine,[70] naloxone[71] and quinine[72] were identified in urine.

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[62] Medical Investigation Report of Dr Matthew Lynch dated 14 August 2015.

[63] Ibid.

[64] Ibid.

[65] Ibid.

[66] Dr Lynch added that with traumatic axonal injury (TAI) there is a spectrum of severity from mild subclinical TAI to the widespread axonal damage seen in diffuse axonal injury (DAI). Individuals who have sustained diffuse traumatic axonal injury are typically unconscious from the moment of impact, do not experience a lucid interval and remain unconscious, vegetative or at least severely disabled until death. Lesser degrees of traumatic axonal injury are however compatible with recovery of consciousness, with or without persisting neurological deficits of varying severity (Ellison D and Love S. Neuropathology. 3rd edition. Elsevier 2013. P.281).

[67] Medical Investigation Report of Dr Matthew Lynch dated 14 August 2015.

[68] Norbuprenorphine is the metabolite of buprenorphine.

Baclofen[73] was detected in stomach contents at a level of 3.5mg,[74] but not in blood.[75] Synthetic cannabinoids and synthetic cathinones were not detected.[76]

Forensic pathology opinion

54. Dr Lynch observed that patients withdrawing from Baclofen can experience acute confusion and seizures.[77]

55. The forensic pathologist reported that the cause of Robert's death and the mechanism by which the injuries were sustained was not entirely clear.[78] The injuries to Robert's face and head were consistent with non-specific blunt trauma and it was possible, given neuropathological findings, that they resulted in a concussive brain injury and death. In such a scenario, however, it would be unusual in an adult to find no evidence of intracranial haemorrhage.[79]

56. Dr Lynch commented that the haemorrhage to Robert's neck involving the strap muscles raised the possibility of some form of compressive force having been applied. He noted that pressure applied to the neck can result in reflexive cardiac rhythm disturbances including cardiac arrest.[80]

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[69] Morphine is available as morphine tablets or injection, morphine infusions in hospital, or it may derive from the use of heroin or poppy seeds. Occasionally, small amounts of morphine are associated with codeine use.

[70] Buprenorphine is used to treat pain and opioid dependency. It is available as transdermal patches, as well as sub-lingual tablets for the treatment of opioid dependence. It is available in Australia as products including Suboxone and Norspan Transdermal Patches.

[71] Naloxone is a synthetic opioid antagonist that is used for the treatment of opioid dependency by preventing or reversing the adverse effects including respiratory depression, sedation and hypotension.

[72] Quinine is a drug used for the treatment of muscle cramps and now less commonly malaria.

[73] Baclofen is a synthetic analogue of gamma-aminobutyric acid. It is used clinically for the relaxation of voluntary muscle spasm in multiple sclerosis; and spinal lesions of traumatic or infections degeneration.

[74] Baclofen tablets contain 10mg or 25mg.

[75] Toxicology Report dated 22 June 2015.

[76] Supplementary Toxicology Report dated 15 March 2017.

[77] Medical Investigation Report of Dr Matthew Lynch dated 14 August 2015.

[78]

[79] Medical Investigation Report of Dr Matthew Lynch dated 14 August 2015.

[80] Ibid.

57. Dr Lynch opined that while some of Robert's injuries may have been self-inflicted, the possibility that injuries were inflicted by another individual could not be excluded and the 'blow out' fracture of the orbit was commonly seen in the setting of a blow to the face.[81]

58. Dr Lynch concluded that the cause of Robert's death remained undetermined.[82]

Family concerns

59. In a letter to the Court dated 16 February 2016, Christopher Love raised concerns about what he regarded as a lack of explanation of the injuries Robert sustained and doubts about the thoroughness of the Police investigation, and the events on Friday 13 February 2015, the last time Robert was seen alive.

Coroners Prevention Unit Review

60. Following the receipt of the Form 26, I asked the Coroners Prevention Unit (CPU)[83] to review the circumstances of Robert's death, specifically in respect of the prescription of Baclofen for alcohol cravings and anxiety.

61. The CPU informed me that Baclofen is a synthetic form of gamma-aminobutyric acid (GABA), a major neurotransmitter in the human central nervous system. Baclofen binds to a class of GABA receptors called the GABA-B receptors, which inhibit neurotransmitter release in the central nervous system.[84] Baclofen is usually prescribed in tablet form (the available tablet strengths are 10mg and 25mg Baclofen) and taken orally.

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[81] Ibid.

[82] This case was subject to the Victorian Institute of Forensic Medicine's technical review process and was reviewed by Professor Noel Woodford.

[83] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

[84] For more specific information on the function of GABA-B receptors see SJ Enna, "The GABA Receptors", in *The Receptors: The GABA Receptors*, Edited by Enna and Möhler, 3rd edition, Totowa, New Jersey: Humana Press, 2007, pp.10-12.

62. The Therapeutic Goods Administration (TGA) has approved Baclofen in tablet form for the following indications:

> *Suppression of voluntary muscle spasm in: multiple sclerosis; spinal lesions of traumatic, infectious, degenerative, neoplastic and unknown origin, causing skeletal hypertonus and spastic and dyssynergic bladder dysfunction.*[85]

63. It was identified that Baclofen is less commonly administered in solution form as an intrathecal injection[86] for the following TGA-approved indications:

> *[…] patients with severe chronic spasticity of spinal origin (associated with injury, multiple sclerosis, or other spinal cord diseases) or of cerebral origin who are unresponsive to orally administered antispastics (including oral baclofen) and/or who experience unacceptable side effects at effective oral doses.*[87]

64. The review identified that the exact mechanism of action for Baclofen as an antispastic agent is not fully understood, however, researchers hypothesise that it probably works because of its neurotransmitter inhibition effect. Specifically, spasticity is an involuntary activation of muscles,[88] and the Baclofen may act via GABA-B receptor stimulation to suppress the release of the neurotransmitters that in turn elicit this involuntary activation.[89] For this reason Baclofen is often referred to as a muscle relaxant.

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[85] See for example Therapeutic Goods Administration, Department of Health and Ageing, "Summary for ARTG Entry: 77573 CHEMMART BACLOFEN baclofen 10mg tablet bottle", 26 July 2010, p.1. Note that a muscle spasm is by definition an involuntary muscle contraction. The “voluntary muscle spasm” here refers to involuntary spasms of muscles over which humans usually have voluntary control, such as the skeletal muscles.

[86] An intrathecal injection is an injection into the space under the arachnoid membrane of the spinal cord; this space contains the cerebrospinal fluid.

[87] See for example Therapeutic Goods Administration, Department of Health and Ageing, "Summary for ARTG Entry: 53835 LIORESAL Intrathecal Baclofen 10mg/20mL injection ampoule", 4 August 2011, p.1.

[88] Ganesh Bavikatte and Tarek Gaber, "Approach to spasticity in general practice", *British Journal of Medical Practitioners*, vol 2, no 3, September 2009, p.29.

[89] David E Karol, et al., "A case of delirium, motor disturbances, and autonomic dysfunction due to baclofen and tizanidine withdrawal: a review of the literature", *General Hospital Psychiatry*, vol 33, no 1, January-February 2011, p.84.e2; RD Penn, "Intrathecal Drugs for Spasticity", in *Textbook of Stereotactic and Functional Neurosurgery*, Edited by Lozano, Gildenberg and Tasker, 2nd edition, vol 2 of 2, New York: Springer, 2009,

65. In addition to its TGA-approved uses, Baclofen – like all drugs – can be prescribed for a range of other therapeutic purposes. Prescribing for non TGA-approved indications in Australia is known colloquially as “off-label” prescribing and is not necessarily poor clinical practice. As noted in a recent Australian Prescriber review, the fact that the TGA has not approved a drug for a particular indication does not mean the TGA has rejected the indication:

> *There is no legal impediment to prescribing off label, however the onus is on the prescriber to defend their prescription for an indication that is not listed in the product information. If, in the opinion of the prescriber, the off-label prescription can be supported by reasonable quality evidence, for example the indication is identified in the Australian Medicines Handbook, the prescriber should proceed if this is in the patient’s best interests.*[90]

Clinical rationale for prescribing Baclofen in alcohol abuse

66. It was observed that A/Prof Gijsbers prescribed Baclofen for two purposes, one of which was to relieve Robert’s alcohol cravings. Baclofen is not approved by the TGA for this purpose, so the prescribing was off-label.

67. While the Australian Medicines Handbook and the TGA-approved Baclofen tablet Product Information do not approve the use of Baclofen to treat alcohol dependence,[91] neither do they explicitly state this use is contraindicated. There is a warning in the Product Information that Baclofen taken in combination with alcohol increases the risk of respiratory depression and sedation, and therefore it should be used with caution where patients have a history of alcoholism.

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p.1973; Kelly W Shirley, et al., "Intrathecal Baclofen Overdose and Withdrawal", *Pediatric Emergency Care*, vol 22, no 4, April 2006, p.258; A Dario, et al., "Relationship between intrathecal baclofen and the central nervous system", *Acta Neurochirurgica Supplementum*, vol 97, no 1, 2007, p.462.

[90] Richard Day, “Off-label prescribing”, *Australian Prescriber*, vol 36, 2 December 2013.

[91] “Baclofen”, *Australian Medicines Handbook*, 2013, pp.704-705; Alphapharm Pty Ltd, "Clofen Product Information", revised 25 June 2013.

68. In a statement obtained by the CPU, A/Prof Gijsbers explained his Baclofen prescribing with reference to his clinical experience as well as '*a considerable literature*'. Regarding the second of these two reasons, the CPU confirmed that there is an emerging (and substantial) body of literature about Baclofen as an effective treatment for alcohol withdrawal syndrome, though its mechanism of action in this respect is not well understood.[92] Cochrane Reviews in both 2011 and 2015 concluded that at present there is insufficient evidence to recommend Baclofen as a treatment for alcohol withdrawal syndrome, and more randomised control trials are needed;[93] however the CPU identified that a conclusion of 'insufficient evidence' is very different to a conclusion of 'no evidence', and the very existence of two Cochrane reviews is a good indicator that Baclofen for alcohol dependence is well-established in clinical practice.

Clinical rationale for prescribing Baclofen to treat anxiety

69. The second purpose for which A/Prof Gijsbers prescribed Baclofen was to treat anxiety; again, this is not a TGA-approved use, so the prescribing was off-label.

70. The Australian Medicines Handbook does not mention anxiety as an indication for prescribing Baclofen, but includes a general precaution that Baclofen prescribing carries a risk of aggravating psychiatric disorders.[94] The precaution regarding mental illness in the TGA-approved Product Information for Clofen (a brand of Baclofen tablet) is more specific and does not encompass anxiety:

> *Patients suffering not only from spasticity but also from psychotic disorders, schizophrenia, depressive or manic disorders or confusional*

[92] See for example Giovanni Addolorato and Lorenzo Leggio, "Safety and Efficacy of Baclofen in the Treatment of Alcohol-Dependent Patients", *Current Pharmaceutical Design*, vol 16, no 19, June 2010, p.2113; GM Dore et al, "Clinical experience with baclofen in the management of alcohol-dependent patients with psychiatric comorbidity", *Alcohol and Alcoholism*, vol 46, no 6, 2011, pp.714-720; Renaud de Beaurepaire, "Suppression of alcohol dependence using baclofen: a 2-year observational study of 100 patients", *Frontiers in Psychiatry*, vol 3, December 2012.

[93] J Liu and L Wang, "Baclofen for alcohol withdrawal", *Cochrane Database of Systematic Reviews*, Issue 4, 2015, p.9; J Liu and L Wang, "Baclofen for alcohol withdrawal", *Cochrane Database of Systematic Reviews*, Issue 1, 2009, p.9.

[94] "Baclofen", *Australian Medicines Handbook*, 2013, pp.704-705.

states should be treated cautiously with Baclofen and kept under careful surveillance, because exacerbations of these conditions may occur.[95]

71. On this basis, the CPU concluded that there is no extant prescribing advice that explicitly warns against prescribing Baclofen to people who suffer anxiety.

72. To determine whether the use of Baclofen in treating anxiety might be a recognised clinical practice, the CPU searched for relevant literature and identified several studies examining the anxiolytic properties of Baclofen when administered to animals. However there was very little regarding its anxiolytic effects for humans; the CPU found only a 2003 study reporting that Baclofen was effective in reducing post-traumatic stress syndrome symptoms including depression and anxiety in a group of 11 patients.[96] The CPU notes there is currently a clinical trial underway in the United States of America regarding the use of Baclofen to treat alcoholics who have high anxiety levels.[97]

Contraindications and cautions in prescribing Clofen ("Baclofen") *with other drugs*

73. The TGA-approved Product Information for Baclofen lists the following interactions with other medications:

- Increased sedation and respiratory depression may occur when Baclofen is taken concomitantly with other central nervous system depressants including muscle relaxants, opioids and alcohol.

- The effects of Baclofen may be potentiated by tricyclic antidepressants, leading to pronounced muscle hypotonia.

- Combining Baclofen and lithium may result in hyperkinesia (excessive restlessness and excessive movement).

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[95] Alphapharm Pty Ltd, "Clofen Product Information", revised 25 June 2013, p.3.

[96] RG Drake, et al, "Baclofen treatment for chronic posttraumatic stress disorder", *The Annals of Pharmacotherapy*, vol 37, no 9, 2003, pp.1177-1181.

[97] See US National Institutes of Health, "Baclofen for Treating Anxiety and Alcoholism", updated 25 November 2015, <https://clinicaltrials.gov/ct2/show/NCT01751386>, accessed 18 April 2016.

- Combining Baclofen and monoamine oxidase inhibitors (such as the antidepressant moclobemide and the antihypertensive hydracarbazine) may result in increased central nervous system and hypotensive effects.
- Any drugs that impair renal function may inhibit Baclofen clearance from the body, leading to toxic effects.[98]

74. The Australian Medicines Handbook concurs with this advice, however, summarises it in a more general way:

> *Baclofen causes CNS and respiratory depression and hypotension; administration with other drugs that also cause hypotension or depress respiration, or the CNS may add to these adverse effects.*
>
> *Baclofen may lower the seizure threshold; use with other drugs that can also lower this threshold may further increase the risk of seizures; avoid combination in epileptics or those at risk of seizures.*[99]

Documented signs and symptoms of Baclofen overdose

75. GABA-B receptors are distributed throughout the central nervous system and produce a variety of different actions when activated;[100] consequently Baclofen can have a variety of unintended effects when administered, including toxic effects in overdose.

76. The CPU noted that the most common manifestations of Baclofen toxicity include decreased level of consciousness (somnolence), flaccidity, respiratory depression, and apnoea. More serious toxic effects include coma, seizures, and hypotension, which can lead to death.[101] Research suggests that single oral Baclofen doses above 200 mg can

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[98] Alphapharm Pty Ltd, "Clofen Product Information", revised 25 June 2013, p.5-6.

[99] "Baclofen", *Australian Medicines Handbook*, 2013, p.867.

[100] Norman G Bowery, "GABA-B Receptor as a Potential Therapeutic Target", in The Receptors: The GABA Receptors, Edited by Enna and Möhler, 3rd edition, Totowa, New Jersey: Humana Press, 2007, pp.290-291.

[101] Yusuf Tunali, et al., "Intrathecal Baclofen Toxicity and Deep Coma in Minutes", *The Journal of Spinal Cord Medicine*, vol 29, no 3, 2006, p.237; W Su, et al., "Reduced level of consciousness from baclofen in people with low kidney function", British Medical Journal, 31 December 2009, <http://www.bmj.com/content/339/bmj.b4559.full>, accessed 16 August 2011, p.260.

result in serious toxic effects.[102] A number of case studies have been published about malfunctioning or incorrectly implanted intrathecal pumps that deliver too much Baclofen and result in Baclofen toxicity.[103]

77. In addition to the commonly observed depressive effects of Baclofen overdose, the Clofen Product Information lists a range of other signs and symptoms of Baclofen in overdose, including:

> *[…] confusion, hallucinations, agitation, EEG changes (burst suppression pattern and triphasic waves), accommodation disorders, impaired pupillary reflex; generalised muscular hypotonia, myoclonus, hyporeflexia or areflexia; convulsions; peripheral vasodilatation, hypotension or hypertension, bradycardia or tachycardia or cardiac arrthythmias; hypothermia; nausea, vomiting, diarrhoea, hypersalivation; increased hepatic enzymes.*

78. These signs and symptoms do not specifically include self-inflicted injuries, but it is possible that self-inflicted injuries might be a consequence of (for example) confusion, hallucinations and agitation. Self-inflicted injuries could also potentially result from seizures.

79. The website of the Advisory Committee on the Safety of Medicines (ACSOM), an arm of the TGA responsible for monitoring safety and adverse effects of drugs in Australia, was checked to obtain further information about the less common side-effects of Baclofen toxicity. It appeared that ACSOM has not ever released a report regarding Baclofen, so the review was unable to identify whether these side-effects have ever been reported in Australia.

80. In the US, the Food and Drug Administration (FDA) Centre for Drug Evaluation and Research (CDER) is the body responsible for approving drugs and monitoring their

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[102] Nicola Y Leung, et al., "Baclofen overdose: Defining the spectrum of toxicity", *Emergency Medicine Australasia*, vol 18, no 1, February 2006, p.78.

[103] Yusuf Tunali, et al., "Intrathecal Baclofen Toxicity and Deep Coma in Minutes", *The Journal of Spinal Cord Medicine*, vol 29, no 3, 2006, p.239; Kelly W Shirley, et al., "Intrathecal Baclofen Overdose and Withdrawal", *Pediatric Emergency Care*, vol 22, no 4, April 2006, p.259.

safety and adverse effects. Suspected adverse events are reported via the CDER MedWatch system and public reports on various drugs are regularly produced. MedWatch was searched for reports of adverse events involving Baclofen, and none that addressed the side effects of Baclofen were identified. Similarly, the FDA's Drug Safety Communications and Drug Alerts library was searched, but nothing was identified relating to Baclofen overdose and related side effects.

Reasonableness of Baclofen prescribing

81. A prescriber is required to exercise clinical judgement, informed by both past clinical experience and the existing literature in the area, to determine that the off-label prescribing is (in the words of Professor Richard Day) 'supported by reasonable quality evidence'.[104]

82. The CPU literature search established that Baclofen is clearly recognised to be an emerging treatment for alcohol dependence; its potential clinical use as an anxiolytic has also been explored, though not to the same extent as its use in treating alcohol dependence.

83. Additionally, the TGA-approved Product Information for Baclofen as well as the entry for Baclofen in the Australian Medicines Handbook disclosed no explicit contraindications in Australia to prescribing Baclofen either to people with alcohol dependence or to people suffering anxiety (although there are cautions about alcohol dependent patients because of interactions between Baclofen and alcohol).

84. On this basis, the investigation did not identify any concerns with A/Prof Gijsbers' prescription of Baclofen to treat Robert's alcohol dependence and anxiety.

Determination not to hold an Inquest

85. By way of Form 28 dated 6 September 2016, and pursuant to section 52(6)(b) of the Act, I determined not to hold an Inquest into Robert's death. Having reviewed and considered all the available material, I considered it unlikely that holding an Inquest would advance my investigation, enhance the available evidence or uncover important

[104] Richard Day, "Off-label prescribing", *Australian Prescriber*, vol 36, 2 December 2013.

systemic defects, given that the cause of Robert's death was undetermined. I observed that it is not the role of the Coroner to conduct a free-ranging investigation; in this jurisdiction I am obliged to look at the circumstances connected with Robert's death.[105] I had not identified definitive issues which would be greatly elucidated by way of a public hearing.

Additional Family concerns

86. Following the Form 28 determination, the Court received an email from Christopher Love dated 25 November 2016. He expressed ongoing concerns about his son's death including, *inter alia*, that Robert had been in Police custody shortly before his death and that he felt the possibility of homicide had not been excluded.

87. By way of emails dated 16 November 2016 and 30 November 2016, Jeanne Gorman, Barrister and Solicitor, contacted the Court on behalf of Christopher Love. On 1 December 2016, Ms Gorman spoke with staff at the Court, who advised her that any appeal against the determination not to hold an inquest should be filed in the Supreme Court of Victoria, and that the three-month appeal period would expire on 6 December 2016. Ms Gorman flagged that her client remained concerned about inconsistencies between Police statements and advised that she would construct specific submissions for consideration.

88. By email dated 24 April 2017, Ms Gorman outlined 32 queries made on Christopher Love's behalf primarily relating to perceived inconsistencies within the coronial Brief. In particular, Ms Gorman suggested that despite the Police opinion that there were no suspicious circumstances, there was a possibility of third party involvement in Robert's death, such as by a drug dealer and whether a third party may have stolen the remaining Baclofen tablets, as only a small amount was detected in Robert's stomach. Ms Gorman also raised several evidentiary issues, including whether the following materials had been obtained: a copy of an intervention order granted on 27 January 2015 to protect Ms Hunter from Robert; copies of text messages between Robert and Ms Hunter or Mr

[105] *Harmsworth v The State Coroner* [1989] VR 989 at 996, per Nathan J.

Pearse proximate to his death; Robert's arrest and custody records for 13 February 2015; and a more detailed letter from Robert's GP Dr Michaelson.

89. In addition, Ms Gorman asked if the Coroner had considered a number of issues, including that: Ms Hunter allegedly threatened to have Robert attacked in 2011; the relationship between Ms Hunter and Robert was reportedly improving; the sequence of events in which the initial Police investigation occurred; which of Robert's injuries may have been self-inflicted; and the apparent discrepancy between Dr Lynch's report and other materials, namely, that no hair loss was noted during the post-mortem examination.

In-house Legal Services Review

90. In light of the concerns raised by and on Christopher Love's behalf, I referred this matter to the Court's In-House Legal Service for review. In particular, I sought advice about any 'Police contact' issues arising in the period proximate to Robert's death including his arrest and detention in custody on 14 February 2015 and conduct of the police investigation commenced when Robert was found deceased at his home.

91. During this review, Darebin CIU provided additional photographs to the Court. Among them were photographs taken by the MCSU, and those taken of Robert when he was in Police custody. Statements were obtained from all of the Police who had dealings with Robert on 14 February 2015, including: Sergeant (Sgt) Dale Maxwell, who arrested Robert for being drunk in public in Fitzroy; SC Brian Reidy and SC Luke Swain, who transported Robert by divisional van to custody; SC Shane Ruwhiu, the Custody Officer at Prahran Police Station where Robert was lodged until sober; Sgt Marasco, Custody Sergeant at Prahran, who performed the initial welfare check on Robert in the cells; and Sgt Paul Kerr, who conducted a disposal interview with Robert upon his release from custody.

Police Contact with Robert

92. Sgt Maxwell was performing night shift Patrol Supervisor duties when, at approximately 2.55am on 14 February 2015, he heard a job over the Police radio for an alleged drunk male breaching an intervention order. The complainant was Ms Hunter. Police located

Ms Hunter outside the Night Cat Nightclub in Johnson Street, Fitzroy, and she reported that Robert was at the same nightclub, and that she did not want him near her.[106]

93. Police found Robert, who was alcohol affected, and carried out checks confirming that an active intervention order was in place. They told Robert to leave and Sgt Maxwell explained that Ms Hunter was upset about him being there, and that if he refused their request to leave, he would be breaching the intervention order and would be arrested. Sgt Maxwell negotiated with Robert for a short time before he agreed to leave and not approach Ms Hunter again.[107]

94. About twenty minutes later, Sgt Maxwell saw Robert again, arguing with security staff. He arrested Robert for being drunk in a public place. Sgt Maxwell recalled that Robert was clearly alcohol affected that night and appeared upset about the breakdown of his relationship with Ms Hunter, or at least upset about the restrictions placed upon him by the intervention order.[108]

95. SC Reidy and SC Swain were performing divisional van duties in Fitzroy when they were asked by Sgt Maxwell to transport a drunk male. At approximately 3.24am, Sgt Maxwell directed them to issue Robert with an infringement notice and transport him to the Melbourne Custody Centre (MCC). They ascertained that the MCC was fully occupied and so they transported Robert to the Prahran Police Station.

96. SC Swain had a brief conversation with Robert when he told him he would be lodged in a cell for being drunk. He recalled that Robert had slurred speech, was unsteady on his feet, and smelled strongly of alcohol. Robert was compliant with police, and according to SC Swain, during their minimal interaction he did not recall observing any physical injuries, nor any indications of poor physical or mental health.[109] At approximately 4.00am, Robert was moved into the custody area at Prahran Police Station and placed in a cell.

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[106] Statement of Sergeant Maxwell.

[107] Ibid.

[108] Ibid.

[109] Statement of SC Swain.

97. Custody Sergeant Marasco recorded Robert's arrival at 4.01am and satisfied himself that there was a lawful reason to detain him (that he had been drunk in public), Robert understood why he was in custody and that there were no welfare issues. Sgt Marasco recalled that the first general observation of Robert was made at 4.30am and noted on the Custody Module.[110] Robert was checked by the watch-housekeeper approximately every 30 minutes thereafter; he was checked six times between 4.30 and 7.25am.[111]

98. SC Shane Ruwhiu was the Custody Officer at the Prahran Police Station on 14 February 2015 and entered Robert into the Attendance Register. During this process, the offender's identity is confirmed and s/he is photographed, a safety search is performed, health and welfare issues are canvassed and the Law Enforcement Assistance Program (LEAP) is checked for warning flags.[112] If the offender is drunk or drug affected, the custody officer performs regular checks, where a verbal answer from the offender is required. Once the offender is sober, the Custody Officer asks questions regarding his/her welfare prior to release from custody.

99. Custody Module notes indicate that Robert was in custody from 4.00am until 7.50am on 14 February 2015 and nothing of note occurred.[113] The Prahran Suspect Checklist shows that Robert's property – a lighter, a set of keys, an I-phone, a belt, a wallet and $149 in cash[114] – was checked in at 4.05am and Robert signed for its release at 7.45am on 14 February 2015. Sgt Marasco made the entries in the Attendance Register, the Custody Module and the Suspect Property Sheet.

100. Robert's Attendance Summary indicated no signs of mental incapacity, no visible signs of injury and that during his disposal interview he said he was satisfied with the way he was treated by Police and thanked them.

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[110] Statement of Sgt Marasco.

[111] Statement of Sergeant Maxwell, page 2.

[112] Statement of SC Shane Ruwhiu, dated 21 February 2017, page 1.

[113] Statement of SC Shane Ruwhiu.

[114] Prahran Suspect Checklist.

101. Sgt Paul Kerr was the morning shift Sergeant at Prahran Police Station. Although he had no specific recollection of Robert, his standard practice when releasing those who have been in custody for drunkenness is to make an assessment of their sobriety prior to releasing them, including that they are sufficiently able to manage themselves to not be a danger to themselves or others.[115]

102. Robert's custody photographs, taken at 4.21am on 14 February 2015, do not depict any injuries.

103. The In-House Legal Services review identified nothing of concern arising from Robert's interaction with police on 14 February 2015.

Review of Family concerns

104. The In-House Legal Services also reviewed the concerns raised in Ms Gorman's correspondence dated 24 April 2017.

105. The review observed that there was no evidence of third-party involvement in Robert's death, and that as a result, the potential involvement of a drug dealer had not been pursued, nor had the allegation that Ms Hunter threatened to have Robert attacked in 2011.

106. DLSC Breer oversaw the investigation of Robert's death, with input from DSC Scott Riley of the Homicide Squad, who also attended the scene. Dr Lynch's forensic pathology report was considered by police. The Homicide Squad determined that there were no suspicious circumstances, and the matter was re-classified as a non-suspicious death with DLSC Breer remaining the reviewer of SC Webber's ongoing coronial investigation.

107. In relation to evidentiary issues, the review observed that the intervention order granted on 27 January 2015 was not sourced in the investigation because there was no direct nexus between it and Robert's death. For the same reason, text messages between Robert and Mr Pearse on Friday 13 February 2015 were not obtained.

[115] Statement of Sgt Paul Kerr.

108. SC Webber advised that nothing further of use to the investigation, such as text messages, was obtained from Robert's mobile phone.[116] The review identified that photographs of text messages and missed calls on Robert's phone that were taken when it was examined at the scene on 18 February 2015 were provided to the Court.

109. The review attached little weight to considerations that the relationship between Robert and Ms Hunter had recently been improving, as it was unclear what relevance this had to the investigation or Robert's death.

110. The inconsistencies pointed out by Ms Gorman[117] – slight differences between the statements provided by the first-responding Police – largely related to the sequence of events and initial search of Robert's home.

111. The review observed that Robert's consumption of Baclofen was a major consideration in the coronial investigation. However, it considered Ms Gorman's suggestion that a third party may have stolen remaining Baclofen tablets was hypothetical and could not be substantiated.

112. The In-House Legal Service considered the suggestion that a more detailed letter from Robert's GP be obtained would serve no clear purpose given that Robert's medical records had been obtained.

113. In relation to considering which injuries of Robert's injuries may have been self-inflicted, the review opined that this issue was beyond the scope of a forensic pathologist's role and was open only to speculation due to the lack of evidence.

114. Finally, the review considered Ms Gorman's observation of a discrepancy between the observations made by Police at the scene of clumps of hair strewn about on the floor (and clearly illustrated in scene photographs) and Dr Lynch's report in which 'no hair loss'[118] was noted. Given that the photographs taken of Robert while in police custody

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[116] Email correspondence from SC Webber dated 9 March 2017.

[117] Some of the questions posed by Ms Gorman were excluded from the review as they were considered more relevant to a criminal, rather than coronial investigation; for example, queries in relation to the preservation of the scene, and descriptions of the front door.

[118] Medical Investigation Report of Dr Matthew Lunch dated 14 August 2015.

on 14 February 2015, Dr Lynch was asked to provide a supplementary report addressing the apparent discrepancy.

115. Dr Lynch reviewed the photographs of Robert in custody on 14 February 2015, photographs taken at the scene and photographs taken at the VIFM mortuary. In a supplementary report, Dr Lynch stated that the photographs provided evidence that hair may have been traumatically avulsed from the scalp but there had been no evidence of this on Robert's skin at the time of his examination.[119]

116. The In-House Legal Services review concluded that no 'Police contact' issues required further examination.

Directions Hearing

117. A Directions Hearing was held on 9 October 2017. Ms Jessica Wilby, Principal-In-House Solicitor, appeared to assist me while Rachel Walsh of Counsel appeared on behalf of Christopher Love.

118. A summary of my investigation to that point was provided by Ms Wilby and although a number of avenues had been explored at the request of Christopher Love and/or his legal advisor, no advancement had been made in clarifying the immediate surrounding circumstances nor the cause of Robert's death.

119. I indicated my intention to list the matter for Inquest with the hope that the hearing of *viva voce* evidence would provide the desired clarity. In determining to proceed to an Inquest, I did so using my discretionary powers, under section 52(1) of the Act.

120. Ms Walsh informed the Court that Christopher Love was desirous of an attempt to narrow or define more closely his son's movements from the time he was released from police custody and the time that he was found deceased.[120] Robert's mobile telephone had not been interrogated by Police and I agreed that an attempt should be made to do this forensic analysis to better understand Robert's movements or activities proximate to his death. I also agreed that enquiries should be made about Robert's last use/access

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[119] Supplementary Report of Dr Matthew Lynch dated 18 September 2015.

[120] Transcript of Proceedings (**T**) @ p.8.

to his bank account(s), a report from a VIFM Toxicologist would be sought pending receipt of proposed question from Christopher Love. Ms Linda Hunter would be called as a witness as well as Detective Leading Senior Constable Breen from Darebin CIU so he could explain, in more detail, why Robert's death was reclassified from suspicious to non-suspicious.[121]

INQUEST

121. An Inquest was held on 7 August 2018, 8 August 2018, 27 August 2018, 31 August 2018 and 15 May 2020 (via Cisco Webex).

122. The issues explored during the inquest were the circumstances proximate to Robert's death, the mechanism of his injuries and the cause of death and the basis on which his death was determined to be non-suspicious.

Viva Voce Evidence at the Inquest

123. The following witnesses testified at the Inquest:

- Brandon Pearse
- Detective LSC David Breer
- Dr Matthew Lynch, Forensic Pathologist, VIFM
- Professor Marcus Pandy, Independent Expert (obtained by the Love family)
- Dr Dimitri Gerostamoulos, Head of Forensic Science, Chief Toxicologist, VIFM
- Acting Sergeant Simon Webber, Coroner's Investigator
- Linda Hunter (At the resumption of the Inquest in May 2020)

The cause of Robert's death

124. Dr Lynch gave expert evidence from within his specialised area of medical practice, forensic pathology, in which post-mortem examination is used to determine the pathological process, injury or disease that directly result in or initiates a series of

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[121] T @ p. 18.

events that lead to a person's death; in short, forensic pathologists determine the medical cause of death.

125. Dr Lynch testified that there are several possibilities that may explain Robert's death, but he had no scientific or other basis to elevate any of them into a position of precedence over another.[122]

126. The forensic pathologist opined that in the absence of a skull fracture and intracranial haemorrhage it was less likely that some form of head injury was the cause of Robert's death. Indeed, the autopsy finding of a Grade 1 diffuse traumatic axonal brain injury, the brain's response to some external trauma to the skull,[123] did not support head injury as a cause of death. He said that such an injury could lead to concussion but might not lead to unconsciousness. He described this injury as at the *low end of the scale and close to being "nothing to see here" category*.[124] If Dr Lynch had considered the finding of a Grade 1 diffuse traumatic axonal injury to be sufficient to cause death, he would have ascribed the cause of death to blunt head trauma, but he did not.

127. Dr Lynch said: *if the trauma to the head resulted in some sort of concussive brain injury that might have been a prequel to him developing respiratory depression*.[125] He observed that the effects of alcohol or drugs can also lead to respiratory depression and commented that Robert may have experienced some form of seizure activity in the setting of alcohol or drug withdrawal,[126] or Baclofen withdrawal, again leading to an unprotected airway/airway obstruction or an increased risk of cardiac arrhythmia.

128. However, toxicological analysis of post-mortem blood failed to detect alcohol or any drugs at levels likely to produce respiratory depression sufficient to cause death. That said, Dr Lynch observed, if Robert had sustained a concussive injury, he could have been unconscious but alive for some time and that could explain metabolism of alcohol

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[122] T @ p.102.

[123] T @ p.101.

[124] T @ p. 98, 100.

[125] T @ p. 94

[126] T @ p. 108.

and/or drugs and the lack of evidence of these substances in post-mortem toxicological analysis of blood. He stated that what was anticipated to be identified in a toxicological analysis – that's is, to *provide a likely explanation of what's happened*[127] – was not found and so a determinative cause of death could not be provided. Similarly, Dr Lynch noted that he did not see any evidence in Robert's lungs, such as signs of pneumonia that might have, if present, enabled him to conclude that Robert had been alive for a period of time; *but ... absence of that finding doesn't allow me to exclude the possibility that he's been alive for a period of time.*[128]

129. Dr Lynch stated, candidly:

> *I'm trying to provide the court with possible explanations for how a certain constellation of injuries came to be present in Mr Love and there's areas that I'm, you know, reasonably confident about, so that I think this or this – this might have happened, this is unlikely to have happened. There's other areas where there is uncertainty... a post mortem examination only takes things so far.*[129]

130. Testifying consistently with the analysis provided in his report, Dr Lynch stated that some of Robert's injuries may have been self-inflicted but the possibility that they were inflicted by another individual could not be excluded. He emphasised that if he thought there was no possibility that anyone else was involved, he would have been more definitive in his report by stating that *(t)here's no evidence to suggest the involvement of another person in this man's death.*[130]

131. Dr Lynch said that he had not formed a view about the sequence in which Robert's injuries occurred.[131] He said that any of injuries to the head region could have been disabling and the bruising to the back of the scalp reflects some form of blunt trauma

[127] T @ p. 106.

[128] T @ p. 111.

[129] T @ pp 104 – 105.

[130] T @ p. 115.

[131] T @ p. 151, 154.

but *without knowing exactly how that occurred, that's something that could potentially result in altered consciousness.*[132] Later in his evidence, Dr Lynch qualified this comment, stating that *there's nothing in my autopsy findings that allow[s] me to say this blow would have resulted in loss of consciousness.*[133]

132. Dr Lynch acknowledged that his reference to "no hair loss" in his original report,[134] whilst an attempt to address the report of hair at the scene in the Form 83,[135] was probably too brief and he should have asked to see the photograph that was referred to in the summary of circumstances.[136] Dr Lynch conceded that prior to preparing his third report dated 19 October 2017[137] he had not seen the photograph of Robert taken on 14 February 2015 which clearly showed that Robert had hair on the front of his head.[138] He said that as hair was not present in that region at the time of his post-mortem examination it therefore *would seem extremely likely that the hair on the floor at the scene is Robert's[sic] and sometime before he died that hair was attached to his head in the forehead region.*[139] The possible causes of the hair loss included that Robert or another person had pulled it out and that he could not exclude the possibility that some of the hair had been cut. Dr Lynch thought it unlikely that the hair had fallen out and opined that the less plausible explanation would be to attribute the hair loss to Robert's dogs who were found locked in the house with him.[140]

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[132] T @ p. 156.

[133] T @ p. 157.

[134] Exhibit 3.1.

[135] Exhibit 4.

[136] T @ p. 168.

[137] Exhibit 3.3.

[138] T @ p. 169.

[139] T @ p. 170.

[140] T @ P. 179.

133. Dr Lynch had been provided with a copy of the expert opinion of Professor Marcus Pandy,[141] obtained by Christopher Love's lawyers, and testified that its contents in no way affected anything in his own report.[142]

134. Professor Marcus Pandy (**Professor Pandy**) is a mechanical engineer specialising in biomechanical engineering/biomechanics. The choice of him as expert to comment on matters germane to the investigation of Robert's death seemed, *prima facie,* somewhat unusual. That said, as Professor Pandy's opinions were intended to support Christopher Love's contention that a third party was involved in Robert's death and challenge Dr Lynch's opinion as to the cause of death, it was necessary and appropriate to receive his *viva voce* evidence.

135. Professor Pandy explained that his specialisation of biomechanics[143] was the application of knowledge of the discipline of mechanics to the human body. He said that his research over the last 30 years involved using experiments and computer models *to understand how the skeletal system functions,*[144] for example, how does a particular muscle or ligament injury happen, and what forces are involved in causing the injury. Professor Pandy said the calculations performed in mechanics are based on Newton's law and he uses the same law in his own calculations.[145]

136. In attempting to explain how biomechanics could be applied to an analysis of the circumstances of Robert's death, Professor Pandy stated, by way of example, that in trying to analyse what effect there might be if there was a blow to Robert's head....*the first thing I need to do is try to model how that might have happened. So, one scenario would be that there was a person's fist hitting Rob's head. So, I have two separate bodies, one for the head and one for the fist. And then I calculate what happens when*

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[141] Exhibit 5 – Expert Opinion Report of Professor Marcus Pandy dated 26 July 2018.

[142] T @ p.115.

[143] Professor Pandy's Curriculum Vitae amounts to approximately 50 pages. He explained that his main qualification commenced with completing mechanical engineering but that he his experience and area of specialisation since he commenced his PhD has been exclusively biomechanics or biomechanical engineering. - T @ pp 212 – 215.

[144] T @ p. 182.

[145] T @ p. 184.

those bodies collide and I use my fundamental theory, Newton's law, to calculate after the collision how the bodies might move.[146] He said that the analysis provides an estimate of the impact force that must have existed between those bodies – in this case, the fist and the head. Consequent upon that analysis, Professor Pandy said he could *determine how the head might move*[147] noting that *the level of acceleration, just the movement of the head, that's going to cause injury to the brain*.[148]

137. Qualifying the conclusion reached in his report that the 'most likely cause of death was some form of brain injury resulting from a single impact or multiple impacts to the head',[149] Professor Pandy observed, given all of the injuries, the blow to the head is the 'most likely catalyst' for Robert's death.[150] But as to the mechanism and medical cause of death, the biomechanic conceded that he was 'not qualified to say.'[151]

138. In relation to the avulsion of hair from Robert's scalp, Professor Pandy explained that he had calculated the amount of force required to remove hair from the scalp under two conditions, that is, when a person removes it themselves and if another person removes the hair.[152] His calculations, based on how he imagined the different scenarios unfolding and accounting for the likelihood that more muscles could be used by another person than could be used by oneself, led him to conclude that twice as much hair could be pulled out by another person than one could pull out of one's own head.[153] Using Dr Lynch's observation that some form of compressive force may have been applied to Robert's neck, Professor Pandy said that he developed a scenario that might explain the culmination of injuries, namely, that if hair is being extracted from the scalp by another

[146] T @ p. 188.

[147] T @ p. 189.

[148] T @ p. 189.

[149] Exhibit 5 – Expert Opinion Report of Professor Marcus Pandy dated 26 July 2018.

[150] T @ p. 207.

[151] T @ p. 207, 211.

[152] T @ p. 199.

[153] T @ p. 202, 243-244.

person, it would be a natural thing to restrain the head to do this and this, in turn, explains the compressive injury to the neck.[154]

139. Professor Pandy observed that whether Robert's injuries were self-inflicted or sustained by another person was 'more difficult' question to answer.[155] In forming his opinion about the matter, he considered the number and apparent severity of Robert's injuries and the order in which they 'might have happened';[156] although he conceded that he was not able to determine the sequence of the injuries.[157] Despite this concession, Professor Pandy concluded by reference to the sequence of injuries – with the head/brain injury sustained first and, in the alternative, sustained last – it was 'more easy' to explain the injuries if that they were inflicted by someone other than Robert.[158]

Toxicological Analysis

140. Dr Gerostamoulos clarified the capabilities of toxicological analysis of specimens including its limitations in detecting the presence of certain drugs, in particular the synthetic cannabinoids and synthetic drugs in general.

141. The toxicologist opined that the identification of morphine in Robert's urine maybe related to his past use of heroin but in his view, the most likely explanation for the morphine in urine related to ingestion of codeine or paracetamol, traces of which were identified in the analysis.[159]

142. In relation to Baclofen, Dr Gerostamoulos said that there was a very small amount present in blood,[160] it was below a "detectable level" or below the laboratory's capacity to measure the drug. Nevertheless, Dr Gerostamoulos could not entirely rule out Baclofen toxicity in Robert's case. He was aware that Baclofen is prescribed for

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[154] T @ p. 204.

[155] T @ p. 208.

[156] T @ p. 208.

[157] T @ p. 208-209.

[158] T @ p. 209.

[159] T @ p.252.

[160] T @ p 254.

alcohol dependency although it is mainly prescribed for muscle spasticity, and although there are other drugs that can be prescribed for alcohol dependency, there is some anecdotal evidence that it is effective for some people with alcohol dependence. He said that Baclofen is *not a frontline therapy for alcohol dependency*.[161]

143. Dr Gerostamoulos said he could not rule out that Robert had an adverse reaction to Baclofen in combination with alcohol consumption, even though the toxicological analysis did not identify alcohol. He observed that alcohol should not be taken with prescription medication particularly if is *designed as a treatment for someone who is alcohol dependent ... because the drug ... is administered as part of the pharmacotherapy process ... to reduce those cravings or those wants for the original drug*,[162] alcohol.

144. Similarly, the toxicologist could not rule out an adverse event associated with Baclofen ingestion *which has led to some enhanced respiratory depression.*[163] He said Baclofen *in excess can cause central nervous system depression, can cause respiratory depression and can enhance some of the toxic effects of some of the other drugs that may have been consumed, and that includes alcohol ... buprenorphine and ... morphine.*[164]

145. Dr Gerostamoulos stated that a clinician prescribing Baclofen for alcohol dependency would need to be aware if the patient was concurrently prescribed Suboxone for opioid dependency as these drugs are not typically prescribed together.[165]

146. However, the toxicological analysis of blood *per se* did not support that Baclofen directly caused Robert's death and Dr Gerostamoulos said that there was no indication of an excessive amount of drugs in Robert's system at the time of his death.[166] Dr Gerostamoulos provided some further explanation about the difference between the

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[161] T @ p 269.

[162] T @ p. 262.

[163] T @ p 254.

[164] T @ pp 262 – 263.

[165] T @ pp 264 – 265.

[166] T @ p 268.

level of Baclofen identified in Robert's blood and in his stomach contents and said that he could not draw any conclusions from the small amount found in stomach contents (3.5 mgs), such as when it was taken and whether Robert would have been experiencing withdrawal symptoms – he said it was a possibility, but he could not reach a conclusion.[167]

147. Dr Gerostamoulos testified about the effect of unconsciousness on an individual's capacity to metabolise drugs.[168]

Locating Robert and the Victoria Police Investigation

148. Mr Pearce said after Robert was released from prison and their friendship was rekindled; he saw Robert most weekends, had done some work with him and had obtained some plumbing work through Robert. He knew Robert drank quite a bit of alcohol and was aware of a previous suicide attempt. He was also aware that Robert was on "bupe" as a substitute for heroin but did not know if he was getting any treatment for his alcohol or drug use – he knew that he was *doing something in Heidelberg* but did not know if that was in relation to conditions attached to his release from prison or for some other reason.[169] He had some awareness that Robert had been in prison for matters related to family violence associated with Linda Hunter.[170]

149. Between 13 February 2015 and 15 February 2015, Mr Pearce had tried to contact Robert but received no response to his text messages and telephone calls. This was unusual,[171] but it was not until Tuesday 17 February 2015, when he received a telephone call from a client of Robert's asking where he was because he had not turned up for work, that Mr Pearce became really concerned about the lack of contact from Robert.

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[167] T @ p 271.

[168] T @ p 265.

[169] T @ p 18 – 19.

[170] T @ pp 19 – 20.

[171] T @ p 9.

150. On 18 February 2015, Mr Pearce went to Robert's home to seek him out but he knew *something wasn't right* – he was not answering the door yet the dogs were in the house and they never would have been unless Robert was also there,[172] and he could hear Robert's telephone ringing. Mr Pearce said that the front door was closed but he was *pretty sure* that it was open/unlocked; he moved/twisted the handle *but didn't want to push it in case* – he said he just did not *want to see anything*. He could not recall how he had left the door as he was *freakin' out at the time.* Mr Pearce then telephoned his parents, Police and Linda Hunter.

151. On 18 February 2015 Acting Sergeant Donald Webber, a Senior Constable at the time, was stationed at Eltham Police Station and working divisional response zone duties with two colleagues. At approximately 6.35pm they attended at Robert's residence in response to a request from Police communications to perform a welfare check as Robert had not been heard from in a few days.

152. On locating Robert's body in the front right room of the premises, next to the fireplace, the immediate assessment was that the *scene appeared to be of suspicious circumstances*. The scene was cordoned off, a crime scene log commenced, and Police communications notified, which in turn, notified Darebin CIU.

153. In his *viva voce* evidence, A/S Webber explained that his reason for deeming the scene 'suspicious' was because *it didn't look quite right……it just didn't quite add up……there were a number of factors that just didn't look like your normal suicide.*[173] However, he said that he had also begun to think that it could be related to self-inflicted circumstances: he said that in locating the empty packet of Baclofen, Robert had *possibly overdosed or had some sort of psych episode, turned furniture over, pulled out his own hair, had hit his head against the wall and perhaps fallen backwards after hitting himself, hitting his head against the wall.*[174]

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[172] T @ p 11 – 12.

[173] T @ p 287.

[174] T @ p 289.

154. A/S Webber said that he had taken ownership of being the Police investigator by the end of his shift, completed the Form 83.[175] He was aware that this responsibility of the Coroner's investigator would revert to him if the scene was deemed non-suspicious, which it was, and he said that he agreed with that assessment. A/S Webber added that he would not have hesitated to ask for a new investigation if any additional evidence suggested Robert's death was suspicious. A/S Webber said there was no evidence to suggest that there was a third party involved.[176]

155. As a consequence of being categorised non-suspicious, the blood swabs taken at the scene of Robert's death were not sent for analysis. Similarly, A/S Webber said that Robert's telephone had not been interrogated, save for photographs of the locked screen, because he did not *believe it would have brought any analysis or any evidentiary value [sic] to the investigation*.[177]

FURTHER INVESTIGATIONS

156. On 31 August 2018, closing Submissions by Ms Ward and Counsel Assisting were heard and I adjourned the Inquest so that further investigations could occur. These investigations related to blood located at the scene, fingerprint analysis, mobile telephone interrogation and the whereabouts of Linda Hunter.

157. The results of this additional investigations were:

a. Robert's DNA was compared to the DNA extracted from the blood swab taken from the kitchen floor of Robert's home. The result of the analysis is that Robert is "not excluded as the source of the blood in this sample. The DNA evidence is 100 billion times more likely if Robert … is the source of the blood."[178]

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[175] T @ p 338.

[176] T @ p 291.

[177] T @ p 292.

[178] Exhibit 15 – Blood swab analysis by Dr Masha Goray, Senior Forensic Scientist, Victoria Police Forensic Services Centre (detailed in email messages) dated 15 May 2020.

b. The previously unidentified fingerprint located on a beer bottle in Robert's home was identified as belonging to Linda Hunter.[179]

c. Further analysis/interrogation of Robert's mobile telephone identified text messages and photographs as detailed in the statement of my CI.[180]

d. Linda Hunter was located and served with a Summons to appear as a witness at the Inquest into the death of Robert Thomas Love in accordance with section 55(2)(a) and s.55(3) of the Act as I believed it was necessary for the purposes of the Inquest into the death of Robert Love.

RESUMPTION OF THE INQUEST

158. The Inquest was re-listed on 19 March 2020 for the purpose of obtaining Linda Hunter's *viva voce* evidence. However, due to the public health restrictions introduced to reduce transmission of COVID-19, this date was vacated. Subsequently The State Coroner's Practice Direction 1 of 2020 came into effect on 27 March 2020 and delayed resumption of the Inquest until arrangements could be made to enable the family, their legal representatives, Counsel Assisting and the witness, Linda Hunter, to appear remotely through the use of Cisco WebEx.

159. On 15 May 2020, the Inquest resumed, and Linda Hunter was called as a witness. I note in passing that there are obvious disadvantages to hearing from a witness testifying remotely rather than attending the Court in person and these can include technical difficulties, some of which were also experienced.

160. Nevertheless, Ms Hunter cooperated with the process and I found her to be a consistent and credible witness. Ms Hunter gave evidence about her long-term relationship with Robert, including her interactions with him despite the existence of a family violence intervention order, and her attendance at his home proximate to him being found deceased.

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[179] Exhibit 14 – Fingerprint analysis by John Hamilton dated 15 March 2019.

[180] Exhibit 13 – Statement of Sergeant Simon Webber dated 26 June 2019.

161. Significantly, her evidence of attending Robert's address on 16 February 2015 at approximately 10.00am and of hearing him inside, was not challenged. Indeed, her evidence remained consistent throughout and provided a logical explanation for her familiarity with the layout of the premises and for the presence of her fingerprints at "the scene".

COMMENTS

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

1. I acknowledge the grief endured by Robert's family, and the concerns raised by Christopher Love and his legal representative Ms Gorman, in relation to the circumstances of Robert's death. Unfortunately, following an extensive investigation, the uncertainty about the circumstances – including the cause and time of Robert's death – remains unresolved. Additional forensic examination of the evidence has added little, and it has not provided any evidence of third-party involvement in Robert's death.

2. I am cognisant of the concerns raised by Robert's family about the Police investigation including the Homicide Squad's discontinued involvement early on, that the forensic analysis of the scene was not fulsome and the possible involvement of third parties to Robert's death was dismissed without pursuing proper enquiries. The family submitted that the focus of the Police investigation *seems to have been on determining a likely motive for suicide as opposed to inquiring about any other (far more likely) cause of death. The investigation was blinkered and unjustifiably limited from the outset.*[181]

3. I have not, however, reached the same conclusion as Robert's family. Tempting as it may be to be critical of the Police investigation with the benefit of hindsight, the additional investigations undertaken at my direction have not revealed any further issues with the decisions made by investigating Police at the time.

4. I have considered the possibility of the involvement of third parties in Robert's death, but the evidence to support this proposition is scant. Robert's furniture was found in

[181] Paragraph 58 – Supplementary Closing Submissions of the Senior Next of Kin dated 9 June 2020.

disarray and he sustained not entirely explainable injuries but submissions from the family that *it is entirely feasible that* (the neighbour) *heard Rob being assaulted*[182] and *it might be that Rob was attacked by a stranger or someone who Rob had met in custody…*[183] or *the movement of the fridge over the doorway suggests Rob may have been in fear for his* safety or the movement of the fridge from its usual place *suggests that someone was seeking to block Rob's exit from the living room…*[184] are no more than speculation, and wholly unsupported by evidence. Other explanations for the disturbed state of Robert's home could just as likely be a psychotic episode, intoxication or some other disordered state.

5. The evidence of Professor Marcus Pandy did not assist me to make any definitive findings about the cause of Robert's death, nor how he sustained the constellation of injuries described by Dr Lynch. Fundamentally, I was unconvinced that his qualifications in biomechanics were sufficiently relevant to the issues I must determine, and in consequence, I was not persuaded to prefer Professor Pandy's opinion over Dr Lynch's findings and conclusions about Robert's medical cause of death.

6. Dr Lynch is a Forensic Pathologist who has engaged in this specialist area since 1993 and has performed over 1,500 autopsy examinations during this time. Professor Pandy formulated many inferences from "facts" he had imagined, and he could not adequately explain how his expertise in the movement of the musculoskeletal system enabled him to conclude that the likely cause of death was a head injury, based on his calculations about the force required to cause injury. In addition, his theory on the force required to avulse hair from the human head, whether self-attained versus inflicted by a third party, lacked peer and/or academic/scientific endorsement.

7. Similarly, I was unconvinced that his area of expertise equipped him with the same level of expertise as a Forensic Pathologist when it came to expressing opinion about whether any, or all of Robert's injuries were self-inflicted or inflicted by a third party. His opinions were speculative at best. I do not dismiss that Professor Pandy's area of

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[182] Paragraph 15 – Supplementary Closing Submissions of the Senior Next of Kin dated 9 June 2020.

[183] Paragraph 33 - *ibid*

[184] Paragraph 40 - *ibid*

expertise, biomechanics, maybe of assistance where for example, the contribution of different forces to an injury may require analysis. Indeed, he saw his area of expertise as one that could compliment forensic pathology and that there is evidence of current research by the separate disciplines highlighting that there are common interests.[185] However, I did not find Professor Pandy's area of expertise convincingly relevant to a scenario where so little evidence about the circumstances is known. Ultimately, I attach no weight to Professor Pandy's evidence.

8. I have not been able to exclude the possible contribution of drugs to Robert's death, nor the possible contribution of toxicity to Baclofen leading to either self-inflicted injuries or injuries sustained during seizures.

9. In view of the toxicology report and that all Baclofen tablets were missing from the container found by police, I sought the CPU's review as to the reasonableness of A/Prof Gijsbers' prescription of Baclofen to Robert. The review did not identify any shortcomings in prescribing practices. In particular, I note that off-label prescribing is in many respects the domain of experts and acknowledge A/Prof Gijsbers is an expert in addiction medicine; he is a consultant to the Drug and Alcohol Clinical Advisory Service, a Fellow of the Chapter of Addiction Medicine, and former Head of Addiction Medicine at the Royal Melbourne Hospital.[186]

10. In the course of the investigation into Robert's death, I refused a Request for an Inquest because all lines of the initial investigation led me to determine that an Inquest was unlikely to elucidate the cause and circumstances of Robert's death. However, I openly considered additional information, evidence and the hypotheses suggested by the family about the circumstances surrounding Robert's death that were submitted to me after that determination. Ultimately, an Inquest was commenced in 2018, I then directed that further investigations and forensic testing be undertaken and reconvened the Inquest in May 2020 after Ms Linda Hunter was located.

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[185] T @ pp 246 -247. (The area of common research discussed was in relation to "short distance falls")

[186] On 30 October 2020, Her Honour Deputy State Coroner Caitlin English held an Inquest into the death of a woman provided an off-label prescription for baclofen. Her Honour's Findings are forthcoming: COR 2015 6534.

11. I am now in a position to discharge my statutory obligations pursuant to s 67(1) of the Act where I must find *if possible* (my emphasis) the identity of the deceased, the cause of death and the circumstances in which the death occurred. Additionally, I have not identified any pertinent issues connected to the death of Robert Thomas Love that would warrant the making of Recommendations pursuant to section 72(2) of the Act.

FINDINGS

Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

1. I find the identity of the deceased is Robert Thomas Love born on 19 April 1981.

2. I find on the balance of probabilities, with reliance on the circumstantial as opposed to scientific evidence,[187] that the death of Robert Thomas Love occurred sometime after 10.00am on 16 February 2015 but before approximately 6.35pm on 18 February 2015 when he was located, at his residence, Unit 1 of 40 Railway Road, Briar Hill, Victoria 3088.

3. The exact circumstances of Robert Thomas Love's death have not been elucidated by the coronial investigation, evidence heard at the Inquest in August 2018, additional forensic investigations nor from the reconvening of the Inquest on 15 May 2020 to hear from Linda Hunter.

4. The evidence indicates that Robert Thomas Love had a significant history of mental ill-health, alcohol abuse and illicit drug use. While I acknowledge that Robert Thomas Love had made a number of attempts to take his own life in the past, I have not identified any definitive evidence that would support a finding that he intended to end his own life.

5. My investigation highlighted the possible contribution of Baclofen toxicity to the death of Robert Thomas Love, but has not identified concerns relating to prescription of this drug to treat Robert Thomas Love's alcohol dependence and anxiety. The evidence indicates that he continued to abuse alcohol proximate to his death and research into the

[187] See the evidence of Dr Matthew Lynch – T @ p. 113 - 114.

effects of Baclofen suggest it could have played some role in his death. That said, I cannot be definitive about a causal connection between the ingestion of Baclofen and Robert Thomas Love's death.

6. I have considered the additional evidence obtained in the course of the review by In-House Legal Services and have not identified anything to suggest Police contact with Robert on the morning of 14 February 2015 was inappropriate.

7. While I have not been able to exclude the possibility of the involvement of third parties in the death of Robert Thomas Love, there is a paucity of evidence to support the making of Findings to the requisite standard of proof. Nor is there any evidence before me of anyone other than Linda Hunter attending Robert Thomas Love's home in the days leading up to his death, and no witness that contradicts her account of that attendance.

8. It is regrettable that despite the prolonged and extensive investigation the outcome is unsatisfactory to the extent that the cause and immediate surrounding circumstances of Robert Thomas Love's death remains undetermined.

9. Save for the comments I have made that more extensive forensic analysis of the scene and scene samples may have provided some certainty to Robert Thomas Love's family about the thoroughness of the investigation, I make no adverse Finding against the Victoria Police investigation. Assessing the contemporaneous decisions made by Victoria Police has not led me to conclude that any different actions, avenues of investigation or inquiries would have led to a different or more definitive position on the cause or circumstances of his death.

10. I accept the evidence, and adopt the opinion, of Dr Matthew Lynch and I find that the medical cause of Robert Thomas Love's death remains undetermined.

11. Having conducted an investigation and held an Inquest into the death of Robert Thomas Love, a reportable death under section 4 of the Act, it is not possible for me to make definitive Findings as to the cause and circumstances of Robert Thomas Love's death.

12. I express my condolences to the family of Robert Thomas Love.

13. Should new and compelling evidence be obtained, an application to reopen the coronial investigation can be made.

To enable compliance with section 73(1) of the Coroners Act 2008 (Vic), I direct that the Findings will be published on the internet.

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

Mr Christopher Love

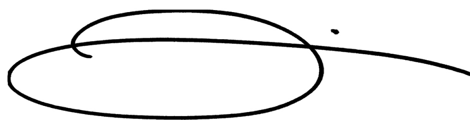
Ms Jeanne Gorman, Barrister & Solicitor

Ms Linda Hunter

Senior Constable Simon Webber

Therapeutic Goods Administration

Signature:



AUDREY JAMIESON

CORONER

Date: **6 November 2020**