IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 0165

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

Inquest into the death of: David Patrick MCCLUSKEY-HARDISTY

Delivered on:	26 August 2022
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing dates:	April 20 – 22 2022
Findings of:	Coroner John Olle
Representation:	Ms N. Hodgson of Counsel, Counsel Assisting Ms A. De Souza, for the family Ms M. Isobel, for the Chief Commissioner of Police Ms R. Kaye, for Ambulance Victoria

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I, John Olle, Coroner, having investigated the death of David Patrick McCluskey-Hardisty, and having held an inquest in relation to his death at Melbourne:

find that the identity of the deceased was David Patrick McCluskey-Hardisty

born on 10 October 1986

and that the death occurred on 9 January 2019

at 41 Elvington Avenue, Cowes, Victoria 3922

from: 1(a) Mixed drug toxicity

SUMMARY

1. David Patrick McCluskey-Hardisty (**David**) died between the hours of 7.45am and 4.00pm on 9 January 2019 at the age of 32. David lived with his partner, Ms Ashley Roney and their two young daughters in Cowes.
2. He was located deceased in his bedroom in circumstances of prescription drug overdose.

MEDICAL EXAMINATION

3. A preliminary examination was conducted on the body of David by Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine, who formulated a reasonable cause of death to be 'mixed drug toxicity.'
4. A toxicological analysis revealed oxycodone in the amount of ~0.7 mg/L, tramadol in the amount of ~0.9 mg/L, methylamphetamine in the amount of ~0.1 mg/L, amphetamine in the amount of ~0.03 mg/L, THC in the amount of ~5 ng/L in blood and ~ 100 ng/L in urine.

THE CORONIAL INVESTIGATION

5. David's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act* 2008 (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.[1]

[1] The Act, section 4(2)(a).

PURPOSE OF A CORONIAL INVESTIGATION

6. The purpose of a coronial investigation of a *reportable death*[2] is 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, and is confined to those circumstances sufficiently proximate and causally relevant to the death, not merely all circumstances which might form part of a narrative culminating in death.[4]

7. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[5] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the 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 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 important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or maybe, guilty of an offence.[8]

9. I was assisted in my investigation by Detective Senior Constable Syd Hadley.

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[2] Defined exhaustively in section 4 of the Act to include relevantly *"the death of a person who immediately before death was a person placed in custody or care;"* For the purposes of the Act, a *person placed in custody or care* is defined in section 3 of the Act and includes relevantly *"(e) a person in the legal custody of the Secretary to the Department of Justice…"* See also footnote 37.

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

[4] This is the effect of the authorities – 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 now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[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.

EVIDENCE AND STANDARD OF PROOF

10. This finding is based on the entirety of the investigation material comprising of the coronial brief of evidence compiled by Detective Senior Constable Hadley including material obtained after provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest and any documents tendered through them, together with other documents tendered through the course of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprise my investigation into the death of David Patrick McCluskey-Hardisty.
11. In addition, I have been greatly assisted by the respective submissions of members of Counsel, including Counsel Assisting. I also acknowledge and thank Mr Lindsay Spence, Principal In-House Solicitor who has provided me with invaluable assistance in this investigation.
12. I have thoroughly reviewed and carefully considered all the material, however will only refer to that which is directly relevant to my findings or necessary for narrative clarity.
13. In the coronial jurisdiction, facts must be established on the balance of probabilities.[9]

SECTION 67 FINDINGS

14. Prior to the commencement of the inquest, it was apparent that David's identity and the medical cause of his death were not in dispute.
15. My scope of inquest was as follows:
    A. Prior to attending 41 Elvington Avenue, Cowes, on 9 January 2019, what information did Victoria Police members and Ambulance Victoria paramedics (**Emergency Services Personnel**):
        i. Hold in respect of David and/or the reason for their attendance; and
        ii. Access in respect of David and/or the reason for their attendance.
    B. What further information became available to Emergency Services Personnel in respect of David and/or the reason for their attendance:
        i. Upon attending 41 Elvington Avenue, Cowes, but prior to entering the premises;
        ii. Whilst inside 41 Elvington Avenue, Cowes, with David; and
        iii. Upon exiting 41 Elvington Avenue, Cowes, but prior to departing the address.
    C. What, if any, advice or information was provided by Emergency Services Personnel to David, Ms Roney or Ms Jessup, prior to leaving the event?

[9] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

D. On what basis/rationale (including whether any collateral information was obtained and considered) did Emergency Services Personnel leave the event without transporting David to hospital, on 9 January 2019?

E. Were the actions of Emergency Services Personnel on 9 January 2019, in accordance with their organisations' policies and procedures?

F. Based on the evidence of the observations of David prior to his death, the post mortem autopsy and toxicology reports and any other relevant information before the Court:

  i. Is it possible to establish a time of death; and/or

  ii. When the analytes noted in the post mortem specimens had been ingested by David.

The Witnesses

16. The following witnesses gave evidence at the inquest:

  a) Ashley Roney.
  b) Jacqueline Jessup.
  c) Sergeant Peter Barry (Sgt Barry).
  d) Leading Senior Constable Dean Sprunt (LSC Sprunt).
  e) Paramedic Scott Newman (Mr Newman)
  f) Paramedic Francis Mendes (Mr Mendes)
  g) Associate Professor Dimitri Gerostamoulos (A/P Gerostamoulos).

CIRCUMSTANCES IMMEDIATELY PROXIMATE TO DEATH

17. In 2017, David was diagnosed with bipolar affective personality disorder and substance abuse and commenced on an anti-psychotic and an anti-depressant. In January 2018 he advised his GP he had ceased taking those medications due to side-effects.

18. Throughout 2018 until final appointment in December 2018, David consulted his GP reporting stable mental health. His consultations related to insomnia and musculoskeletal pain.

19. On the afternoon of 8 January 2019 David was having trouble with knee pain for which he was taking tramadol. He was irritable and angry. An argument ensued, causing Ms Roney to leave the house with the children.

20. At 12.11 am on 9 January Ms Roney received a concerning farewell text message from David, which caused her to immediately return home. She found David sitting on the bathroom floor. He was angry, his speech was slurred and swallowed a handful of pills.

21. Ms Jessup followed Ms Roney to the house, arriving shortly afterwards. She went inside and spoke to David and then came outside of the house and called triple zero requesting an ambulance for a friend who was not in a good state and who had taken a handful of Valium.

22. Both Victoria Police and Ambulance Victoria members were dispatched following that call to David's address and the event was described as an overdose. Records reveal the police were to attend in case of any violence or for safety for the paramedics. Police arrived at the address at 12.51 am and shortly after the paramedics, arriving at 12.56 am.
23. Ms Roney and Ms Jessup met emergency services personnel upon their arrival.
24. Upon entering the house, David reported that he had only taken his regular medication. Though not aggressive, he repeatedly asked the police and the ambulance officers to leave his house. After approximately 10 minutes, emergency services personnel left the house. Records reveal the ambulance and police left the address at 1.10 am and 1.14 am respectively.
25. Ms Jessup returned to her home, and Ms Roney went back inside with David. She left the home to purchase cigarettes at David's request. At 2 am, David vomited and returned to bed. She remained with him during the night and left him as he slept around 7.45am.
26. Ms Roney returned home later after 4 pm and sadly found that David had passed away.

Scope Issues

A. Prior to attending 41 Elvington Avenue, Cowes, on 9 January 2019, what information did Victoria Police members and Ambulance Victoria paramedics (Emergency Services Personnel):

i. Hold in respect of David and/or the reason for their attendance; and

ii. Access in respect of David and/or the reason for their attendance.

27. In the triple zero call made by Ms Jessup for emergency assistance for David, she described him as being, '*not in a good state. He's taken a handful of Valium right in front of* [her].' Further, that he was '*quite aggressive*,' that he was awake and breathing, was not changing colour, was breathing normally and was '*walking around*.' Ms Jessup did not state on the call that David was suicidal or threatening or attempting to take his life, or that he was depressed or had any mental health issues.
28. Ambulance Victoria had no previous records in respect of David. At the relevant time, a patient's previous health information was not available to paramedics attending a scene. Paramedics received a radio dispatch of the case, which informed them of the address and described the case as a, '*31 year old man has taken a hand-full of Valium, [police] have been organised, possibly violent, this was intentional, patient being verbally aggressive*.' The pager information available to the Paramedics was very limited and wasn't as detailed as that displayed on the CAD chronology, but included the information contained on the Patient Care Record (**PCR**) under the heading '*Case Dispatch*.'. That information included "*Case Type: Emergency. Case Given As: OVERDOSE/POISOING, OVERDOSE (NPS)*

(VIOLENT/COMBATIVE.) Location: 41 ELVINGTON Avenue, COWES, VIC, 3922."

29. Police members received information on their in-car Mobile-Data-Terminal (**MDT**), as is set out on the CAD Event Report. Sgt Barry gave evidence he was aware that the chief complaint was overdose poisoning ingestion for a 31-year-old male and that he had taken a hand full of Valium, that "*it's not known but possible that he is violent*," that it was intentional. Sgt Barry said when he arrived at the job, in his mind he was attending to a possible overdose to assist Ambulance Victoria in the event of violence. Despite the words in Sgt Barry's second statement about attending to '*assist with a possible suicidal male*,' it was not in his mind that he was attending to '*a possible suicidal male*'.

30. LSC Sprunt said he would have access to the information in the CAD Event Report, he also said he would have received information over the radio. LSC Sprunt said as the driver, he would not have been able to read the MDT enroute to the address. He said it was usual practice for the passenger of the vehicle to be operating the MDT and he could not recall if he turned the screen towards himself to look at it. He said he could not recall if Sgt Barry read him the information from the screen, or what information he was aware of from the information now contained in the CAD Event Report, given the passage of time. LSC Sprunt could not recall if he had heard over the radio or was otherwise aware of the report that the overdose was intentional. That their job was to assist the ambulance with a violent male, who had possibly taken medication, more than prescribed.

B. What further information became available to Emergency Services Personnel in respect of David and/or the reason for their attendance:

- **i. Upon attending 41 Elvington Avenue, Cowes, but prior to entering the premises;**
- **ii. Whilst inside 41 Elvington Avenue, Cowes, with David; and**
- **iii. Upon exiting 41 Elvington Avenue, Cowes, but prior to departing the address.**

Descriptions of David prior to emergency services arrival

31. Ms Jessup described David's presentation prior to the arrival of emergency services as *"I've never seen him this way and it was very clear to me the look on his face his speech he swaying it was very clear he was, he had taken something else.*" She went on to say his pupils were different and his speech was a little bit slurred, and he was unsteady on his feet.

32. Ms Roney described David as slurring his speech and thought he was intoxicated and that he'd done other drugs and thought he presented differently to other times he taken both drugs and

alcohol and what was different about it was the "*darkness*." Ms Roney said that he hobbled to the bedroom and then back to the bathroom.

Information reportedly given to the Police Members by Ms Roney and Ms Jessup at the scene

33. Ms Roney recalls telling police that David had sent goodbye messages and when they asked if he had any mental illnesses, she named his GP at Cowes Medical Clinic and he had bipolar and depression and that he had taken a handful of pills.
34. She could not remember if she showed police the text messages but that she definitely told them about the goodbye messages although she was unsure of what words she used. She explained "*like why else would they be there for like if it was an overdose and he was passed out like why would the police have to come like I just, I don't understand. Like, I am, it was definitely known that it was suicide.*" When asked if she ever used the words *suicide* or *threaten to kill himself*, she said it definitely would've been one of those words but could not recall the exact wording.
35. Ms Jessup said she told the police members that David had depression and that he wasn't on medication. She named his GP and that he had attempted to take his life. She told them that David had sent goodbye messages to Ashley and that when she arrived, he was aggressive towards her. She could not recall if she said messages or text messages, but she thought she used the words "*he's attempted to take his life.*"
36. Ms Jessup recalled saying to police that he's taken a handful of pills and he will have taken other illicit drugs.

Information reportedly given to the Ambulance Members by Ms Roney and Ms Jessup at the scene

37. Ms Roney explained she did not mention goodbye messages to the ambulance members and thought that because she'd already been over it with the police, she didn't have to do it again with ambulance members.
38. Ms Jessup said that she only recalls seeing one ambulance officer that night and that she told them, "*Ashley believed he'd taken a whole box of diazepam and was likely to have taken tramadol and possibly OxyContin.*" Ms Jessup said she told the ambulance officers David said his goodbyes. She did not recall Ms Roney showing the text messages to the emergency services. Ms Jessup said that she told the ambulance officer that David had a history of mental health issues and that he wasn't taking medication for his mental health, and she had tried to get him back onto antidepressants. She said she told the ambulance officer about his mental health issues, bipolar and depression.
39. Sgt Barry:

- conversed with Ms Jessup and Ms Roney while he was seated in the passenger seat of the police vehicle and LSC Sprunt was in the driver's seat.
- recalled as Ms Jessup spoke he was "*confronted with quite a barrage of emotion.*"
- attempted to get information from the two women, noting Ms Roney had more contact with David, however the information was coming to them second hand by Ms Jessup, who stated "*we had to take him away straight away*."
- recalled being told about Valium and marijuana and that David had depression. He also said he recalled being told that David saw a local doctor in Cowes but did not recall the name of the GP.
- did not recall being told David had sent "*a goodbye message*" or that he was intentionally attempting to overdose.
- stated upon entering the house his concern was to ascertain if David had overdosed and assess his demeanour.
- would have done LEAP checks and from memory there wasn't a lot of involvement with police.
- recalled the ambulance arrived a couple of minutes after police and the police members made their way to the ambulance. He did not recall whether Ms Roney and Ms Jessup spoke to the paramedics, but he says that emergency services agreed to all go into the house to try and find out what the situation was and that police went in first.
- did not recall if he relayed to paramedics the timeframe of when David had taken the Valium, despite being told it was half an hour before.
- did not recall relaying to paramedics that it was "*a strip of Valium,*" rather than the number 10, which he says was the amount conveyed to him by the women.
- did not recall whether he relayed to the paramedics the information about marijuana or depression, in respect of David.
- explained he would have relayed to paramedics all of the information he had received.
- described finding David laying on the floor in his ensuite bathroom, which did not concern him given the state of the room which contained a bong, tobacco butts, and empty medication blister packs but he agreed that David laying on the floor was "*odd*." Explaining in the context of being called to an overdose, he was not concerned, primarily because David was communicating with him.
- thought David was under the influence of something and said, "he wasn't a sober person." That David was very focused on his knee that was causing him a lot of pain.
- did not consider David was slurring his words while he was talking to him.
- did not ask David any questions about his mental health and whether he was depressed, as his main concern was the hammer lying on the floor next to David.

- explained that "*the main conversation as far as his health issue was directed to Ambulance Victoria*."
- directly asked him, "*David, I've been told you may have abused your prescription medication tonight, is that true?*" and David responded "*What? No, I'm fine, I'm speaking to you clearly and rationally, aren't I?*"
- said he would have asked David to explain the empty blister packs in general conversation, saying, "*there would've been basic questions as to why is this why is that.*"
- did not ask David if he was depressed or trying to end his life. He agreed that in the circumstances, asking questions about whether he was trying to end his life was important and trying to find out whether David was trying to harm himself or end his life was the most important thing to find out.
- described David's gait as hobbling because of his knee rather than because of being substance affected.
- explained David told him he taken his normal dose.
- was careful not to question David, without antagonising him.
- did not tell the paramedics about the blister packs in the ensuite because he believed they would've seen them,

40. LSC Sprunt:
    - spoke with Ms Roney and Ms Jessup in the street when he arrived at the address but could not recall if the conversation took place when he was sitting inside the car, or if he was out of the car.
    - overheard Sgt Barry speaking to Ms Roney and Ms Jessup, as he was taking '*the lead on the job*,' and he was happy for him to do so.
    - described Ms Jessup as quite assertive and "*full on with trying to get her point across.*"
    - had no independent recollection of this conversation, and the matters set out in his statement to the Court, made over 11 months after the event were based on his review of the CAD data.
    - had a clear recollection of David having a knee injury, which he's been informed about prior to entering the house.
    - did not recall being told that David had a history of depression or that he'd ceased his medication for it.
    - recalled being told that David had taken more than his prescribed amount of Valium but did not recall being told about any other medication and believed he would have recalled it if he had been told.
    - explained either he or Sgt Barry relayed the information regarding the Valium to the paramedics.

- did not recall if he was told anything by Ms Roney and Ms Jessup about David taking or using illicit drugs.
- did not recall being told anything by Ms Roney and Ms Jessup about David sending a goodbye message, threatening to kill himself or take his life.
- was '*gearing up to a 351*' and building their information about a job and what they are going to do with it.
- agreed that he was attending to someone who overdosed who was potentially violent.
- explained police often turn up and it becomes their job, not the ambulance's job and this was because police have powers to detain a person under section 351.
- further explained they would have passed on to the paramedics, all of the information they had to hand, which was standard practice, though he had no specific recall in this case.
- could not recall whether police and paramedics entered the house at the same time but was sure that police entered first because of the possibility of violence.
- recalled that Sgt Barry entered the ensuite before him and he could hear the conversation between Sgt Barry and David but couldn't get in far enough because the room was quite small and could only initially get a glimpse of David.
- due to his position, was unable to observe any items within the ensuite.
- could not recall the conversation that took place between Sgt Barry and David and could only provide evidence on what would usually occur.
- noted however David was calm, and his speech did not sound like he was substance affected.
- couldn't be sure if ambulance paramedics asked David questions about his mental health but could be sure they asked him questions in relation to medication and his knee.
- was unsure whether Sgt Barry asked David any questions about his mental health but said that it would be a gap if such questions had not been asked.
- observed no decline in David, including in his ability to talk to them, and did not notice anything in his mood other than him becoming more heightened because he wanted emergency services to leave.

41. Paramedic Francis Mendes:
    - recalled that police pulled up at the address shortly ahead of the ambulance and they got out of their cars at roughly the same time.
    - explained he received very quick information from the two women outside and his next thoughts were of the person inside, who may or may not require their help.
    - was told by the women, David gets like this around the Christmas period.
    - explained he entered the house on the basis the women believed David had taken the medications to harm himself.

- did not know that David had sent goodbye messages and was shocked to hear that evidence in Court - that such information would have been a "*game changer*" which would have caused him to attempt to take David to hospital.
- could did not recall if he received any additional information from police. In particular, he did not recall if police had provided him any information about the history of mental health issues for David and believes he would have remembered being told that and would have written it into the PCR. He said at the time of his assessment he didn't know that David had a mental health history.
- was not told that David was a marijuana user but explained it would not have impacted on his treatment on the night.
- did not recall being told about David's local GP and said if he had been told, he would've questioned if there was more information about David's history of presentations.
- recalled the police going into the bedroom and recalled that paramedics did their assessment in the open-plan lounge-kitchen area, explaining David kept returning to the bedroom.
- had a vague recollection of being told David was in the bathroom and that he might've been sitting on the floor. However, did not believe the description of him laying on the floor with headphones on would've changed anything and seemed like a "*pretty normal thing to do.*"
- did not know there were empty medication blister packs around David (in the ensuite/bedroom) and said that would have been a "*very, very strong part of his information gathering.*"
- said that if he known about the empty blister packs, he would've pushed that line of inquiry rather than taking David's word for it and would have taken, "*the gloves off a little bit and – and I'd be a lot more forceful and direct because I'd have something – some kind of proof - to work on.*"
- explained however, he was unable to break down the barrier enough to have an open conversation with David. Though he'd been told David had taken a sedative-type medication, there was no sign of such in David and didn't appear to be adversely affected.

42. Paramedic Scott Newman:
    - did not recall speaking to any bystanders outside of the address upon arrival at the address.
    - believed the police were entering the house or inside the house when paramedics arrived on the scene.
    - did not recall being told David had a history of depression or any previous mental health issues.
    - was unaware of any goodbye texts or suicidal intentions.

- did not recall whether he was told that David had taken a strip of Valium and that he was a regular marijuana user, or being told the name of David's local GP.
- explained inside the house, did not recall the police ever being with David by themselves but recalled David being in the lounge room and moving back-and-forth between that area and what he thought was the bedroom.
- agreed that it would be essential that questions about whether someone was trying to or intending to harm themselves, in the circumstance of David's partner saying he taken too many Valium and pain relief tablets. However, he could not say whether those questions had been asked or not because he did not have any recollection of the conversations.
- recalled David was walking about and was alert to time, date, and place and that he did not recall David slurring his speech, and further, did not recall David limping and believes he was walking without any issues.
- considered information of slurred speech, David laying on the floor of the en-suite and empty blister packs were important information, which he was unaware.

C. What, if any, advice or information was provided by Emergency Services Personnel to David, Ms Roney or Ms Jessup, prior to leaving the event?

43. Ms Roney did not recall being told by emergency services to contact triple zero if David's breathing got bad or if he deteriorated but did recall Ms Jessup giving her that advice. She sated LSC Sprunt raised concerns of potential domestic violence concerns and that she should leave.

44. LSC Sprunt:
    - recalled following a conversation with one of the paramedics before he left the address he spoke to the women alone explaining a paramedic believed David "*will have a good sleep*".
    - said that he did not consider it unusual for paramedics not to speak to family and friends before leaving and that it happened quite often on jobs which became police jobs.
    - explained he spoke to Ms Jessup and Ms Roney before leaving rather than Sgt Barry because he, *"was obviously aware of the tension between them."*
    - did not recall that Ms Jessup told him that David had been threatening suicide but was aware that she wasn't happy that they were not taking David.
    - believed Ms Jessup and Ms Roney were very concerned they were leaving because David wouldn't be happy police were called and that he may get violent towards them
    - to watch out for any deterioration in David, if they chose to remain.

45. Sgt Barry:

- did not recall receiving any information from the paramedics to pass on to Ms Roney and Ms Jessup.
- did not speak with Ms Roney and Ms Jessup upon leaving the house, having confidence that LSC Sprunt would convey the information required.

46. Paramedic Francis Mendes:
    - was satisfied that David was not trying to self- harm and so he considered that he was leaving David, rather than leaving the women. That their concerns had been negated and allayed. He was satisfied that police would speak to the women.
    - on reflection, he thought it would have been a nice courtesy and wished he had spoken to the women before leaving.

D. On what basis/rationale (including whether any collateral information was obtained and considered) did Emergency Services Personnel leave the event without transporting David to hospital, on 9 January 2019?

47. Sgt Barry:
    - explained he acted with the information he had at the time from both parties including that "*David said he was fine. He does not abuse his medication. He does not seek any help. He wanted us to leave*."
    - noted further, that the decision to leave, in compliance with David's request, was made collectively being the emergency services personnel.
    - was on the basis of David's responses, was satisfied he was not presenting as a "*351*" and was not posing an imminent harm to himself.
48. LSC Sprunt explained said David did not fit the criteria of section 351, by reason he was not satisfied David had a mental illness or that he was in serious or imminent harm.
49. Paramedic Francis Mendes:
    - explained that the communication between the four emergency services personnel, comprised a couple of statements, including "*what do you guys think, and they thought about it and looked at each other and said look there's no grounds for…a 351 or there's …no grounds to take this further*."
    - attested because David; wasn't a child, had capacity with a GCS of 15, was fully conscious, had no signs of overdose on medication, there was no benefit fit in speaking to the two women again.
    - thought it was, "*quite a simple case of misunderstanding*" and said so, "*I didn't take it any further with the women.*"
50. Paramedic Scott Newman:

- did not recall a conversation with police about leaving David at home but said there a conversation would have taken place.
- could not recall having a conversation about utilising section 351 of the *Mental Health Act* and cannot say either way whether it occurred.

E. Were the actions of Emergency Services Personnel on 9 January 2019, in accordance with their organisations' policies and procedures?

Victoria Police

51. Section 351 of the *Mental Health Act* 2014, states, *inter alia* -

> *A police officer, or a protective services officer on duty at a designated place, may apprehend a person if the police officer or the protective services officer is satisfied that—*
>
> *a) the person appears to have mental illness; and*
> *b) because of the person's apparent mental illness, the person needs to be apprehended to prevent serious and imminent harm to the person or to another person.*
>
> *(2) A police officer or a protective services officer is not required for the purposes of subsection (1) to exercise any clinical judgement as to whether the person has mental illness.*

52. In accord with section 351,VPM for *Apprehending Persons under the Mental Health Act*[14] notes that members are not required to exercise clinical judgement as to whether a person has a mental illness. However, it does not seem to provide any guidance on making such a determination.

53. According to French CJ, in *Stuart and Anor v Kirkland-Veenstra and Anor* (2009) 237 CLR 215, before a person can be apprehended by police, the person must appear to the apprehending officer to be mentally ill and this requires a subject opinion. French CJ goes on to say the requisite opinion to be formed by police is an opinion formed having regard to the behaviour and appearance of the person, that the person has a mental condition characterised by a significant disturbance of thought, mood, perception, or memory.

54. Counsel submitted the police members did not form the view that David had a mental illness. Further, there is no evidence that David presented in a manner which suggested he had a mental illness.

55. Ms Jessup and Ms Roney conveyed David's history of mental illness to Sgt Barry. However, conveying a history of a mental illness does not mean that someone appears to have a mental illness. Ms Roney considered there was a '*darkness*' in David and Ms Jessup said that he was different to how he usually presented on drugs and alcohol. However, I the evidence does not reach a level suggestive that David presented to police on the night in a manner which suggested he had a mental illness.

56. I accept the submission of Counsel for CCOP that it is sufficient to find that the police were given adequate information by Ms Jessup and Ms Roney in order to fulfill their dual role: to make the scene safe so that paramedics could do their job, and to do a Section 351 assessment of David. Counsel for CCOP correctly submits that the question for me is not whether there were other reasonable options open to the members but rather it is a question whether what was done was reasonable. Both members accepted that irrespective of the precise conversation with Ms Jessup and Ms Roney following a discussion, the members believed that David had taken an overdose and that he might be violent. However, upon entering the house they formed the view that David "appeared fine, denied taking an overdose, displayed no aggression to the emergency officers, but simply asked them to leave."

57. Accordingly, I accept Counsel Assisting's submission that Sgt Barry and LSC Sprunt did not act contrary to their policies and procedures.

Ambulance Victoria

58. Ambulance Victoria provided the organisation's policies and procedures to the Court and submitted the only issue that arises in respect of the policies is in relation to the Mental State Assessment CPG A0106.

59. Mr Mendes said that the Mental State Assessment in the Clinical Practice Guidelines (CPG) contains about nine or ten points and said quite a few of them you can cross off through observations alone, so the fact that he couldn't get David to engage didn't negate completely the Mental State Assessment.

60. The Mental State Assessment special notes, second dot point states, "*the most effective way to ascertain if a patient is considering self-harm is to ask them directly. Questions such as "Are you thinking of killing yourself?" or "Have you thought about how you would do it?" helps to avoid misinterpretation and they do not encourage a person to engage in self-harm."*

61. Mr Mendes explained the paramedic would "*look at your patient and decide which tack you're going to use because some people ... are quite open to a conversation and you can use blunt and closed questions or open questions... Other people ...they're not ongoing with their feedback to me and my questions and not engaging in a conversation* [so] *I need to be a lot more careful because a couple of words and you can close down the entire conversation. So, I need to open the conversation and that's when I use open ended questions."*

62. Mr Mendes did not ask David any questions directly about self-harm but said the way he answered questions about the medication made it clear to Mr Mendes that he had not taken it for self-harm reasons but for analgesic purposes.

63. Mr Mendes said that he didn't "*go for broke*" and ask pointed questions at the end because he believed he had enough information to safely leave David at home. He said he left the house *thinking everything was going to be OK because there was nothing sticking out that I was worried about. …It seemed open and shut at the time.*

64. AV acknowledged that the special notes contained in the CPG, are meant to guide paramedics but also allow for clinical experience and discretion to be exercised. AV submitted for reasons set out in its submission, paramedics were not aware of information that would have likely resulted in the direct questioning recommended in the CPG. However, in circumstances where a patient is not fully engaging and a paramedic determines not to ask direct questions in order to keep the conversation going, AV submitted that there appears to be little harm and only benefit in, as described by Mr Mendes, *going for broke* and asking pointed questions at the end.

I accept this submission.

Victoria Police

F. Based on the evidence of the observations of David prior to his death, the post-mortem autopsy and toxicology reports and any other relevant information before the Court:

- **i. Is it possible to establish a time of death; and/or**
- **ii. When the analytes noted in the post-mortem specimens had been ingested by David.**

65. Despite the concerns that David had taken more than his prescribed amount of Valium, A/Prof Gerostamoulos forensic toxicologist attested there was no diazepam (the generic name of Valium) in the post-mortem toxicology. A/Prof Gerostamoulos was able to conclude that David hadn't taken diazepam within the past few days, or even up to a week before.

66. A/Prof Gerostamoulos explained that the amount of oxycodone in David's post- mortem toxicology was 0.7mg/L which is "*a very high amount of oxycodone and [can] cause death in its own right.*" He said, "*it's a significant concentration that can lead to respiratory depression and... cardiac arrest."* The evidence before the Court suggests that David had not been legally prescribed oxycodone, and A/Prof Gerostamoulos said that use without prescription increases the risk of taking the drug.

67. A/Prof Gerostamoulos identified oxycodone as the only analyte in a dose sufficient to cause death on its own, but that ultimately, it was the combination of the drugs, including the

oxycodone, the benzodiazepines and the erectile disfunction agents, that led to David's death.

68. In his opinion, the oxycodone was taken up to 48hours prior to David's death - it wasn't possible to discern whether it was before or after the assessment by the paramedics.

69. He noted that whether the formulation was slow release or immediate release would impact on how long it took to be absorbed within the bloodstream. It was dependent upon whether David had taken it frequently, and whether he had a high tolerance for the drug. In circumstances where oxycodone was not taken by David on prescription, the evidence is not clear as to; what kind of formulation he took, how frequently he took it and his tolerance.

70. A/Prof Gerostamoulos said that it was hard to reconcile the description of David he heard in the *viva voce* evidence of the paramedics, with the amount in David's post- mortem toxicology. Noting the observations of David slurring his words or appearing substance affected could be as a result of some of the other drugs present, such as etizolam and cannabis and not necessarily the other drugs detected such as oxycodone. A/Prof Gerostamoulos noted there may have been some oxycodone in David's bloodstream prior to being seen by paramedics and he may have taken additional oxycodone taken after he'd been seen. He said that significant amounts of oxycodone would lead to someone being very lethargic, drowsy, and perhaps even unconscious. He agreed that this presentation was inconsistent with David's presentation to paramedics, but noted that in slow-release tablets, they could be in David's stomach for some time before being released and absorbed into his bloodstream.

71. While the photograph of a single empty oxycodone blister packet found in David's home the next day is marked as '*modified release*,' [16] it is not possible to conclude that David took oxycodone from this, and only this packet, or the type of release formulation of any other oxycodone he mayhave taken.

72. A/Prof Gerostamoulos opined that it was not possible to establish David's specific time of death, stating it was between 0745hrs and 1600hrs.

73. Accordingly, on the evidence before the Court, it is not possible to conclude the actual time of death with any greater specificity, and importantly, I am unable to find when David ingested the drugs found in his post-mortem toxicology.

CONCLUSION

Ms Roney

74. I endorse the submission of Counsel for Ms Roney that "both Ms Roney and Ms Jessup should be found to have been essentially honest witnesses who have imperfect memories and made appropriate concessions."

75. The evidence before the Court is that when Ms Jessup contacted Triple Zero, she made no mention of David threatening suicide or having a history of mental health issues. Ms Jessup states that she told police members about the text messages and that David had mental health

issues. She says she told the ambulance member that David had said his goodbyes and that David had mental health issue.

Ambulance Victoria

76. In respect to the attending paramedics, irrespective of the discrepancies in the precise nature of information conveyed between the various individuals, I consider the critical issue is whether the paramedics performed clinical assessment of David aware of an allegation of overdose with the intention of self-harm. I am assisted in this regard by the submission of Counsel for Ambulance Victoria "the paramedics entered the house understanding that Ms Roney and Ms Jessup believed that David had taken too much medication with the intent of self-harm." I accept the accuracy of this submission.
77. I am satisfied that Ambulance Victoria assessment of David was clearly focused on assessing the alleged risk of intentional overdose with a view to self-harm. The paramedics were experienced and dedicated. Their assessment of David was not assisted by David's clear and repeated requests that they leave his home, but nonetheless, were able to assess his mental state, his physical presentation and verbal responses. Ultimately, on the information in their possession, there was no reasonable basis to support the concern of intentional overdose and further, no reasonable basis to require David to be transported to hospital.
78. I endorse the submission in reply of Counsel for Ambulance Victoria, that the paramedics, having spoken to the two women prior to entry to the house, received a plausible explanation for the belief that David had taken the medication to harm himself – due to relationship and child custody issues, David got like that around Christmas time.
79. Mr Mendes attests that information not known to him during his assessment of David included a history of mental illness and blister packs on the en-suite floor. He considered this information would have assisted him in the exercise of his clinical judgement, and had the potential to impact his decision.
80. He explained however, had he known David had sent Ms Roney good-bye texts that evening, he would have changed his decision to transport David to hospital. Ms Roney stated that she told police members about the text messages and that David had mental health issues. Ms Roney did not suggest she'd told paramedics this information.
81. Though paramedics could have spoken to the women before leaving, in the circumstances, I do not consider it unreasonable that LSC Sprunt who was known to Ms Jessup, performed that role. Further, the information he conveyed was not inconsistent with the clinical judgement of the paramedics.

Victoria Police

82. LSC Sprunt stated that he was not aware of the text messages or a suggestion of suicide or a history of depression or mental illness. LSC Sprunt also did not observe any empty blister medication packets in the house.
83. Sgt Barry stated that he was not aware of the text messages or of any suggestion of suicide. He would have considered good-bye texts important information, which he would want to read. He acknowledged however being aware of David's depression and although he couldn't recall doing so, he believed he would have relayed that information to paramedics. Sgt Barry didn't discuss the empty blister packs on the ensuite floor as he believed the paramedics had seen them.
84. I am satisfied that irrespective of the precise information conveyed by the members to the paramedics, the police members endeavoured to convey relevant information to assist the paramedics to perform their clinical task. It follows, any failure to provide relevant information was either inadvertent or not in the knowledge of the police members.
85. I am aware there was initial tension between Sgt Barry and Ms Jessup. The most neutral explanation is that each are assertive individuals.

Counsel Assisting

86. Though a missed opportunity, Counsel Assisting correctly submits that despite the inconsistencies in evidence between the witnesses, it is not suggested that any witness was lying or that their credibility in anyway should be impugned. Given the passage of time since the events and the undoubted impact the knowledge of the outcome might have on recollections, it is unsurprising that the various accounts of the night differ.
87. Counsel Assisting submitted in respect to Mr Mendes evidence regarding above pieces of information, highlighted the good-bye texts as game changer. He graphically explained he was 'gob-smacked' when he first learnt of the texts during the inquest. He said that he was not aware that David had a history of depression or mental health issues and said that "*in retrospect given everything that I now know it would have pointed to getting more information from the people outside*," Mr Mendes also said that he was not aware of the empty blister packs and that it would have changed his approach to questioning David.
88. In my view, the dynamic nature of this call out must not be understated. There was significant time pressure on the VicPol and Ambulance Victoria responders to perform their respective roles.
89. I consider all witnesses before me were impressive and honest – who gave their best to recall the events of the evening.
90. However, I am acutely aware of the reality of hindsight bias. Witnesses face an extraordinary challenge, excluding knowledge of a tragic outcome, when striving to recall conversations

which occurred years earlier. The magnitude of the challenge is exponentially heightened in the absence of contemporaneous notes.

91. It is hardly surprising that respective recollections varied - recollections of truthful witnesses can be flawed.
92. Though there was important information which was not in the possession of all emergency services personnel, I consider it is significant that irrespective of the divergence in respective recollections, the critical issue confronting the paramedics was to assess David's risk of self-harm. The evidence is clear. The paramedics entered the house and assessed David in the knowledge that Ms Roney and Ms Jessup were concerned that David had intentionally overdosed in order to self-harm.
93. I am satisfied that their assessment was at all times focused on this risk. His demeanour, his presentation, his responses. Despite his curt answers and clearly articulated request that all Emergency Services personnel leave his home, there was no reasonable basis to find that David was a risk of self-harm.
94. It follows, upon departing the home, in light of the paramedics' assessment, VicPol had no reasonable grounds to require David be conveyed to hospital on a S 351 warrant.
95. I am unable to determine whether or not good-bye messages were communicated to emergency services personnel. In so finding, I make no criticism of Ms Roney or Ms Jessup. However, I find the Emergency Services Personnel evidence as to the significance of good-bye texts was compelling. If the messages were mentioned, the sole explanation for not being acted upon is communication failure the explanation for which I am unable to ascertain.
96. It is important to recall the expert evidence of Associate Professor Gerostamoulos, it is not possible to discern whether David took the oxycodone before or after the assessment by the paramedics.
97. In respect to recommendations suggested by Counsel for Ms Roney that AV consider the creation and utilisation of handover checklists, whilst theoretically attractive, in my view would pose "very significant and complex logistical issues" as submitted by Counsel for AV. Though making no adverse finding in this case, and am not persuaded to make a Recommendation, I nonetheless applaud the submission of Counsel for Ms Roney, which highlights the need to provide emergency services personnel the best opportunity to ensure critical information is both obtained and shared, in what I note are invariably stressful and challenging scenarios.
98. I take this opportunity to offer Ms Roney and her daughters my sincere condolences and reiterate my comments expressed to her at the conclusion of the inquest in which I publicly acknowledged her unstinting love and support for David.

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Ms Ashley Roney

CCOP

Ambulance Victoria

Coronial Investigator

Signature:

Date: 26 August, 2022

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 investigation. 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.