IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001302

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF ANTHONY LAURENCE PARISI

Findings of:	Coroner Simon McGregor
Delivered on:	4 March 2026
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria 3006
Hearing Dates:	4 March 2026
Counsel Assisting the Coroner:	Ms Elizabeth Morris, Senior Legal Counsel Coroners Court of Victoria
Representation:	
Chief Commissioner of Police	Ms Nicola Morgan, Maddocks Lawyers
Ambulance Victoria	Ms Fiona Ellis of Counsel, instructed by Meridian Lawyers
Keywords:	death in police custody; drug toxicity; gamma hydroxybutyrate (GHB); methamphetamine (ice); police operational safety and use of force; care and control; sedation safety

INTRODUCTION

1. Anthony Laurence Parisi (**Anthony**) was 39 years old when he died on 9 March 2025 at Royal Melbourne Hospital.

2. Immediately before his death, Anthony was in the custody of police, having been taken into care and control under section 232 of the *Mental Health and Wellbeing Act 2022* (Vic) on the afternoon of 8 March 2025. For safety reasons, Anthony was handcuffed and restrained by police officers, while awaiting the arrival of ambulance paramedics.

3. When the paramedics arrived on scene, they assessed that it was necessary to administer sedation to Anthony and he was administered ketamine.

4. Shortly afterwards, Anthony stopped breathing and went into cardiac arrest. Cardiopulmonary resuscitation was promptly commenced and this initially achieved return of sustained heart rhythm. However, Anthony remained in a critical condition and suffered a further cardiac arrest at the scene. Anthony was then transported to Royal Melbourne Hospital for further advanced in-hospital therapies. However, despite intensive treatment, Anthony was found to have suffered an irreversible circulatory collapse.

5. Anthony died in the early hours of the next day, 9 March 2025.

THE CORONIAL INVESTIGATION

Jurisdiction

6. Anthony's death was reported to the Coroner as it fell within two limbs of the definition of a 'reportable death' as defined in section 4 of the *Coroners Act 2008* (Vic) (**'Coroners Act'**) as the death:

    (a) appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly from an accident or injury;[1] and

[1] Coroners Act, s 4(2)(a)

(b) was of a person who immediately before death was a person placed in custody or care,[2] having been in the custody a police officer immediately before his death.[3]

The role of the coroner

7. The Coroners Court of Victoria is an inquisitorial jurisdiction.[4] The role of a coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[5]

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

9. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

10. The broader purpose of a coronial investigation is to contribute to a reduction in the number of preventable deaths through the investigation findings and recommendations that are made by coroners. This is generally referred to as the prevention role. To advance this prevention role, coroners are empowered to:

    (a) report to the Attorney General on a death;[6]

    (b) comment on any matter connected with a death that has been investigated, including matters of public health or safety and the administration of justice;[7] and

    (c) make recommendations to any Minister or public statutory authority, entity or agency on any matter connected with a death, including public health or safety or the administration of justice.[8]

11. The powers to comment and make recommendations are inextricably connected with, rather than independent of, the power to enquire into a death or for the purpose of making findings.[9]

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[2] Coroners Act, s 4(2)(c).
[3] Coroners Act, s 3(1)(f).
[4] Coroners Act, s 89(4).
[5] Coroners Act, s 67(1).
[6] Coroners Act, s 72(1).
[7] Coroners Act, s 67(3).
[8] Coroners Act, s 72(2).
[9] *Harmsworth v The State Coroner* [1989] VR 989 at 996.

12. It is not the coroner's role to lay or apportion blame, but to establish the facts.[10] Coroners are unable to determine civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of an offence.[11]

Standard of proof

13. All coronial findings must be made on proof of relevant facts on the balance of probabilities.[12] The strength of the evidence necessary to prove relevant facts varies according to the nature of the facts and circumstances in which they are sought to be proved.[13]

14. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[14] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

15. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[15] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[16]

16. It is also important to recognise the benefit of hindsight and to discount its influence on the determination of whether a person or persons acted appropriately. I am conscious of the need to judge the actions of all who interacted with Anthony in the period proximate to and at the time of his death, having regard to the information known to them at the time.

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[10] *Keown v Khan* (1999) 1 VR 69.
[11] Coroners Act, s 69(1).
[12] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[13] *Qantas Airways Limited v Gama* (2008) 167 FCR 537.
[14] (1938) 60 CLR 336.
[15] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[16] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp362-3 per Dixon J.

Mandatory inquest

17. Section 52(2)(b) of the Act provides that a coroner must hold an inquest into a death if the death occurred in Victoria and the deceased was, immediately before death, a 'person placed in custody or care'. Because Anthony was in the custody of a police officer immediately before his death, an inquest was mandatory.

18. In conducting my investigation, I had the benefit of extensive audiovisual material which provided me with an objective record of key events as they unfolded in the emergency services response to Anthony on 8 March 2025. This included the body worn camera footage recorded by the attending police officers, as well as audio recordings of police radio communications, calls to Triple Zero Victoria, and calls between Ambulance Victoria paramedics and clinicians. These materials corroborated the detailed statements provided by the attending police officers and paramedics.

19. After considering this evidence, I was satisfied that there were no significant factual disputes or evidentiary conflicts which required the calling of witnesses to give *vive voce* evidence. Further, I considered there was sufficient evidence to enable me to discharge my statutory functions and make the findings required under section 67 of the Act.

20. Accordingly, the matter proceeded in a manner which has come to be called a 'summary inquest'. That is, an inquest where the evidence may be regarded as complete and uncontentious and where it may be admitted in a summary form without the need to examine witnesses. This took place on 4 March 2026.

21. All interested parties who appeared at inquest were given an opportunity to make submissions in relation to the evidence.

Sources of evidence

22. Acting Senior Sergeant Jack Hubbard (**A/S/Sgt Hubbard**) was appointed the Coronial Investigator[17] and compiled a coronial brief of evidence at my direction, which has been supplemented by additional material obtained by the Court.

[17] The coronial investigator is a police officer who is nominated by the Chief Commissioner of Police to assist a coroner in relation to an investigation into a reportable death. At the time Anthony's death was reported to the Court, Acting Senior Sergeant Hubbard was a Detective Acting Sergeant of the Homicide Squad of Victoria Police. He has

23. This finding draws on the totality of the coronial investigation into the death of Anthony Laurence Parisi including evidence contained in the coronial brief prepared by A/S/Sgt Hubbard and submissions made by Counsel Assisting at inquest. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

24. In considering the issues associated with this finding, I have been mindful of Anthony's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

BACKGROUND

25. Anthony was the much-loved son of Kathleen, and father of two children. At the time of his death, Anthony was in a relationship with Priscilla Mansour.

26. Anthony was a passionate fan of the Essendon Football Club, and regularly went to games with his son. He loved animals, and often cared for strays.

27. When he was a teenager, Anthony began using marijuana and later methamphetamine (also referred to as 'ice') and gamma hydroxybutyrate (**GHB**). After the death of his father, Anthony's drug use escalated and he began using GHB and ice on a regular basis. He had multiple interactions with emergency services and admissions to hospital due to the adverse effects of these drugs in the years prior to his death.[18]

28. Anthony's family report that he was a different person when affected by drugs, and their deepest wish was that he would stop using drugs. Anthony undertook drug rehabilitation at Odyssey House and counselling through First Steps. However, he gradually relapsed, and in later years, he declined further referrals to drug treatment services.[19]

29. In the months preceding his death, Anthony's use of ice and GHB steadily increased. In early January 2025, he was found in an altered conscious state walking into traffic and laying on

since been promoted to the rank of Sergeant and has moved to a different unit within Victoria Police where he is currently performing upgraded duties as an Acting Senior Sergeant.

[18] Exhibit 11, Recording of conversation with Kathleen Parisi; Exhibit 23, Body worn camera footage of previous interactions with Anthony Parisi between 2019 and 2025; Exhibit 25, Ambulance Victoria Patient Care Records of previous attendances on Anthony Parisi.

[19] Royal Melbourne Hospital Records, pp 13-16.

the road after taking GHB and ice. On that occasion, Anthony required sedation and was transported to hospital for medical assessment.[20]

30. Anthony's mother, Kathleen, continued her efforts to try to discourage Anthony from using ice and GHB, without success.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

Anthony's movements on the morning of 8 March 2025

31. On 8 March 2025, Anthony spent the morning at Priscilla's home in Glenroy. At about 8am, Anthony received a call from a friend, Antonius Mokbel. A short time later, Antonius picked him up from Priscilla's home and they drove to a phone store in Point Cook.[21]

32. At 9.37am, Anthony sent a text message to Priscilla saying *"Gonna go get juicy and be a dog"*.[22] This appears to be a reference to Anthony's plans to use GHB, commonly referred to as 'juice'.

33. Antonius was not willing to provide a statement for the coronial investigation. He verbally confirmed to investigators that Anthony regularly took ice and was a user of GHB. However, he denied that Anthony used ice on this occasion.[23]

34. At about 11.30am, Antonius dropped Anthony back at Priscilla's home.[24] Priscilla reported to investigators that when Anthony returned home, he already appeared to be under the influence of drugs, he was unable to recognise her and began to throw things around the house. She became concerned for her safety and contacted friends to help her.[25]

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[20] Statement of Detective Leading Senior Constable Jack Hubbard (as he then was) dated 30 July 2025, Coronial Brief (**CB**), pp 183-4; Ambulance Victoria Patient Care Record dated 2 January 2025, CB p 291-3.
[21] Transcript of conversation with Priscilla Mansour dated 10 March 2025, CB pp 114-5; Statement of Detective Leading Senior Constable Jack Hubbard dated 30 July 2025, CB p 183.
[22] Exhibit 26, Phone Download Data
[23] Statement of Detective Leading Senior Constable Jack Hubbard dated 30 July 2025, CB p 183.
[24] Exhibit 26, Phone Download Data
[25] Transcript of conversation with Priscilla Mansour dated 10 March 2025, CB pp 115-6.

35. Priscilla also told investigators that Anthony had reportedly been sipping a "*bottle of juice*" on the morning of 8 March 2025 and that Anthony had thrown this bottle at her. However, she had not retained the bottle, so it was unable to be taken for forensic testing.[26]

36. In a later conversation with the Coronial Investigator, in July 2025, Priscilla disclosed that Anthony drank the entirety of a 25ml bottle of GHB in front of her on the day of his death.[27]

37. Another friend of Anthony's – Joey Barilla – told the Coronial Investigator in April 2025 that Anthony used liquid GHB and methylamphetamine every day, and had been admitted to the emergency department numerous times due to drug use.[28] On 8 March 2025, Joey received a call from Priscilla in which she told him that Anthony had taken a lot of GHB, had threatened her, and was going to *"smash up the house"*. When Joey arrived at Priscilla's home, Anthony had already left, and Priscilla reportedly told him that Anthony had consumed 13-14ml of GHB. [29]

38. The usual recreational dose of GHB is 1 to 2 grams.[30]

39. Priscilla and Joey both declined to provide a statement for the coronial investigation.[31]

000 calls for assistance

40. At 2.05pm, a call was made to Triple Zero Victoria by an unidentified male requesting police attendance at Priscilla's home. The caller reported that Anthony was *"bashing her and hes …carrying on and threatening to kill her"*.[32] Investigations have been unable to confirm the identity of the person who made this call.

41. Between 2.25pm and 2.49pm, nine (9) further calls were made to Triple Zero Victoria, the Police Assistance Line, and the Broadmeadows Police Station requesting police and ambulance for a male who was behaving erratically in the vicinity of Chapman Avenue, Glenroy.

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[26] Transcript of conversation with Priscilla Mansour dated 10 March 2025, CB pp 127-8.
[27] Statement of Detective Leading Senior Constable Jack Hubbard dated 30 July 2025, CB pp 183-4.
[28] Second Statement of Acting Senior Sergeant Jack Hubbard dated 2 March 2026, [6].
[29] Second Statement of Acting Senior Sergeant Jack Hubbard dated 2 March 2026, [6].
[30] VIFM Toxicology Report, CB p 174.
[31] Statement of Detective Leading Senior Constable Jack Hubbard dated 30 July 2025, [87], CB p 20.
[32] Exhibit 20, Transcript of Triple Zero Victoria Call_Audio_16108956, p 1.

42. Witnesses reported the male was shirtless, yelling, punching himself and at one point urinated into a letterbox. He was also reported to have thrown himself against a fence. Concerns were raised that he was potentially drug effected or experiencing a mental health crisis.[33] One witness reported that his behaviour was suggestive of an overdose of gamma-hydroxybutyrate (**GHB**).[34]

43. CCTV from residences in Chapman Avenue and Kennedy Street, Glenroy, capture some of Anthony's movements during this period. His movements were erratic; at times running or walking at a very fast rate of speed, swinging his arms and at times yelling out.[35]

Police arrival and initial engagement with Anthony

44. A task for a priority one welfare check event was created, but there were no police units available to attend. Enquiries were made with patrol supervisors for neighbouring police service areas for an available unit.

45. At 2.40pm, Broadmeadows patrol unit with call sign Broadmeadows 212 was dispatched to attend the incident after clearing from a previous event.[36] Broadmeadows 212 comprised First Constable Caroline Rutledge (**FC Rutledge**) and Constable Nathan Zygmunt (**Const Zygmunt**).

46. At 2.54pm, the Broadmeadows 212 unit arrived on scene and sighted a male on the nature strip on Chapman Avenue, Glenroy who matched the description detailed in information conveyed to the unit about the event via Police Communications.

47. The identity of the male was not known to police officers at the time of their interaction with him but was later confirmed to be Anthony.

48. Both police officers activated their body worn cameras in accordance with the requirements of Victoria Police Manual (**VPM**) 'Body worn cameras'. This chapter of the VPM provides that members wearing body worn camera footage must start a recording to capture their attendance at a Triple Zero Victoria task resulting in contact with a member of the public.[37]

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[33] Exhibit 20, Transcripts of Triple Zero Victoria Calls.
[34] Exhibit 20, Triple Zero Victoria Call Transcript_Audio 15977278_Transcript, p 1.
[35] Exhibit 22, CCTV from residence on Chapman Avenue, Glenroy.
[36] Statement of First Constable Caroline Rutledge, CB p 51.
[37] VPM Body Worn Cameras, updated 21 August 2024, [3.2].

49. The subsequent police interaction with Anthony is captured in full in this footage from multiple vantage points, along with footage recorded by other police officers who later attended the incident.

50. The officers approached the male who had several abrasions on his back and elbows, was visibly sweating, and was moving erratically and unsteadily on his feet. He punched at the air several times, got onto the ground and kicked his legs up in the air above his head, before standing up again and continuing to throw further punches at the air and himself.

51. The officers asked Anthony if he was alright, explained that they were the police and invited him to sit on the ground. Anthony did not respond. He did not appear to be aware of his surroundings or of the presence of the police officers. He continued to move erratically.

Taking Anthony into care and control

52. The officers determined to take Anthony into their care and control under section 232 of the *Mental Health and Wellbeing Act 2022* (**MHW Act**) as he appeared to have a mental illness[38] and they were concerned about Anthony's risk of harm to himself and others due to his erratic behaviour.[39]

53. Section 232 of the MHW Act provides that a police officer may take a person into care and control if satisfied the person appears to have a mental illness and because of the person's apparent mental illness, it is necessary to take the person into care and control to prevent imminent and serious harm to the person or to another person.

54. FC Rutledge asked the Police Communications Centre via police radio to arrange for an urgent ambulance to attend their location. An advanced life support (**ALS**) unit was dispatched to attend the incident two minutes later.

55. At 2.56pm, the officers explained to Anthony that they were going to put handcuffs on him for his safety. As the officers went to apply the handcuffs, Anthony fell to a seated position on the ground with his legs in front of him, and the officers secured his hands behind his back with handcuffs.

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[38] Statement of First Constable Caroline Rutledge, [6], CB p 52.

[39] Statement of First Constable Caroline Rutledge, [7-8], CB p 52; Statement of Constable Nathan Zygmunt, [12], CB p 59; [27], CB p 61; Statement of First Constable Djordje Aleksic, [8], CB pp 79-80.

56. Anthony struggled against the handcuff restraints. He yelled, kicked out and rolled on the ground towards the roadway, and spat once at the officers. The officers continued to attempt to reassure Anthony and pulled him away from the edge of the nature strip abutting the roadway, as an approaching car passed by.

57. Over the next two minutes, the officers remained largely hands off Anthony, continuing to reassure him. They informed him that an ambulance was on its way and encouraged him to calm down and sit still on the ground. However, Anthony remained non-verbal and continued to roll around on the ground and kick out. At one stage, Anthony stood up, and the officers assisted him back to the ground.

58. At about 2.58pm, the officers moved to restrain Anthony's legs and arms in order to limit his movements, while Anthony was on his side, on the ground and continuing to kick out. Anthony repeatedly yelled the word 'help'. Both FC Rutledge and Const Zygmunt asked Anthony to tell them what was going on, why he needed help and requested that he stop moving so they could help him. Anthony did not respond and continued to actively struggle against the officers and yell out.[40]

59. First Constable Rutledge also asked Police Communications Centre for assistance of another unit as they continued to try to control Anthony's movements.

60. At 3.00pm, Anthony shifted his position onto his stomach. The officers held Anthony's legs and upper arms in a prone restraint, with a knee on his lower back to limit his movements. Anthony continued to yell out, move his head and neck, and attempted to kick out his legs and pull his hands out of the handcuffs. The officers verbalised that they felt it was not safe to put Anthony back on his side in the recovery position due his ongoing movements and resistance.

61. At 3.03pm, a second unit – a Fawkner Highway Patrol Unit, with call sign 650 – comprising Sergeant Michael Free and Leading Senior Constable Glen Jenkins – arrived on scene and assisted in continuing to restrain Anthony in a three-point hold. Sergeant Free encouraged Anthony to calm down, and breathe, and asked Anthony for his name. Anthony continued

[40] Statement of First Constable Caroline Rutledge, [9-10], CB p 53.

to be non-responsive. He intermittently yelled out and continued to resist and struggle against the officers restraining him.

62. Additional units subsequently attended the scene to assist, and the officers rotated between themselves to avoid fatigue as they continued to restrain Anthony while awaiting the arrival of ambulance paramedics. The officers continued to attempt to engage with Anthony and reassure him.

63. During this period, the officers verbalised their concerns for the safety and welfare of Anthony due to his positioning and the risk of positional asphyxia. However, the officers felt there was no alternative but to keep him in a prone position to control his movements. The officers continued to maintain observations of Anthony's breathing and condition as they restrained him. They made repeated requests via police communications to escalate the need for urgent attendance of paramedics which was also escalated to the ambulance Victoria Duty Manager.[41]

64. At the direction of Sergeant Free, the officers obtained bottles of water from a nearby residence and poured this over the back of Anthony's neck and head in an effort to help cool him down due to the heart of the day. They also obtained a blanket and held this up as a makeshift shade to reduce the direct sunlight on Anthony. Anthony continued to resist the restraint, moved his head and neck freely, and occasionally screamed, but did not respond to the officers' attempts to reassure, calm or engage with him.[42] The officers also attempted to identify Anthony but were unable to locate any identification on him.

Ambulance arrival and sedation

65. En route to the scene, the ALS unit received information about Anthony's condition, his physical aggression and likelihood that he was under the influence of drugs. They spoke with the Ambulance Victoria Clinician and requested dispatch of a Mobile Intensive Care Ambulance (**MICA**) unit to the scene given the likelihood sedation would need to be

[41] Exhibit 14, Transcript of Police Radio Communications.
[42] Statement of First Constable Caroline Rutledge, [14-15], CB p 54.

administered and as advanced airway support may be required. A MICA unit was dispatched at 3.14pm, on a Code 2 priority.[43]

66. At about 3.16pm, the ALS unit arrived on scene. They found Anthony lying prone on the ground, physically restrained by six police officers. They observed that he was profusely sweating, making loud verbal outbursts and thrashing around while being held by the police officers.[44]

67. The paramedics assessed Anthony with the 'Sedation Assessment Tool' as having a score of +3, the highest score indicating combative, violent, out of control behaviour with continuous loud verbal outbursts. They considered sedation was the only viable and safe management option in the circumstances given Anthony's agitation, his non-responsiveness to de-escalation attempts, and due to the risk he presented to himself and others.[45]

68. The ALS unit considered the administration of ketamine was the safest option and prepared a dose of 300mg, in accordance with the Clinical Practice Guideline 'Acute Behavioural Disturbance'.[46] They also escalated the request for attendance of a MICA unit, which was upgraded to a priority of Code 1.[47]

69. Prior to administering ketamine, the ALS unit prepared the ambulance stretcher and monitoring equipment near Anthony, including a Bag-Valve Mask, oxygen equipment, a ZOLL monitor, and a 'red bag' containing medications and fluids. Due to Anthony's positioning and ongoing movements, it was not possible to obtain a set of vital signs or attach the monitor before administering ketamine.[48]

70. At about 3.21pm, the paramedics administered 300mg ketamine via intramuscular injection. The paramedics sought assistance from police to assist in physically restraining Anthony's lower body to enable the safe and accurate administration of ketamine due to Anthony's ongoing movements.[49]

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[43] Ambulance Victoria ERTCOMM Event Register, CB p 308; Ambulance Victoria Patient Care Record ALS 1792, CB p 298; Statement of AV Clinician dated 28 October 2025, p 2.
[44] Ambulance Victoria Patient Care Record ALS 1792, CB pp 295, 297-8
[45] Ambulance Victoria Patient Care Record ALS 1792, CB pp 295, 298.
[46] Statement of Ambulance Victoria Graduate Bridging Paramedic dated 23 October 2025, pp 2-3.
[47] Ambulance Victoria Patient Care Record ALS 1792, CB pp 297-8.
[48] Ambulance Victoria Patient Care Record ALS 1792, CB p 298.
[49] Statement of Ambulance Victoria Graduate Bridging Paramedic dated 23 October 2025, pp 2-3.

71. Shortly afterwards, the paramedics took Anthony's temperature which was recorded at 40.3°C.[50]

72. At 3.23pm, the police officers placed Anthony on his left side and then lifted him from the ground onto the ambulance stretcher, where he was placed in a semi-recumbent position. The police handcuffs were removed and soft mechanical restraints applied to Anthony's wrists and ankles.

Cardiac arrest and emergency treatment

73. At 3.25pm, after the soft restraints had been applied, the paramedics observed Anthony's breathing become shallower and he stopped breathing.

74. The paramedics immediately commenced manual ventilation using the Bag-Valve Mask, assisted by police, which had a good seal and effective ventilation. An oxygen saturation monitor was placed on Anthony's finger and a cardiac monitor applied.[51]

75. A single responder MICA unit arrived on scene a minute later and took over management of Anthony's airway. He found Anthony was not breathing, did not have a pulse and the cardiac monitor indicated Anthony had an agonal rhythm – a very slow and irregular heartbeat that occurs just before cardiac arrest.[52]

76. CPR was commenced, with the assistance of police officers on scene, and a second MICA unit was dispatched to attend on a priority 0 – being the highest priority.

77. At 3.33pm, after three rounds of CPR, the paramedics obtained a return of spontaneous circulation, which is the resumption of a sustained heart rhythm. However, Anthony remained in an unstable and critical condition, and was found to have low blood pressure and low blood sugar.[53]

78. Anthony was transferred into the ambulance with the air conditioning on to commence cooling and was administered glucose and saline via an intravenous drip.

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[50] Ambulance Victoria Patient Care Record ALS 1792, CB p 297.
[51] Ambulance Victoria Patient Care Record ALS 1792, CB p 298.
[52] Ambulance Victoria Patient Care Record, MICA Response 1, CB p 304.
[53] Ambulance Victoria Patient Care Record, MICA Response 1, CB p 301.

79. At 3.40pm, the second MICA unit with two responders arrived on scene and assisted in managing Anthony's clinical care to stabilise him for transport to hospital. Anthony was administered metaraminol and noradrenaline to address hypotension and provide perfusion support for Anthony's circulatory and respiratory systems.[54]

80. Despite increasing the noradrenaline infusion and giving multiple increments of metaraminol, Anthony's cardiac rhythm deteriorated.[55]

81. At 3.59pm, Anthony suffered a further cardiac arrest at 3.59pm and CPR was re-commenced. His heart rhythm was found to be asystole, with no electrical cardiac activity.

82. The attending paramedics administered 1mg adrenaline boluses at 4-minute intervals in line with the clinical practice guideline for cardiac arrest. Anthony was intubated and was also administered sodium bicarbonate and calcium to address suspected high potassium levels.[56]

83. The attending paramedics sought advice from the Ambulance Victoria Clinician on Duty regarding the ongoing clinical management of Anthony.[57] Advice was also sought from the Ambulance Victoria Doctor on Call, who is a senior critical care physician who provides clinical support to paramedics on the ground or to the paramedic clinicians where paramedics have exhausted all treatments advocated in their clinical practice guidelines.[58]

84. The AV Doctor on Call was concerned about the possibility of excited delirium with profound hyperthermia[59] resulting in tissue breakdown and resultant metabolic acidosis and hyperkalaemia[60].[61]

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[54] Ambulance Victoria Patient Care Record, MICA Response 1, CB pp 304-5.
[55] Statement of Ambulance Victoria MICA 14 Paramedic, p 2.
[56] Statement of Ambulance Victoria MICA 14 Paramedic, p 2; Ambulance Victoria Patient Care Record, MICA Response 1, CB p 305.
[57] Statement of AV Clinician dated 28 October 2025, p 2; Ambulance Victoria, Audio Recording 16131983.
[58] Statement of AV Doctor on Call dated 24 October 2025, pp1-2; Statement of AV Clinician dated 28 October 2025, p 2; Ambulance Victoria, Audio Recording 16131983.
[59] Hyperthermia is the dangerous elevation of core body temperature, most commonly due to environmental exposure, dehydration or strenuous exertion.
[60] Hyperkalaemia is high potassium in the blood and can lead to lethal cardiac dysrhythmias.
[61] Statement of AV Doctor on Call dated 24 October 2025, p 2.

85. On advice from the AV Doctor on Call, Anthony was transported to Royal Melbourne Hospital under mechanical CPR for consideration of further advanced in-hospital therapies.[62]

86. At about this time, police identified the male as Anthony, after a passerby reported to police she had located a mobile phone on Kennedy Street, Glenroy, which was subsequently identified by police as belonging to Anthony.

Admission to Royal Melbourne Hospital

87. At 4.39pm, Anthony was admitted to Royal Melbourne Hospital. On admission, Anthony was found to be profoundly hypoglycaemic and hyperkalaemic. He was placed on extracorporeal membrane oxygenation (**ECMO**) support and administered calcium and sodium bicarbonate to address hyperkylaemia.

88. Despite intensive treatment, Anthony remained asystole with no electrical cardiac activity, and was found to have suffered irreversible circulatory collapse.

89. Anthony died at 12.17am on 9 March 2025 at Royal Melbourne Hospital.

Critical incident

90. The incident was declared to be a critical incident at the scene,[63] and the Homicide Squad was briefed. All members involved in the incident underwent mandatory drug and alcohol testing in accordance with Victoria Police policy and were provided with welfare support.

91. Following Anthony's death, the investigation was assigned to the Homicide Squad in accordance with police policy for the investigation of deaths that occur in police custody, which has been oversighted by the Professional Standards Command.

Identity of the deceased

92. On 8 March 2025, Anthony Laurence Parisi, born 15 October 1985, was visually identified by his mother, Kathleen Parisi.

93. Identity was not in dispute and required no further investigation.

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[62] Statement of MICA 1 Paramedic; Statement of MICA 14 Paramedic; Statement of AV Doctor on Call.
[63] Statement of Acting Inspector Michael Pope, CB pp 108-10.

Medical cause of death

94. On 9 March 2025, Adjunct Associate Professor Hans de Boer (**A/Prof de Boer**), Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on Anthony's body and provided a written report of his findings dated 9 July 2025.

95. Prior to autopsy, A/Prof de Boer considered the Victoria Police Report of Death to the Coroner (Form 83) and request for autopsy, the VIFM contact log, post-mortem computed tomography (**CT scan**) and medical deposition from Royal Melbourne Hospital. Following autopsy, A/Prof de Boer was also provided and reviewed medical notes from Royal Melbourne Hospital, the Ambulance Victoria electronic patient care record, and four clips of body worn camera footage depicting the period while Anthony was in police custody.

96. A/Prof de Boer's report detailed his findings on examination and his opinion as to the matters which have causes or contributed to Anthony's death, including in respect of:

    (a) the physical injuries identified on autopsy;

    (b) the effects of the prolonged physical restraint on Anthony;

    (c) drugs detected in toxicological analysis; and

    (d) other potential contributing factors.

Physical injuries

97. The post-mortem examination identified multiple blunt force injuries, with multiple bruises, abrasions and small lacerations observed to the head, neck musculature, chest, abdomen, back, shoulders, arms, wrists, hands, legs and feet. There were also fractures of the nasal bone, the right cheek bone, anterolateral ribs, and a transverse sternal fracture.

98. A/Prof de Boer noted that medical intervention may have caused, augmented and/or obscured some injuries.

99. He considered that the bruising observed on the right side of Anthony's neck was likely caused by intravenous cannulation of the jugular vein to administer medications, fluids and take blood samples. The fractures to the ribs and sternum were typical for those seen after chest compressions, which were administered to Anthony after the two cardiac arrests.

100. A/Prof de Boer noted the bruises, abrasions and small lacerations were all caused by impact with blunt object or surface.

101. To assist in his interpretation of the observed injuries, A/Prof de Boer reviewed the body worn camera footage. He commented that some of the minor bruises and abrasions appeared to have been present prior to police restraint. This is evident on the body worn camera footage and is also referred to in some of the calls to Triple Zero and the statements of the first responding police unit.

102. A/Prof de Boer commented that the injury pattern of minor bruises and abrasions was entirely in keeping with the footage provided, and the period of prolonged physical restraint in a prone position with handcuffs around the wrists, fixation of the arms and legs, and pressure applied to the lower back.

Prolonged physical restraint

103. A/Prof de Boer explained that prolonged physical restraint may carry a risk of cardiorespiratory collapse and death, particularly where there is smothering, neck compression, positional asphyxia and/or mechanical asphyxia.

104. Each of these mechanisms hamper breathing and oxygenation. A/Prof de Boer explained that smothering involves covering of the nose and mouth. Neck compression limits oxygenation of the brain. Positional asphyxia hampers respiration by the position of the body. Mechanical asphyxia hampers respiration through pressure on the chest or abdomen.

105. On his review of the body worn camera footage, A/Prof de Boer did not observe any evidence of smothering, neck compression or positional asphyxia during the period Anthony was under prone restraint. Anthony appeared conscious throughout this period, and his loss of consciousness appeared temporally related with the administration of ketamine. Accordingly, A/Prof de Boer considered the physical restraint alone did not cause the cardiac arrest and death.

106. A/Prof de Boer commented that he could not exclude a degree of mechanical asphyxia due to pressure on the trunk but did not consider this to be sufficiently present to fully explain the cardiac arrest. He opined that some degree of mechanical asphyxia may have occurred due to pressure on Anthony's trunk while he was prone. This – in combination with the

physiological effects and metabolic demands associated with Anthony's prolonged struggle – may have contributed to the risk of a cardiac arrest.

Drug toxicity

107. Toxicological analysis was undertaken of an ante-mortem plasma specimen collected at Royal Melbourne Hospital at 5.48pm shortly after his admission. This was approximately 2 hours and 15 minutes after the first cardiac arrest.

108. The toxicological analysis detected gamma hydroxybutyrate (**GHB**) (~160 mg/L), methylamphetamine (~2.2 mg/L), amphetamine (~0.1 mg/L) and ketamine (~0.4 mg/L) in the ante mortem specimen. No novel psychoactive substances or alcohol were detected.

109. A/Prof de Boer explained that:

    (a) the effects of GHB include drowsiness, euphoria, nausea, unconsciousness and visual disturbances. Higher doses can cause acidosis, bradycardia, hypersomnolence, hypotension, respiratory depression, seizures, coma and death.

    (b) the levels of GHB at the time of the cardiac arrest were likely considerably higher than that detected in the toxicology analysis. This is because GHB has a short elimination half-life of approximately 20 to 60 minutes, and over 2 hours had elapsed before the ante mortem specimen was obtained in-hospital. Deaths attributed to acute GHB overdose have detected postmortem blood concentrations averaging 294 to 561 mg/L.

    (c) methylamphetamine – also known as 'ice' - can cause anxiety, confusion, hallucinations, hypertension, cardiac arrhythmias, circulatory collapse, coma and death. It can also cause hyperthermia, and A/Prof de Boer noted Anthony was markedly hyperthermic (40.3°C) when paramedics took his ambient temperature. In addition, due to its strong stimulatory effects on the cardiovascular system, methylamphetamine lowers the threshold for cardiac ischemia – that is reduced blood flow to the heart.

    (d) the level of methylamphetamine detected in the ante mortem serum –2.2mg /L – was potentially fatal. This is higher than the median concentration of methylamphetamine in deaths attributed to methylamphetamine toxicity in published reports – being 0.2 mg/L.

(e) chronic methylamphetamine users have an increased risk of cardiovascular disease, including cardiac arrhythmias and accelerated coronary artery atherosclerosis. Consistent with this, moderate atherosclerosis was identified at autopsy of the left anterior descending artery, with approximately 60% stenosis (that is, narrowing of the coronary artery).

110. A/Prof de Boer was unable to confirm whether the ketamine detected in toxicological analysis was entirely due to the intramuscular administration by paramedics, or if Anthony had used ketamine prior to the attendance of emergency services.

111. A/Prof de Boer stated that the level of ketamine detected in the ante mortem specimens could not explain the cardiac arrest. as fatalities attributed to ketamine have shown much higher blood concentrations than shown in this case. In this respect, Dr de Boer explained that fatalities associated with ketamine have reported detections in the region of 2.5 - 27 mg/L – significantly higher than the 0.4 mg/L detected in Anthony's ante mortem specimen.

112. However, given the temporal relation between the administration of ketamine and cardiac arrest, A/Prof de Boer commented that the effects of ketamine, superimposed on the effects of other drugs may have contributed to the cardiac arrest.

113. A/Prof de Boer provided an opinion that the toxic effects of GHB and methylamphetamine were sufficient to explain the cardiac arrest. He also considered that the effects of ketamine, superimposed on the effects of these drugs, also probably contributed to the cardiac arrest.

Other potential contributors

114. A/Prof de Boer commented there was no evidence of natural disease which could explain the cardiac arrest in isolation.

115. A/Prof de Boer considered the narrowing of the coronary artery found at autopsy was insufficient to explain the death in the absence of contributory factors. He opined that it may have contributed to the death in the setting of increased cardiovascular demand.

116. A/Prof de Boer noted that at autopsy was also an incidental and inconsequential finding of renal adenomatosis. There was also bilateral patchy bronchopneumonia with features of aspiration. A/Prof de Boer considered the bronchopneumonia was a secondary event not relevant for the cause of the cardiac arrest.

117. A/Prof de Boer commented that the high outdoor temperature, together with Anthony's agitation and hyperactivity prior to the restraint may have increased the risk of hyperthermia and physiological or metabolic derangement, and thus of cardiac arrest.

Conclusion on cause of death

118. A/Prof de Boer noted this is a complex case in which the ultimate cause of the cardiac arrest and death were difficult to determine.

119. He opined that the toxic effects of GHB and methylamphetamine are sufficient to explain the cardiac arrest and death.

120. The effects of ketamine, superimposed on the effects of the other drugs consumed by Anthony (being GHB and methylamphetamine) probably contributed to his cardiac arrest. In addition, the physical restraint, physical exertion, underlying coronary artery disease, and hot outdoor temperature may also have contributed to the cardiac arrest.

121. A/Prof de Boer concluded that the medical cause of death was:

    1(a) Multidrug toxicity (GHB, methylamphetamine, ketamine) in a setting of restraint and moderate coronary artery atherosclerosis

122. I accept A/Prof De Boer's opinion.

REVIEW OF EMERGENCY SERVICES RESPONSE

123. As Anthony's death occurred while he was in the custody of police, the circumstances of his death require additional scrutiny. This is because this involves the exercise of exceptional powers conferred on police members to take or hold a person in their custody. It is imperative that the circumstances of death be thoroughly reviewed to ensure this duty of care has been adequately discharged and the use of powers conferred by the State have been exercised in a reasonable, justifiable way, and have not been abused.[64]

[64] Royal Commission into Aboriginal Deaths in Custody [4.5.41].

124. In reviewing the circumstances of Anthony's death, I considered:

(a) whether the actions of the police members in taking Anthony into their care and control and using force to handcuff and restrain Anthony was lawful, proportionate and reasonable;

(b) whether the police officers took appropriate steps to manage Anthony's welfare and ensure his safety during the period he was under their care and control;

(c) whether the paramedics followed applicable clinical practice guidelines in the administration of sedation to Anthony and his post-sedation care; and

(d) whether there are any opportunities for prevention that arise in respect of Anthony's death.

Taking Anthony into care and control under Mental Health and Wellbeing Act

125. Section 232 of the *Mental Health and Wellbeing Act 2022* provides that a police officer, protective services officer or a member of a prescribed class of persons, may take a person into care and control if they are satisfied that:

(a) the person appears to have a mental illness, and

(b) because of the person's apparent mental illness, it is necessary to take the person into care and control to prevent imminent and serious harm to the person or to another person.

126. When Broadmeadows 212 arrived on scene, they observed Anthony to be in an altered conscious state, with no apparent awareness of his surroundings. He appeared drug-affected, had several abrasions across his body and limited control of his limbs. He was unsteady on his feet and fell several times. He repeatedly punched at the air, and hit himself. Efforts to verbally engage with him were unsuccessful.

127. I am satisfied that the decision of FC Rutledge and Const Zygmunt to take Anthony into their care and control was reasonable and justifiable and met the requisite threshold under section 232 of the *Mental Health and Wellbeing Act* as:

(a) Anthony appeared to have a mental illness – as he appeared to be exhibiting a significant disturbance of thought, mood, perception or memory; and

(b) because of that mental illness it was necessary to take into him care and control to prevent imminent and serious harm to himself or to another person – with the contemplated harm being injuries sustained in a fall or hitting his head on the ground, the apparent lack of control of his limbs (including punching the air and hitting himself), and as he appeared to be unaware of his surroundings including the roadway next to his location with passing cars.

128. Section 250 of the *Mental Health and Wellbeing Act* provides that a police officer may use bodily restraint – being physical or mechanical restraint - on a person who is being taken into, or is in, their care and control if –

(a) all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable; and

(b) the use of bodily restraint is necessary to prevent imminent and serious harm to the person or to another person.

129. The Victoria Police Manual 'Care and Control under the Mental Health and Wellbeing Act 2022', provides further guidance to police officers that where bodily restraint is used, police officers must continually assess whether the use of bodily restraint is necessary to prevent imminent and serious harm to the person or another person.[65]

130. In the exercise of force, police officers are required to have regard to the operational response principles outlined in the Victoria Police Manual chapter on Operational Safety and the Use of Force. These principles are Service, Safety and Harm Minimisation, and set out expectations to police officers that they are:

(a) trained, equipped and empowered to perform tasks which may be considered inherently unsafe, to provide a service to the Victorian community in line with their legislated responsibility;

(b) required to identify hazards and mitigate risks to themselves and others as far as is practicable, consistent with the requirements of the *Occupational Health and Safety Act*; and

[65] VPM – Care and control under the Mental Health and Wellbeing Act 2022, [4.1].

(c) required to minimise harm caused by the actions of police or the actions of others.[66]

131. The VPM further provides that:

> *"Members… are expected to protect themselves and the public while fulfilling their duties. To do this effectively, they may need to use force."*[67]

132. The VPM Operational Safety Equipment provides further guidance on the use of operational safety equipment by members, including in respect of the use of handcuffs. The VPM states that any person arrested or taken into custody should be handcuffed if it is reasonably believed to be necessary in the circumstances.[68]

133. Both First Constable Rutledge and Constable Zygmunt stated that they considered it necessary to handcuff Anthony for the safety of Anthony and police.

134. I am satisfied that the decision to handcuff Anthony was reasonable and justifiable in the circumstances to ensure the safety of Anthony and the attending police officers in circumstances where Anthony's movements were erratic and unpredictable, and where he appeared to have limited control of his limbs and had hit himself in the face, and shadow boxed the air. It was also necessary to ensure the ambulance paramedics (who had been requested to attend) would be able to safely provide care to Anthony.

135. There do not appear to have been other less restrictive measures available to the officers where their attempts to verbally de-escalate and engage with Anthony had proved unsuccessful. I am satisfied the police officers did not apply any more force than was reasonably necessary in the circumstances. After Anthony was handcuffed, the officers did not immediately apply any other force to Anthony other than to pull him away from the edge of the nature strip abutting the roadway where there were passing cars. They encouraged him to sit on the ground while awaiting the arrival of ambulance paramedics and attempted to reassure and engage with him.

136. The officers applied additional force to restrain Anthony's arms and legs to limit his movements when Anthony repeatedly rolled around on the ground, kicked out, stood up, and

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[66] VPM – Operational safety and the use of force, [4].
[67] VPM – Operational safety and the use of force, [Context].
[68] VPM – Operational safety equipment, [6.3].

attempted to get out of the handcuffs. I consider that at this stage, there was no practicable alternative available to the officers but to restrain Anthony due to the risk he presented to himself and the officers because of his agitation, resistance, and erratic movements. Efforts to verbally de-escalate were unsuccessful, and restraint was necessary to reduce the risk of harm to himself and others from his unpredictable and forceful movements.

137. Having carefully reviewed the body worn camera footage, I am satisfied that the officers did not apply any unreasonable or excessive force against Anthony during the period of restraint. I consider the actions taken by the members in restraining Anthony appear lawful, reasonable, and proportionate, and consistent with applicable legislative requirements and the officers' training.

Management of Anthony's welfare while in care and control

138. The Victoria Police Manual chapter on 'Care and control under the Mental Health and Wellbeing Act 2022 requires police officers who are responding to a person in a mental health crisis to –

    a) identify and address all safety concerns at the scene of an incident prior to health professionals or other non-police personnel engaging directly with the person;

    b) seek advice from a health professional where reasonably practicable in the circumstances, including from an attending Ambulance Victoria paramedics;

    c) act compatibly with a person's human rights under section 38 of the *Charter of Human Rights and Responsibilities*;

    d) arrange for the transport of the person to the nearest specified body – including hospital, for examination where an on-scene mental health assessment is not reasonably practicable; and

    e) seek assistance from Ambulance Victoria to provide transportation, with police transportation to only be used as a last resort.

139. Further, when holding a person under physical restraint, the Victoria Police Manual chapter on 'Operational Safety Equipment' instructs police officers to:

    - *Keep any person who is physically restrained under close observation. Take care to ensure the person is placed in and maintains a position that allows*

unrestricted breathing. If any restriction or impairment to respiration is observed or suspected, immediately seek assistance.

- *Restraint techniques that could impair a person's unrestricted breathing should only be used when absolutely necessary and for the briefest possible time.*
- *When using handcuffs, prevent the possibility of positional asphyxia by ensuring people do not have their face covered and are not left lying face down with their hands restrained behind their back.*[69]

140. I am satisfied the attending police officers took appropriate steps, consistent with the requirements of Victoria Police policy, to ensure the safety, security, health and wellbeing of Anthony insofar as they were able in the circumstances. The officers:

(a) were alert to the risk of positional asphyxia and maintained careful and ongoing monitoring of Anthony's breathing and movements;

(b) considered whether it was possible to place Anthony on his side, but ultimately did not do so due to the ongoing risk posed by Anthony's erratic movements;

(c) ensured Anthony's face was not covered and that he was able to freely move his head and neck during the period of restraint, with no pressure placed on his neck or chest;

(d) sought medical assistance for Anthony as a matter of urgency from ambulance paramedics, and made numerous attempts to escalate this request during the period of restraint;

(e) provided Anthony with water and shade to attempt to cool him down while awaiting the arrival of ambulance paramedics;

(f) placed Anthony on his side and transferred him to the ambulance stretcher as soon as practicable after the administration of sedation, where the handcuffs were immediately removed and soft restraints applied.

141. The comments made by A/Prof de Boer following autopsy confirm there is no evidence to suggest that any smothering, neck compression or positional asphyxia occurred while Anthony was restrained. Indeed, Anthony appeared conscious throughout the period of prone

[69] VPM – Operational safety equipment, [7.2]

restraint, and the loss of consciousness appeared temporally related to the administration of ketamine.

142. Having regard to all the evidence, I am satisfied the police officers took all reasonable and appropriate steps to ensure the safety, security, health and wellbeing of Anthony while he was in their care and control, and to minimise the risk of positional asphyxia and hyperthermia while he was in a prone position.

Medical treatment rendered

143. In reviewing the medical care provided to Anthony by attending paramedics, I have had the benefit of an in-depth case review report completed by Ambulance Victoria following Anthony's death in accordance with their policies for the management of patient safety incidents.

144. I have formed my own view on the evidence before me, having the benefit of the body worn camera footage and other materials in the coronial brief not available to the review authors. Nonetheless, I consider the in-depth case review provides helpful information about Anthony's presentation, his clinical management, the qualifications and experience of the attending paramedics, and the factors considered in their clinical response and management, as well as their post-incident reflections to consider whether there were any opportunities to improve patient care.

145. The in-depth case review confirms that the first attending paramedics on scene had completed the 'Plan to Sedate, Plan to Resuscitate' education campaign run by Ambulance Victoria's Clinical Officers. This training encourages paramedics to ensure they take appropriate steps in planning and preparing for sedation, including organising for a specialist MICA unit to attend the scene, to prepare monitoring and resuscitation equipment prior to sedation, and to complete the sedation checklist.

146. Consistent with this training, and the applicable clinical practice guidelines, the Advanced Life Support paramedics – under considerable time pressure – undertook all appropriate steps in assessing the need for, and planning and preparing for sedation to be administered to Anthony.

147. Due to his extreme safety risk in the context of violence, psychostimulant overdose and ongoing significant resistance to police restraint, the paramedics considered that sedation was required before vital signs could be safely performed. They ensured all resuscitation equipment was on hand, the stretcher was near the patient and physical restraints were prepared. A MICA unit had been requested to attend prior to their arrival, and this request was again repeated when a decision was made at the scene to sedate. The dose of ketamine administered was consistent with applicable guidelines, being 300mg for a person between 60 to 90kg.

148. Having considered the body worn camera footage and the statements of the attending paramedics, I am satisfied the paramedics closely monitored Anthony's condition prior to and following the administration of sedation. His temperature was taken – and the results conveyed to the AV Clinician on duty. As soon as the sedation appeared to begin taking effect, Anthony was transferred to the ambulance stretcher. The paramedics subsequently identified and appropriately responded to the rapid deterioration in Anthony's condition when he went into respiratory arrest and immediately administered cardiopulmonary resuscitation with the assistance of police officers at the scene. Advice was also sought on Anthony's clinical management due to the complexities of his condition from a senior critical care physician through the Ambulance Victoria Doctors on Call clinical telephone support service.

149. In the circumstances, I consider that all reasonable and appropriate actions were taken by the attending paramedics consistent with the requirements of the clinical practice guidelines.

150. The in-depth case review report referenced discussions in the in the post-incident debrief by the intensive care paramedics about the adequacy of their perfusion management choices following Anthony's first cardiac arrest.

151. The paramedics administered noradrenaline infusions and gave multiple increments of metaraminol in accordance with the clinical practice guideline for drug induced hyperthermia. However, Anthony could also have been managed under the clinical practice guidelines for return of spontaneous circulation management or hyperkalaemia, which advise to manage perfusion with adrenaline. Given the degree of metabolic derangement, the review authors considered it was unlikely this medication choice impact Anthony's outcome.

152. I accept this opinion. There is no evidence to suggest that this discrete medication choice had or may have had a significant impact or contribution on Anthony's outcome in this case.

153. I commend the paramedics on their candid self-reflection in the post-incident review. This review process – which is made with the benefit of hindsight – enhances a culture of continuous improvement and supports patient safety by identifying opportunities to improve patient care in the future.

FINDINGS AND CONCLUSION

154. Pursuant to section 67(1) of the Act, I make the following findings:

    (a) the identity of the deceased was Anthony Laurence Parisi, born 15 October 1985;

    (b) the death occurred on 9 March 2025, at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, from multidrug toxicity (GHB, methylamphetamine, ketamine) in a setting of restraint and moderate coronary artery atherosclerosis.

    (c) in the circumstances described above at paragraphs [31] to [89].

155. I find the decision of the attending officers to take Anthony into care and control, and to use force in applying handcuffs and subsequently physically restraining Anthony was lawful, proportionate and reasonable in all the circumstances because of his presentation, erratic behaviour and the risk Anthony posed to himself and others.

156. I am satisfied the responding officers took appropriate steps to provide care for Anthony during the period he was in their care and control, including by seeking medical assistance for Anthony, monitoring his breathing, and providing him with water and shade to attempt to cool him down while awaiting the arrival of ambulance paramedics.

157. I further find the attending paramedics followed applicable clinical practice guidelines in administering sedation to Anthony. Under considerable time pressure, they took appropriate steps in planning and preparing for sedation, including organising for a specialist mobile intensive care ambulance unit to attend the scene, and preparing the monitoring and resuscitation equipment to be available immediately after the ketamine was administered.

158. I find the paramedics closely monitored Anthony's condition after they administered sedation to him. Shortly after Anthony was transferred to the ambulance stretcher, the

paramedics observed the deterioration in Anthony's condition. They immediately administered cardiopulmonary resuscitation with the assistance of police officers at the scene and sought advice on clinical management from senior critical care physicians through the Ambulance Victoria Doctors on Call clinical telephone support service while treating Anthony.

159. I am satisfied that the responding police officers and ambulance paramedics took all reasonable and appropriate steps in responding to Anthony on 8 March 2025.

160. Having considered all of the available evidence, I am satisfied that Anthony's death was the unintentional consequence of his intentional use of GHB and methamphetamine.

COMMENTS

I make the following comment(s) connected with the death under section 67(3) of the Act:

161. Anthony's death is one of many deaths involving GHB and methamphetamine investigated by this Court over the past few years.

162. My investigation has established that Anthony chose to continue to use GHB and methamphetamine, despite frequently experiencing adverse effects from these drugs requiring hospitalisation, and notwithstanding his mother's advocacy for him to cease using these drugs. Anthony also declined referrals to drug treatment services when these were offered to him during hospital admissions.

163. In these circumstances, I have not identified any clear prevention opportunities or measures arising from Anthony's death which might contribute to a reduction in the number of preventable deaths. However, the findings made following this investigation may contribute to the evidence-base regarding fatalities involving illegal drugs and may inform the development of harm reduction initiatives.

164. The Coroners Court of Victoria regularly publishes data on overdose deaths to make mortality data accessible to the community and to organisations engaged in reducing preventable deaths. This data is shared with government and health agencies to inform their work in reducing drug harms.

165. In August 2025, the Coroners Court of Victoria published the Victorian Overdose Deaths 2015-2024 report.[70] This report collates mortality data for deaths where the acute toxic effects of a drug or drugs played a contributory role in the death, for the ten-year period from 1 January 2015 to 31 December 2024. The report indicates there has been a significant and concerning increase in deaths involving GHB and methamphetamine over this period.

166. In 2015, there were no deaths involving GHB reported in Victoria. The following year, 2016, five deaths involving GHB were reported. Since that time, the number of deaths involving GHB has trended steadily upwards, reaching a peak of 31 in 2024, the year prior to Anthony's death. While data is not yet available for the 2025 year, it is not anticipated there will be a substantial reduction in the number of GHB-related deaths in Victoria.

167. Similarly, there has also been a significant upward trend in deaths involving methamphetamine, from 76 deaths in 2015 to 215 deaths in 2024. After heroin, methamphetamine is the next most frequent contributing illegal drug in Victorian overdose deaths in 2024, and over the decade 2015 to 2024 more broadly.

168. In April 2024, the Victorian Government committed to a Statewide Action Plan to address the harms associated with alcohol and other drugs through a health-led approach. Among the initiatives to be implemented through the Action Plan are:[71]

    (a) an overdose prevention and response helpline to offer anonymous support and advice to individuals at risk of overdose across Victoria, encouraging safe drug use practices and assist emergency services responses;

    (b) expansion of specialist services in the central business district to provide health and mental health care for people who use drugs and expanding cohealth street outreach teams to Footscray and St Kilda;

    (c) establishment of an Alcohol and Other Drugs Ministerial Advisory Committee to strengthen advice, drive reform and innovation, and support delivery of priority harm reduction initiatives.

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[70] Coroners Court of Victoria, Victorian Overdose Deaths 2015-2024 report published 12 August 2025
[71] Department of Health, 'Statewide Action Plan to reduce drug harms'.

169. On 5 December 2025, the Victorian Government published the Victorian AOD Strategy 2025-35 (**AOD Strategy**), a health-led approach which aims to address drug-related harm in Victorian community over the long term by ensuring Victorians can access the right information, support and care at the right time.[72] The AOD Strategy focuses on five key areas: information and access; harm reduction, treatment and system design; culturally safe, self-determined responses for Aboriginal Victorians; system innovation and continuous improvement; and integration across intersecting systems. [73]

170. The AOD Strategy is designed to provide a holistic approach to reduce alcohol and other drug-related harm and stigma that maximises the health, mental health and wellbeing of Victorians. The objectives of the AOD strategy include that:

    (a) Individuals, families, supporters and diverse communities have access to prevention and early intervention support.

    (b) Individuals, families, supporters and diverse communities have access to information and are supported to navigate the AOD system;

    (c) Victorians can access effective harm reduction services to reduce fatal overdose and other AOD-related harms; and

    (d) Victorians receive quality care through services, treatment and supports that meet individual needs.[74]

171. Action items identified in support of these objectives include to strengthen education about identification of, and responses to potential AOD harm, increase health promotion efforts, and improve access to accurate and up-to-date harm reduction information through a central information point.[75] Further, to strengthen Victoria's early warning system to identify changes in drug markets and trends to enable timely public health advice and appropriate system responses, and continue to expand proactive overdose prevention and response initiatives.[76]

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[72] Department of Health '[Victorian alcohol and other drugs strategy 2025-2035]', p 7.
[73] Ibid, p 8.
[74] Ibid, p 17.
[75] Ibid, p 25. See Action Items 1.1.2, 1.1.3, 1.2.1, 1.2.2.
[76] Ibid, p 27. See Action Items 2.1.3, 2.1.4.

172. The Strategy is intended to be developed in three phases between 2025 to 2035. The first phase of initiatives over the first three years of the strategy, from 2025 to 2028, is focussed on strengthening existing AOD services and identifying opportunities for future actions. Initiatives currently underway include enhanced outreach, the care coordination model, wraparound supports, expanded access to pharmacotherapy and Salvation Army health clinic in Melbourne's CBD.[77]

173. The Victorian Government has committed to implementing monitoring and accountability mechanisms to track progress against the AOD Strategy using clear, measurable milestones and outcomes.[78]

174. I commend the Victorian Government's ongoing work in this area to support harm reduction and address drug-related harms in the Victorian community. To inform ongoing work to develop and implement harm reduction initiatives, I will direct that this finding be provided to the Secretary of the Department of Health.

REMARKS

I convey my sincere condolences to Anthony's family for their loss.

ORDERS AND DIRECTIONS

I order that this finding be published on the Internet in accordance with section 73(1) of the Act.

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

The family of Anthony Parisi

Chief Commissioner of Victoria Police, c/ Maddocks Lawyers

Ambulance Victoria, c/ Meridian Lawyers

Jenny Atta PSM, Secretary of the Department of Health

[77] Ibid, p 46.
[78] Ibid, p 47. See also Action Items 4.1.1-4.1.5, p 34.

Acting Senior Sergeant Jack Hubbard, Coronial Investigator

Signature:

Coroner Simon McGregor

Date: 04 March 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.