IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 0210

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the Coroners Act 2008

Findings of:	Katherine Lorenz, Coroner
Deceased:	David Philip Walter Perry
Delivered on:	18 August 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	17 August 2021
Assistant to the Coroner:	Sam Brown Principal In-House Solicitor

INTRODUCTION

1. David Perry (**Mr Perry**) was a 35-year old single man who lived alone in an apartment block on Wellington Street in St Kilda (**the apartment block**) at the time of his death.

2. On the evening of 9 January 2019, Victoria Police were called to an incident at the apartment block at which Mr Perry was apparently substance-affected and refusing to come down from a first-floor roof. The incident was resolved peacefully, with Mr Perry arrested pursuant to section 351 of the *Mental Health Act 2014* (Vic) (**MH Act**) and transferred by ambulance to The Alfred Hospital (**the Alfred**) for psychiatric assessment.

3. Mr Perry was discharged from the Alfred around 10.30am on 10 January 2019.[1]

4. In the early hours of 11 January 2019, it was alleged that Mr Perry attempted to murder a man by stabbing him at the apartment block after breaking into one of the apartments and attacking the occupants.

5. After the alleged stabbing, Mr Perry absconded in a stolen car and later that evening, he died of unascertained causes during his arrest by Victoria Police members at Great Ocean Road, Bellbrae, Victoria.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. Mr Perry's death constitutes a '*reportable death*' as that phrase is defined in section 4 of the *Coroners Act 2008* (Vic) (**the Act**), as he ordinarily lived in Victoria[2], the death appeared to have been unexpected, unnatural, violent or the result of an accident or injury[3] and because he was, immediately before his death, a person placed in custody or care. The relevant definition of a person placed in custody or care under the Act includes a person who a police officer is attempting to take into custody.[4]

7. Mr Perry's designation as a 'person placed in custody or care' is significant. This is because the Act recognises that people in the control, care or custody of the State are vulnerable and therefore, irrespective of the nature of the death, requires the death to be reported to the coroner and so be subject to the independent scrutiny and accountability of a coronial investigation.

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[1] Mr Perry's Alfred Health Records.
[2] Section 4.
[3] The Act, section 4(2)(a).
[4] Section 3 of the Act provides an exhaustive definition of a 'person placed in custody or care'.

8. An inquest into Mr Perry's death was mandatory pursuant to section 52(2)(b) of the Act because he was a 'person placed in custody or care' and his death was not due to natural causes.[5]

9. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[6] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[7]

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

11. For coronial purposes, the phrase "*circumstances in which death occurred*,"[8] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

12. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[9] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[10] or to determine disciplinary matters.

13. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of comments and recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

14. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[11] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[12] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

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[5] Section 52(3A) of the Act stipulates that a coroner is not required to hold an inquest in the circumstances set out in subsection (2)(b) if the coroner is satisfied that the death was due to natural causes.
[6] Section 89(4) of the Act.
[7] Preamble and section of the Act.
[8] Section 67(1)(c) of the Act.
[9] *Keown v Khan* (1999) 1 VR 69.
[10] Section 69(1) of the Act.
[11] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[12] (1938) 60 CLR 336.

INVESTIGATION AND SOURCES OF EVIDENCE

15. Detective Senior Sergeant (**DSS**) Mark Colbert of the Homicide Squad was appointed the Coroner's Investigator and prepared a coronial brief of evidence in relation to the investigation of Mr Perry's death.

16. As Mr Perry's death occurred while he was in police custody, investigators from the Victoria Police Professional Standards Command (**PSC**) conducted oversight of the investigation of his death and a copy of the Interim Report prepared by DSS Allan Brown was provided to the Court.

17. Coroner John Olle originally had the carriage of this investigation. I took over this investigation in February 2021, at which point the coronial brief had been filed with the Court and additional materials had been obtained at Coroner Olle's direction. Among those materials were additional statements from police members involved in efforts to locate Mr Perry on 11 January 2019, statements concerning Mr Perry's management by paramedics on that date, and preliminary advice from the Coroners Prevention Unit about Mr Perry's clinical management at the Alfred on 9-10 January 2019, and by Ambulance Victoria (**AV**) at Bellbrae.

18. At my request, Victoria Police Manual (**VPM**)[13] procedures and guidelines and training materials relating to operational safety and the use of force were obtained along with information from the Chief Commissioner of Police responsive to issues raised in the PSC Interim Report.

19. At the conclusion of my investigation, I was satisfied I was able to make findings about the deceased's identity, the cause of death and the circumstances in which death occurred, so this case was listed for inquest in accordance with the Act. The Inquest was a Summary Inquest – one conducted without oral testimony – as there were no evidentiary conflicts or discrepancies that would justify calling witnesses.

20. This Finding draws on the totality of the coronial investigation into Mr Perry's death, including the Court file and the Coronial Brief reconfigured to incorporate the additional materials obtained after it was filed. In writing this Finding, I do not purport to detail all the evidence before me. I have referred to relevant parts of it and only in such detail as appears warranted by

[13] The VPM is issued under the authority of the Chief Commissioner of Police pursuant to section 60 of the Victoria Police Act 2013.

its forensic significance and the interests of narrative clarity. The absence of reference to any aspect of the evidence should not lead to the inference that it has not been considered.

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

Events on 9 January 2019

21. On 9 January 2019, at approximately 7:00pm, Victoria Police responded to an incident involving Mr Perry that was developing within the St. Kilda response area. Mr Perry was standing on a first level portico roof between two balconies at the apartment building, in which he resided. Mr Perry was agitated and belligerent, he was refusing to come down from the roof. He was fidgety, had trouble remaining still and was pacing from one end of the portico to the other. Attending police made a number of attempts to engage with Mr Perry, but without success. Mr Perry made a number of comments about feeling paranoid, that he had consumed synthetic cannabis, that synthetic cannabis always affects him poorly and he was depressed. He was yelling at passing pedestrians, saying that he needed help, that the police were there to kill him and he was expecting to die that night. He stated that he believed police were watching him from the surrounding buildings. Police were concerned that Mr Perry appeared to be in significant distress and was having a mental health crisis.[14]

22. Attending police called the Critical Incident Response Team (**CIRT**) to assist the St. Kilda units. Upon arrival, CIRT Leading Senior Constable Lee Wolahan (**LSC Wolahan**) attempted to negotiate with Mr Perry. After some time and with great difficulty due to Mr Perry's agitated mental state, LSC Wolahan was successful at engaging with Mr Perry, who climbed down from the roof and eventually cooperated with the police. Mr Perry was arrested under section 351 of the MH Act and taken to the Alfred for assessment.[15]

23. He was discharged from hospital at 10.30am on 10 January 2016. [16]

Events on 11 January 2019

24. At some time in the early hours of 11 January 2019, Mr Perry broke into the apartment of Ms TM[17] at the apartment building. At approximately 3.00am, Ms TM and her partner, Mr AG[18]

[14] Statement of Sergeant Timothy Lambourne, Coronial Brief, p 34.
[15] Statement of LSC Lee Wolahan, Coronial Brief, pp 36-39.
[16] Statement of Dr Sean Arendse, Coronial Brief, pp 43-44.
[17] A pseudonym.
[18] A pseudonym.

returned to Ms TM's apartment after having been at work in the city. Upon entering the apartment Mr Perry appeared from the bedroom, wearing clothes owned by Ms TM. Mr Perry confronted them, shouting and holding a knife to them. He was behaving aggressively and erratically, repeating "*how do you know my dead daughter*?" and "*why are you in this apartment?*"

25. Suddenly, Mr Perry lunged towards Ms TM and tried to slash her face. Mr AG rushed to assist Ms TM and she managed to escape from the apartment and ran to the Fitzroy Street and Princes Street intersection in St. Kilda where she raised the alarm and urgently requested police.

26. Mr AG attempted to block Mr Perry and to take the knife from him. Mr Perry and Mr AG engaged in a wrestle. Mr Perry stabbed Mr AG approximately twelve times; to his left bicep, his right shoulder, the left side of his lower cheek and upper neck, the right side of his jaw, the left side of his abdomen, twice to the back of his head, twice to the back of his neck, and three times to the back of his torso. Mr AG attempted to overpower Mr Perry and pinned him to the ground. He grabbed Mr Perry's right wrist with both hands to try to control the knife. With his left hand, Mr Perry attempted to gouged Mr AG's eyes. Mr AG managed to pry the knife from Mr Perry but Mr Perry continued to gouge Mr AG's eyes. Using the knife he had pried from Mr Perry, Mr AG stabbed him three or four times to the abdomen. Mr AG stood up and then dropped the knife, pushed Mr Perry over the coffee table and fled the apartment.

27. Mr AG ran to the street and waved down a car. The occupants of the car called emergency services and police and ambulance attended to Mr AG.

28. Just after the incident, Mr Perry telephoned '000' using Ms TM's telephone. He said, "*I'm just reporting I just finished my mission."*

29. Mr Perry left the apartment building in Ms TM's Holden Astra car, using the keys Ms TM had left in the apartment.[19]

30. Police attended at the apartment building, believing that a siege may be developing with an armed man inside. At first, the police did not know the identity of the suspect.

31. At 4.41am, a man telephoned St. Kilda Police station from a public payphone in Brighton Road, Elwood. Senior Constable Sloan (**SC Sloan**) spoke with the man, who asked to speak to Senior Sergeant Paul Rudd (**S Sgt Rudd**). SC Sloan told the man that S Sgt Rudd was not available

[19] Police did not realise that Mr Perry had taken Ms Moroney's car until much later that day after it was found on the side of the road at Great Ocean Road, Bellbrae.

and the caller ended the call. Shortly after the telephone call to the station, police suspected, on the basis of the serious incident on the portico roof at the same address on 9 January 2019, that Mr Perry was the perpetrator of the stabbing of Mr AG.

32. Following this, Victoria Police commenced an investigation and made various attempts to locate Mr Perry during 11 January 2019.

Mr Perry's Arrest at Bellbrae

33. Just before 6.50pm on 11 January 2019, two cyclists were riding along the Great Ocean Road at Bellbrae. In that location, the Great Ocean Road has a single lane each way, for east and westbound traffic separated by a solid white line. Adjacent to each travelling lane is a narrow asphalt emergency stopping lane, bordered on the outer edges by a steel guard rail beyond which there is scrubby bushland.

34. Not far from the Hurst Road intersection they came across a blue Holden Astra, parked in the service lane of the road, close to the crash barrier, with the front passenger door open and clothing and other items scattered on the ground. The key was in the ignition and there appeared to be blood on the gear stick.

35. One of the cyclists called '000' and then both of them walked into nearby bushes to see if they could locate the driver. Approximately 15 metres into the bushes they saw a man standing in a paddock, nude and looking disoriented and confused. The man had cuts and scratches on his body and a large wound on his back. The two cyclists walked back with the man to the Holden Astra and found some clothes for him to put on. The man was acting erratically, climbing onto the roof of the Holden Astra and darting on and off the road.[20] An off-duty SES member also stopped at the scene and turned on his vehicle's emergency lights to slow down the traffic and warn drivers of a hazard. He also called '000' and asked for police to attend.[21]

36. At 6.50pm, Sergeant Brian McKiterick (**Sgt McKiterick**) and Leading Senior Constable Roderick Kearney (**LSC Kearney**) from the Torquay Police Station received the first Intergraph call for a welfare check on an abandoned Holden Astra vehicle, with blood on the steering wheel. LSC Kearney did a registration check and established that the car was registered to Ms TM and that she had been the victim of in a stabbing incident earlier that morning at St. Kilda. LSC Kearney also checked his emails in relation to the alleged offender at stabbing

[20] Statements of HS and TE, Coronial Brief, pp 89-116.
[21] Statement of MH, Coronial Brief, pp 117-119.

incident and printed off a copy of the circular[22] relating to Mr Perry and took it with him. Although there had been no report of the Holden Astra having been stolen, LSC Kearney suspected that Mr Perry was the driver of the Holden Astra on Great Ocean Road.

37. Several minutes after the first call, Sgt McKiterick and LSC Kearney received a second call, which alerted them that a drug affected man was running in and around traffic at Great Ocean Road, Bellbrae.

38. The police officers left the station at 7.05pm. On the way to the location, they discussed options for the arrest. They had no immediate back up in the vicinity and their statements refer to their belief that they needed to act quickly given the irrational behaviour of the man on a busy road and the need to ensure the safety of the community.

39. Sgt McKiterick and LSC Kearney arrived at the scene at approximately 7.15pm and as they did, they observed a man standing on the roof of a car. There was significant traffic congestion and cars had come to a 'stand still'. The man then sprang off the roof of the car onto the highway and began to walk across the road from one side to the other. The stopped the police vehicle approximately 10 to 15 metres from him,alighted from the vehicle and approached him.

40. They could see that the man looked like the suspect in the photo in the global circular, being Mr Perry. Sgt McKiterick told Mr Perry he needed to come with them and he took hold of his right arm and LSC Kearney took his other side. Mr Perry tried to violently break away so the officers forced him to the ground by pushing forward on his shoulders as they each held one of his arms. Mr Perry continued to thrash around and struggle as Sgt McKiterick tried to hold him down while LSC Kearney tried to apply handcuffs.

41. The struggle continued, with Mr Perry eventually brought to the ground again, this time hard up against the guard rail abutting the emergency lane. Mr Perry continued to resist arrest and continued to struggle violently. He was extremely strong and the police officers could not get his arms to his back to enable them to handcuff him. He started to get off the ground and

[22] A circular is a category of internal information the distribution of which is governed by the VPM "Internal information distribution". Within the definitions of the VPM the circular referred to in the case of Mr Perry is a "KALOF" (Keep a look out for) disseminated by email to relevant group within Victoria Police.

continued to struggle. Sgt McKiterick deployed his OC spray[23] to Mr Perry's face but Mr Perry continued to resist.

42. The two cyclists who had originally found the car ran over to the police to assist them. Sgt McKiterick deployed his OC spray again but unfortunately the spray hit LSC Kearney in the left eye. The two cyclists assisted the police to try to calm Mr Perry and assisted with holding him down so the police could get him in a position to put on the handcuffs. After further struggle, the police, with the assistance of the cyclists, handcuffed Mr Perry by using two sets of cuffs linked together and with Sgt McKiterick using his knee to hold him down. At around this time, Sgt McKiterick activated his Body Worn Camera which partially captured subsequent events.[24]

43. Shortly after the handcuffs were placed on Mr Perry, the ambulance arrived. Sgt McKiterick remained with Mr Perry, continuing to hold him down with his knee in his back, while Mr Perry lay on the ground, continuing to struggle.

Assessment by paramedics

44. At approximately 7.20pm, an ambulance crew from the Mount Duneed Advanced Life Support unit arrived at the scene. Because of the uncontrolled nature of the scene, they parked some distance away to use their ambulance to help protect themselves and others from oncoming traffic. Ambulance officers carried out their initial assessment and determined that Mr Perry was drug affected and was posing a risk to emergency service workers, bystanders and himself by continuing to struggle against the police on the edge of the road. The ambulance officers decided to sedate Mr Perry and as they commenced preparations to draw up ketamine.[25]

45. At around the same time, LSC Kearney went over to the ambulance in some distress as a result of the OC spray in his eye. Ambulance officers gave him a towel and some saline to treat his eye. As the ambulance officers prepared a stretcher with psychiatric restraints, they noticed that Mr Perry had stopped screaming and was fighting less against the police restraint. They checked his vital signs and found that he was in cardiac arrest. They commenced cardio-pulmonary resuscitation (CPR), which continued until 8.20pm.

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

[23] Oleoresin capsicum (**OC**) or "**pepper spray**."
[24] Exhibits 2 and 4 comprise the body worn camera footage of Leading Senior Constable Kearney and Sgt McKiterick, respectively.
[25] Ketamine is an anaesthetic drug.

46. On 14 January 2019 Mr David Perry, born 26 October 1983 was identified by fingerprint comparison.

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

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

48. On 12 January 2019, Dr Joanna Glengarry, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, reviewed the Police Report of Death to the Coroner, Mr Perry's records from the Alfred and Ambulance Victoria, post-mortem CT (**PMCT**) scans of the whole body and conducted an autopsy. Dr Glengarry provided a written report, dated 19 December 2019.

49. External examination revealed multiple blunt force injuries to the head and face, abrasions to the neck, front and back of the body and limbs that had adherent sticky black material (tar or other road surfacing material) and asphalt. There was bruising to the neck, with small numbers of petechial haemorrhages of the left eye, as well as around both wrists, the torso bilaterally and to the back, particularly on the midline and lower back that extended into subcutaneous tissue; there were incised wounds to the upper left and lower back, and right hand. External examination also showed areas of probable capsicum spray deposition to the left side of the face under ultraviolet light, and evidence of medical intervention including bilateral intercostal drain insertion associated with the bilateral pneumothoraces and fluid collections seen on PMCT scans.

50. Internal examination revealed a sternal fracture, subcutaneous haemorrhage adjacent to the left posterior tenth rib (but no rib fracture) and significant cardiac disease, in excess of that normally expected in individuals of Mr Perry's age. There was a critical narrowing of one of the coronary arteries by atherosclerosis, which decreases blood flow, starving heart muscle of oxygen and nutrients known clinically as ischaemic heart disease.

51. Post-mortem toxicological analysis of blood detected ibuprofen, but no alcohol nor synthetic cannabinoids or synthetic cathinones. Benzodiazepines (diazepam, temazepam and oxazepam), paracetamol and cannabis were each detected in urine but not blood.

52. The absence of synthetic cannabinoids in blood and urine does not necessarily negate their use proximate to death as they may be metabolised rapidly. It is also possible that despite a large database of synthetic cannabinoid compounds tested for, a novel (new) compound was present in the drug that Mr Perry allegedly smoked.

53. Cocaine, methylamphetamine, benzodiazepines, ketamine and several synthetic cannabinoids were detected in hair suggesting use of these substances in the three months prior to death.

54. Dr Glengarry commented that it was likely that Mr Perry's death was multifactorial, resulting from multiple overlapping and interacting factors.

55. Dr Glengarry observed that Mr Perry's behaviours before his death give rise to the possibility of *excited delirium syndrome* as a cause or contributor to his death. Excited delirium syndrome is a purely clinical presentation, recognised by those working in emergency medicine, though it is not acknowledged in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as a diagnosis. Excited delirium syndrome is primarily a consolidation of clinical features characterised by acute psychosis and aggressive agitated behaviour. It is usually a rare complication of drug use.

56. In Dr Glengarry's view, Mr Perry's case exhibited some features suggestive (but not diagnostic) of excited delirium syndrome, most notably his behaviours; autopsy findings are non-specific so diagnosis cannot safely be made post-mortem. Moreover, other clinical syndromes such as drug intoxication, infection, metabolic or endocrine disorders, head injury or hyperthermia may explain the same constellation of signs and symptoms.

57. Dr Glengarry observed that many of the behaviours associated with excited delirium syndrome and observed in Mr Perry's presentation – such as exhibiting bizarre behaviour (including removal of clothes), agitation, aggression, and exhibiting significant to extraordinary strength – often lead to police involvement, and the use of various forms of restraint. The mortality rate of such encounters is significant, with 10% resulting in death after the person is noted to become quiet and suffering cardiac arrest.

58. Dr Glengarry considered the possible contribution of chemical (OC spray), mechanical (handcuffs) and physical (prone) restraint, and the possibility of the use of a neck hold, to Mr Perry's death.

59. She considered that contribution of chemical restraint to Mr Perry's death was negligible in the absence of any observation of behaviour consistent with airway spasm or wheeze.

60. The pattern of injuries – abrasions over the body and limbs, adherent tar and back bruising – was consistent with forcible contact between Mr Perry's body and a road surface. Dr Glengarry observed that prone restraint is associated with impaired breathing by inhibiting the chest wall and abdominal movement: the greater the pressure on the back, the greater the risk of impaired

respiratory function. Although precisely how Mr Perry had been physically restrained while prone was not clear from the information available at the time of autopsy, Dr Glengarry could not exclude the requirement for vigorous restraint, including prone positioning as a contributor to Mr Perry's death.

61. The autopsy findings were not definitive regarding whether a neck hold was used as part of the restraint. Although abrasions and bruising to the neck and petechial haemorrhages to an eye may be seen in cases where the neck is compressed, they do not indicate that it definitively occurred. It is equally possible that these injuries were sustained in bizarre behaviour just prior to Mr Perry's death.

62. Dr Glengarry commented ischaemic heart disease may cause cardiac arrhythmias and sudden death and it is well recognised that periods of heightened emotional physical exertion may trigger cardiac arrhythmias in those with underlying heart disease. She observed that early-onset atherosclerosis may be associated with the use of illicit drugs like methylamphetamine and cocaine and that the precise effects on the cardiac system of synthetic cannabinoids were unclear though the literature does suggest an increasingly compelling association between their use and chest pain, cardiac arrhythmias, myocardial infarction and electrolyte abnormalities that may predispose to cardiac arrhythmias. Moreover, synthetic cannabinoids have been linked to agitated and erratic behaviour and it was considered possible that some deaths attributed to synthetic cannabinoids are associated with the excited delirium syndrome.

63. Dr Glengarry concluded that the cause of Mr Perry's death was "*Unascertained"* despite a full autopsy and ancillary testing.

Supplementary medical examiner's report

64. On 4 February 2020, Dr Glengarry received correspondence from Coroner Olle advising of the existence of police body worn camera footage depicting the immediate events preceding Mr Perry's death.

65. Dr Glengarry was provided with a USB stick containing the footage and she reviewed both the video files contained on it, comprising exhibits 2, 4, 7 and 42 as well as the transcripts of the body worn camera footage contained within the inquest brief.

66. Dr Glengarry reviewed the footage and transcript and provided a supplementary report dated 5 February 2020, commenting that these observations in the footage and transcript are strongly suggestive of the excited delirium syndrome. As set out in her report dated 19 December 2019,

those with excited delirium syndrome may exhibit significant to extraordinary strength, may be hot to touch and they may seek water. It is also noted that the person may become quiet with a subsequent cardiac arrest. The video footage is therefore strongly supportive of the excited delirium syndrome being present and being a significant factor in the death.

67. Dr Glengarry also commented that the man was restrained in the mid and lower back and, briefly, the left shoulder. No 'neck hold' is shown in the video footage. Whilst being restrained, Mr Perry was yelling for some minutes, indirectly implying that he does not appear to be unduly adversely affected by the method of restraint at that point. The autopsy examination demonstrated bruising of the mid and lower back in keeping with the method of restraint depicted in the video footage. Therefore, whilst restraint including prone positioning cannot be entirely excluded as a contributor to death, in Dr Glengarry's opinion it has not played a significant role.

68. Dr Glengarry noted that the transcript referred to a "*massive chest trauma*".[26] Dr Glengarry further commented that the autopsy examination demonstrated bruising and abrasions of the chest, a fracture of the sternum and no evidence of rib fractures. There were bilateral pneumothoraces present on the CT scan. However, intercostal catheters had been inserted and are a recognised cause of pneumothoraces. There was no internal trauma to the organs of the chest. Therefore, in Dr Glengarry's opinion, the injuries to the chest were not reasonably described as "*massive*". There is no evidence of injury to the chest that is a cause of or contributed to death. It may be that some of the findings within the chest, such as the sternal fracture and the pneumothoraces, can be attributed to resuscitation attempts.

69. Toxicological analysis of hair samples showed the presence of numerous drugs including synthetic cannabinoids. Also detected were diazepam, methylamphetamine, cocaine and ketamine. According to the VIFM toxicology report the approximate time frame of drug use in order to have appeared in the hair sample was between 11 November 2019 and 11 January 2019. Given the prolonged time `between Mr Perry's initial erratic behaviour on 9 January 2019 and his death on 11 January 2019, it is certainly possible that one or a combination of these drugs were a cause of his behaviour leading up to his death.

70. As noted in her report dated 19 December 2019, the post-mortem examination also revealed significant natural disease as contributory to his death. Accordingly, Dr Glengarry concluded that the cause of death, as "*unascertained*" was unchanged.

[26] Transcript from Sgt McKiterick's body worn camera, Coronial Brief, p 314.

71. I accept Dr Glengarry's opinion as to cause of death.

SCOPE OF THE CORONIAL INVESTIGATION

72. The following issues were examined during the coronial investigation:

    a. Mr Perry's arrest on 9 January 2018 and subsequent medical management at the Alfred on 9 -10 January 2018;

    b. Victoria Police's efforts to locate Mr Perry after the burglary and stabbing at St Kilda on 10 January 2018;

    c. The arrest of Mr Perry at Bellbrae; and

    d. Treatment by Ambulance Victoria at Bellbrae.

Adequacy of Mr Perry's management at the Alfred

73. Mr Perry's admission and discharge from the Alfred was proximate to his arrest and death at Bellbrae on 11 January 2018. Accordingly, Coroner Olle sought advice from the Mental Health Investigators of the Coroners Prevention Unit (**CPU**)[27] who reviewed the available materials and provided advice about the adequacy of the Mr Perry's clinical management at the Alfred, including the decision to discharge him on 10 January 2019.

74. Upon arrival at the Alfred Emergency Department (**Alfred ED**), Mr Perry had grazes and lacerations on his arms and forehead, one requiring sutures, but otherwise he was not injured. His pupils were dilated, and he appeared to hallucinate. His mood was elevated, he was acting erratically and was physically agitated but could easily be redirected to calm down. At times during the assessment, he appeared anxious and scared, but at other times he would laugh. He admitted to the treating team that he had used synthetic marijuana that day. Medical staff assessed Mr Perry's presentation as likely to be the result of substance intoxication. Because of his apparent substance intoxication, he was not able to be assessed by the Emergency Psychiatric Service (**EPS**). Clinical staff at the Alfred ED considered the possibility of an underlying mental illness, resulting in a plan for Mr Perry to be re-reviewed and referred to EPS

[27] The Coroners Prevention Unit (**CPU**) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

once he was sober and alert, if he demonstrated behaviour consistent with ongoing mental health issues or engaged in behaviours of concern.[28]

75. Upon arrival, Mr Perry was considered at risk of harm to himself and others and was therefore mechanically restrained. By 1.00am, Mr Perry reported that he was no longer hallucinating. By 4.52am, Mr Perry was noted to be pleasant, cooperative and aware that he had been paranoid, but still "*slightly*" substance affected.[29] At 5.30am, Mr Perry was noted to be "*still a bit elevated with pressured speech*" but more settled and easily directed.

76. At a medical review the following morning, Mr Perry was sober, no longer agitated, erratic or responding to hallucinations. He said that he had used synthetic cannabis, was remorseful for his actions and seemed to have insight into his paranoid behaviour and suicidal thoughts the previous night. He denied current suicidal ideation. Alfred ED staff conducted a search of mental health database CMI[30] and found no previous public mental health contacts recorded in Victoria, further supporting the assessment that Mr Perry's presentation was due to substance intoxication rather than an enduring mental illness.

77. Mr Perry was discharged without referral to EPS consistent with the plan made the previous evening. The symptoms displayed the previous evening were assessed as being a result of substance intoxication. Mr Perry was discharged at 10.22am on 10 January 2019.

78. The determination by the Alfred ED that Mr Perry's presentation was secondary to synthetic cannabis intoxication were consistent with known symptoms of synthetic cannabis intoxication and based on Mr Perry's admission to having used synthetic cannabis and the clinical assessment and observations by medical staff. Symptoms of synthetic cannabis use include fast and irregular heartbeat, racing thoughts, agitation, anxiety, paranoia, psychosis, aggressive and violent behaviour, chest pain, vomiting, acute kidney injury, seizures, stroke and death.[31]

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[28] Statement of Jacqueline Deschamps, Coronial Brief, pp 45 – 46.

[29] Alfred Health digital medical record, page 24 of 47.

[30] Client Management Interface (**CMI**) and Operational Data store (**ODS**) is the Victorian public mental health client information management system and comprises of the CMI as the local client information system used by each public mental health service and the ODS manages select data items from each CMI and is used to allocate a unique (mental health) registration number for each client, known as the statewide unit record (**UR**) number. CMI shares select client-level data between Victorian public area mental health services (**AMHS**) to support continuity of treatment and care. The ODS meets the various reporting requirements of the Department and supports the statutory functions of the Chief Psychiatrist and the Mental Health Tribunal.

[31] Alcohol and Drug Foundation, Synthetic cannabis, <https://adf.org.au/drug-facts/synthetic-cannabis>, accessed 19 November 2020.

79. The CPU advised that the decision to discharge Mr Perry was appropriate and consistent with the MH Act. Mr Perry did not have a known pre-existing mental illness and his symptoms subsided within a few hours. This is consistent with drug induced psychosis as a result of substance intoxication, as opposed to a psychotic illness requiring ongoing psychiatric treatment such as schizophrenia in which symptoms persist for more than a few hours and in the absence of substances. At the time of his discharge, Mr Perry denied suicidal ideation, no longer expressed paranoia and no longer exhibited concerning behaviours such as aggression, agitation or unpredictability. Further, there was no evidence that he remained a risk of harm to himself or others nor that he required ongoing hospital treatment for a mental illness.

80. Having reviewed the evidence, I accept the advice of the CPU.

Police efforts to locate Mr Perry

81. The police undertook the following activities to attempt to locate Mr Perry on 11 January 2019 following the alleged stabbing at the apartment block:

    a. Positioning crime scene guards at the apartment block.

    b. At 5.21am, telephoning Mr Perry's mobile phone number.

    c. At 7.40am, searching Mr Perry's apartment at the apartment block.

    d. At 8.30am, reviewing CCTV footage of the apartment entry and car park, discovering that Ms TM left the front entrance of the building at 3.57am and Mr AG followed a short time later. The only other person who exited the building was 4.00am via the car park in a Holden Astra car. At this time, police did not realise it was Mr Perry driving the Holden Astra car because they had mistakenly believed that Ms TM did not own a car.[32] At 4.12 am, the car was then identified by a camera at the intersection of Dandenong Road and Kooyong Road, Armidale for the offence of disobeying a red traffic control signal. However, this data capture is not a live feed that is accessible to Victoria Police members. The vehicle was not captured by any other system (including City Link) until it was identified by Police at the Great Ocean Road in Bellbrae later that afternoon.[33]

    e. Door knocking all apartments at the apartment block.

[32] Statement of DSC Dylan Tate dated 16 November 2020 and statement of DSS Mark Colbert dated 5 February 2021.
[33] Statement of DS Mark Colbert dated 5 February 2021.

f. At 9.30am, submitting a "Person Whereabouts" on the Victoria Police Law Enforcement Assistance Program (**LEAP**)[34] for Mr Perry and a "Vehicle Whereabouts" for Mr Perry's last known vehicle, being a silver Holden Commodore Sedan.[35]

g. At 10.12am, S Sgt Rudd tried to call Daniel's mobile in response to the call to him earlier that morning. S Sgt Rudd left a message to the effect that he was available to help Mr Perry and left a message for Mr Perry to call him back. Later that morning, S Sgt Rudd left an SMS message for Mr Perry to call him. Mr Perry did not call back.

h. At 11.00am, ascertaining that Mr Perry's last girlfriend and biological daughter had departed Australia and were in New Zealand. As a consequence, Police issued a State and Territory Police Border Alert Request in order to prevent Mr Perry from leaving Australia.

i. At 2.45pm, executing a search warrant pursuant to section 465 of the Crimes Act 1958 at Mr Perry's residence. One zip lock bag labelled Happy Company "*beneficial herbal blend*" containing a variant of synthetic cannabis was seized.

j. Making a prospective information application for Mr Perry's mobile phone service pursuant to the Telecommunications (Intercept and Access) Act 1979. It ascertained that Mr Perry's mobile phone was not in use and did not disclose the location of his mobile telephone number.

k. At 3.30pm, attending at the Magistrate's Court to seek a charge sheet and warrant for Mr Perry's arrest for the offence of Attempted Murder pursuant to section 321M of the *Crimes Act* 1958 (Vic).

l. At 4.42pm, disseminating a global Circular to all sworn Victoria Police personnel by email. The circular contained photographs of Mr Perry and the Commodore model he was thought to be driving, along with details of the incident giving rise to the charge of attempted murder. The circular warned that Mr Perry may be armed and identified a power to arrest

[34] The Law Enforcement Assistance Program (**LEAP**) is a dynamic, online database used to record information about criminal incidents reported to police for use operational policing purposes.

[35] The Victoria Police Manual policy, 'Tagging of records to locate suspects or offenders,' guides police members' use of a range of alerts used to tag records, locate suspects or vehicles using LEAP and other law enforcement communications platforms. Relevantly, the policy outlines when a person or vehicle whereabouts should be used. Broadly, a 'Whereabouts' will be placed on LEAP in respect of a person (or vehicle) if the person (or vehicle) is wanted by police in connection with an offence and, after enquiries have been made to locate the person (or vehicle) s/he (or it) cannot be found. The Whereabouts will be added to LEAP, with the approval of the members' supervisor, and contain instructions about what action should be taken in respect of the person (or vehicle) if any member has incidental contact in the field. For instance, a person whereabouts would be evident to a police member conducting a name search and could indicate the nature of the offence in relation to which s/he is wanted and whether s/he should be arrested, interviewed or otherwise.

him under s 459 of the Crimes Act 1958. Police members were directed to contact their Supervisor to develop an arrest plan if Mr Perry was sighted;[36]

m. Disseminating a media release to Australian media outlets with an appeal for information for Mr Perry's whereabouts.

Body worn camera footage

82. The footage from Sgt McKiterick's body worn camera contained within exhibit 4 shows limited views of the manner in which Mr Perry was restrained by police.

83. In the footage, it appears that Sgt McKiterick was restraining Mr Perry in a prone, face down position, kneeling in the region of Mr Perry's mid or lower back. No restraints to the neck were evident in the video. One of the bystanders (outside the vision of the footage for most of the time) could be seen assisting Sgt McKiterick by trying to calm and reassure Mr Perry, and another bystander was watching the arrest from nearby the police car.

84. The footage showed the following:

a. From the commencement of the audio on the tape until approximately 3m51s, Mr Perry's voice could be heard speaking and yelling, sometimes in an incoherent manner. During this time, one of the bystanders could be heard trying to calm and reassure Mr Perry as Sgt McKiterick is restraining Mr Perry and giving instructions to Constable Kearney to contact Torquay police.

b. At approximately 1m50s Mr Perry started shouting incoherently, "*white dragon*!" "*I'm not him*!", "*Aquaman*!", "*Poseidon*!", "*Manhunt*!", "*Windsor*!". Someone present noted "*he's as strong as an ox, on substances…wanted for a stabbing…drug affected*".

c. At 3m03s, a hand was placed on the back of Mr Perry's left shoulder.

d. At 3m48s Mr Perry appeared to ask for water. At 4m22s Sgt McKiterick asked "*Are you settling*?" and Mr Perry replied, "*yeah*".

e. At 4m35s Mr Perry was drinking the water that was offered and being told, "*good job mate*" by one of the bystanders.

f. There were no audible words from Mr Perry after 4m51s.

[36] In contrast to the LEAP Whereabouts, a Circular is regarded as a proactive policing tool.

g. At time 5m48s, someone present noted that Mr Perry was "*quite sedate*".

h. At 6m35s Sgt McKiterick could be heard attempting to get his radio to work and at 6m37s asked LSC Kearney for his radio. LSC Kearney could be seen in the footage walking nearby, appearing to be distressed from the capsicum spray injury to his eye.

i. At 7m00s Sgt McKiterick used LSC Kearney's radio to update Victoria Police command about the situation.

j. At 7m38s someone asked, "*can you hear me*?" and at 7m43s, "*open your eyes for me*". One of the ambulance officers leaned over Mr Perry.

k. At 8m44s one of the ambulance officers could be seen leaning over the area where Mr Perry was lying but Mr Perry was not visible from the footage. Both cyclists could be seen observing from close by and the third bystander from near the police car.

l. At 9m49s someone commented that Mr Perry is asleep and at 10m07s one of the ambulance officers appeared to realise that Mr Perry had possibly had a cardiac arrest. Both ambulance officers assessed Mr Perry and commenced resuscitation.

m. At 10m44s Sgt McKiterick said, "*He's just passed away, just died*." At around this time, more police officers arrived to assist as ambulance officers continued with resuscitation.

The use of force during Mr Perry's arrest at Bellbrae

85. The use of force by police officers must be in accordance with legislative provisions and general common law principles. Relevantly, section 462A of the Crimes Act 1958 authorises police to effect or the lawful arrest of a person committing or suspected of committing an offence.

86. The right to use force is limited to that reasonably necessary to carry out the arrest and the force used must be proportionate.[37]

87. These legal principles are incorporated into the VPM, which sets out the policies and procedures on operational safety and the use of force, including handcuffs, physical restraint, OC spray, baton and firearms. Further, the VPM specifically addresses 'restraint techniques and positional asphyxia'. It notes:

[37] *R v Turner* [1962] VR 30.

a. Restraint techniques that could impair a person's unrestricted breathing should only be used when absolutely necessary, and for the briefest possible time;

b. They should keep any person who is physically restrained under close observation; and

c. When using OC spray or handcuffs, they should prevent the possibility of positional asphyxia by ensuring subjects do not have their face covered and are not left lying face down with their hands restrained behind their back.

88. The safety procedures in the VPM are underpinned by 'Safe Tactics', which is an operational safety tool which incorporate a number of tactical considerations and prompts relevant to operational policing with a focus on harm minimisation and consequence management.

89. Following the death of Mr Perry, on 3 May 2019 a police debrief was conducted at Torquay Police Station, convened by Inspector Peter Bitton. The purpose of the debrief was to address, inter alia, whether 'Safe Tactics' principles were incorporated and followed, whether there was adequate Control, Command and Coordination and resources. The debrief identified the following issues relevant to this coronial investigation:

a. There had been no option to carry or use Taser as Torquay Police (at the relevant time) was not allocated with that equipment.

b. There was no information regarding the earlier incidents on LEAP, only on Interpose which was not accessible to the uniform members.

c. Sgt McKiterick's body worn camera was not activated until midway through incident. Body worn cameras had only been operational at Torquay for one week prior to this incident. Members unfamiliar with the new equipment were unclear when their body worn camera was recording.

d. The body worn camera did not produce clear footage due to location on Sgt McKiterick's vest and the vest riding up during the arrest and subsequent struggle.

e. In hindsight, the arresting police could have considered a request for backup prior to attending the incident, as they had already established that the deceased may have been a suspect for an earlier stabbing whereby warnings had been issued, although they stated that the identity of the deceased had not yet been confirmed. The lack of other units, due to

members reporting in sick, has left the area short of officers on the evening and may have contributed to the decision to not request assistance prior to attending the incident.

90. Mr Perry's death was also the subject of a Victoria Police Oversight Investigation undertaken by the Professional Standards Command. The Interim Report dated 9 March 2020 was provided to the Court as part of this investigation.

91. The Interim Report found that Victoria Police acted as necessary to protect their own safety and the safety of others and to lawfully execute an arrest. The Interim Report also identified the same issues as those identified in the debrief.[38]

92. In March 2021, I sought further documents from the Chief Commissioner in respect of the police operation to arrest Mr Perry. One of the categories of information sought was in relation to the information available on LEAP to the arresting officers to determine whether the unavailability of Interpose records identified in the debrief and the Interim Report compromised the ability of the arresting officers to make appropriate and safe decisions for Mr Perry's arrest. On 7 June 2021, the Victorian Government Solicitor's Office provided additional material and information relevant to this line of inquiry on behalf of the Chief Commissioner of Police.

93. Within Victoria Police, electronic recording and communication of information is primarily managed by two software-based programs, namely LEAP and Interpose. LEAP records the facts and circumstances of a complaint or incident reported to police and Interpose is utilised as an investigation management system and intelligence holding. Every sworn member of Victoria Police has access to LEAP. Not every sworn member has access to Interpose. LEAP is Victoria Police's case management system and primary database, and generally, LEAP information is deemed to be factual. The Interpose database is designed to record information and details of specific police investigations or operations. It is designed to be a case management tool which assists investigators and their direct line supervisors to access information and intelligence during an investigation.

94. Following the incidents with Mr Perry at St Kilda on 9 January and 11 January 2019, various documents were submitted and recorded onto LEAP on 11 January 2019. Those documents

[38] Other issues identified in the debrief and Interim Report are not relevant to Mr Perry's cause of death and the circumstances of death but related to the scene at Bellbrae after Mr Perry died.

were provided to this court as part of the investigation and include the various forms and documents recorded onto LEAP on 11 January 2019.

95. In addition to the records placed on LEAP, the Port Phillip Crime Investigation Unit created an Interpose investigation shell, codenamed Operation Hallows-2019. I note that the Interpose narrative of the incident on 11 January 2019 appears at page 358 of the Inquest Brief and is identical to the LEAP "Incident Report and Case Progress" and LEAP – "Text Editor" dated 11 January 2019 and provided to this Court.

96. From the material provided to the court, information was available to the police on LEAP that disclosed that Mr Perry had been involved in the stabbing in St Kilda on 11 January 2019. The Interpose material provided no additional information which would have been of relevance to the attending members in Bellbrae. Accordingly, all relevant information was appropriately recorded onto LEAP, without the need for uniform members to examine the Interpose records.

97. The debrief and Interim Report reveal the conditions under which the arrest was made and the pressures on members of the police who responded to the incident and managed the subsequent scene. I note further that the unavailability of the Taser at Torquay is not likely to have altered the outcome as a firearm was not discharged.

98. Sgt McKiterick's body worn camera footage, in conjunction with the evidence of witnesses, including non-police witnesses is adequate for me to make relevant findings. From reviewing this material, I am satisfied that the force used by police officers was reasonable and proportionate.

Paramedic response

99. The activities undertaken by the paramedics during Mr Perry's restraint is described in the statement by Mr Curwen Walker to the court and are partially seen in Sergeant Kearney's body worn camera. The activities included:

    a. Stopping traffic on a single carriageway to allow the safe removal of the ambulance trolley.

    b. Retrieving and attaching the restraint straps to the trolley.

    c. Retrieving the chemical restraint medication (ketamine) out of secure storage as it is a highly regulated schedule eight drug like opiates and benzodiazepines.

    d. Drawing up ketamine into syringe.

e. Assisting LSC Kearney who asked for assistance after being inadvertently pepper sprayed.

f. Assessing the patient.

100. At the request of Coroner Olle, Dr Mr Perry Anderson, an Intensive Care Specialist who is a retrieval medicine consultant with AV provided a statement setting out the findings of the major clinical case review conducted by AV after the incident. The review included an investigation of the management of the scene, clinical decision making and intravenous access/adrenaline administration following the cardiac arrest.

101. The AV review made a number of findings, summarised in Dr Anderson's statement. Broadly, those findings were that in the circumstances of the environment, including the position of the patient on the edge of a highway with uncontrolled traffic and Mr Perry's presentation, the ambulance officers acted reasonably and within clinically accepted guidelines.

102. At the request of Coroner Olle, the CPU reviewed materials relating to Mr Perry's management by paramedics following his arrest on the Great Ocean Road and provided advice about the adequacy of their initial assessment and monitoring.

103. CPU advised that the decision to sedate and chemically restrain Mr Perry was reasonable because Mr Perry appeared to be drug affected and agitated and was struggling against police on the shoulder of the road, posing a danger to himself and others.

104. Whilst ambulance officers left Mr Perry's side, they did this to facilitate a reasonable and appropriate plan. At that time, Mr Perry was safe in the care of the police and drinking water. When Mr Perry did apparently lose consciousness, it was not recognised immediately by Sgt McKiterick nor the bystanders present, who thought that Mr Perry had merely calmed down or relaxed. Paramedic Curwen Walker noted that while getting his equipment he noticed that Mr Perry had gone quiet and hence, went over on his own initiative to assess him. He stated that Mr Perry was still pink and diaphoretic but as he further assessed him, Mr Perry's lips became cyanosed. In the context of the situation, CPU considered the ambulance officers' responses to be reasonable, and that closer observation would not have altered the outcome and that time away from the patient was necessary to facilitate an appropriate management plan. Further, CPU advised that having one paramedic staying with the patient to more closely 'monitor' while the other retrieved the equipment would have delayed the implementation of the plan which would have increased the time of police restraint without medical intervention.

105. In addition, CPU noted that once the ambulance officers applied defibrillation pads, the initial rhythm analysis showed that Mr Perry was in asystole,[39] and not shock was advised. According to CPU, 'non-shockable' rhythms have lower survival rates compared to shockable rhythms[40] (ventricular tachyarrhythmias); 4% versus 36%.[41] Given that 96% of arrests due to non-shockable rhythms are not salvageable, CPU considered it was unlikely that earlier recognition would have significantly altered the outcome.

106. I accept the advice from CPU.

Excited delirium and restraint

107. In its advice, CPU commented that a recent systematic review of deaths in excited/agitated delirium,[42] noted that the single biggest predictor of death was the presence of restraint with 98% of deaths being associated with some form of restraint and only 2% of deaths having no restraint applied at all. What this implies is that it is rarely the drugs in of themselves that cause death – it is the combination of excited delirium and restraint.

108. Significant complexity underlies the simplicity of this association. Milder cases of excited delirium can be de-escalated with less aggressive means (verbal de-escalation, pepper spray, TASERs), more extreme cases cannot,[43] necessitating the need for physical and mechanical restraint to protect the public and or the person being restrained. That is to say, the more agitated the patient, the more likely restraint is the only option in controlling the situation.

109. While some types of restraint (being 'hog-tied/hobbling', being prone, pressure on neck) are associated with increased rates of death and are thus not recommended, safe and effective alternatives for frontline police officers are limited.

110. CPU noted there are differential opinions in the medical literature regarding excited delirium, particularly in relation to the precise cause and mechanism of its lethality.

111. Mr Perry was restrained in a prone position for up to ten minutes. From the footage, Mr Perry was resisting restraint for up to five minutes. He then stopped speaking and a minute later was

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[39] Also referred to as flatline, **asystole** is the state of total cessation of electrical activity from the **heart**, which means no tissue contraction from the **heart** muscle and therefore no blood flow to the rest of the body.

[40] Defibrillation is indicated and can revert the heart rhythm back to normal.

[41] Podrid Philip J. Prognosis and outcomes following sudden cardiac arrest in adults. In: UpToDate, Olsahnsky, B (Ed), UpToDate, Waltham, MA. (Accessed on September 24, 2020.)

[42] Strömmer, E.M.F., Leith, W., Zeegers, M.P. *et al.* The role of restraint in fatal excited delirium: a research synthesis and pooled analysis. *Forensic Sci Med Pathol* (2020). https://doi.org/10.1007/s12024-020-00291-8

[43] OC spray was ineffective in this case.

noted to be "*quite sedate*". It was a further one and a half minutes before ambulance officers were leaning over Mr Perry to assess his condition and commenced treatment. In this context, I have considered whether the length of time of the restraint was reasonable.

112. Despite the known risks of prone restraints, including positional asphyxia, having carefully reviewed the footage, I consider the length of time of the restraint was reasonable in the circumstances, because of:

    a. Mr Perry's significant resistance to the restraint, despite the reassurances of police and attempts to gain his co-operation, which resulted in a lengthy time in a restrained, prone position and prevented the paramedics from examining his condition;

    b. The injury to LSC Kearney's eye resulting in Sgt McKiterick having to manage the restraint and the scene without the support of another officer; and

    c. The general uncontrolled environment, limiting the paramedics ability to assess and treat their patient.

FINDINGS AND CONCLUSION

113. Having investigated the death, and held an inquest, I find pursuant to section 67(1) of the Coroners Act 2008 that Mr David Perry, born 26 October 1983, died on 11 January 2019 at Great Ocean Road, Bellbrae, from unascertained causes in the circumstances described above.

114. Having applied the applicable standard to the relevant evidence, I make the following findings:

    d. It was appropriate for the Alfred to discharge Mr Perry from the Short Stay Unit after he had been assessed as no longer being substance affected, not experiencing symptoms of a mental illness and no longer at acute risk of harm to himself or others. EPS had been consulted regarding the plan to discharge Mr Perry if there were no symptoms of mental illness or acute risks when no longer substance affected and they agreed to this plan. Given Mr Perry's presentation at the time of discharge, it is unlikely that an assessment by EPS would have resulted in him remaining in hospital. It would not have been appropriate to keep Mr Perry in hospital to prevent a return to drug use, despite the likelihood that his risks would increase when substance affected.

    e. The actions taken by the police to locate Mr Perry were comprehensive and relatively expeditious. Even if the police had identified earlier that Mr Perry had absconded in

the Holden Astra, it is not possible to say that they would have had the opportunity for an earlier sighting and an arrest that did not involve injury or death.

f. It was reasonable in the circumstances for the police officers to arrest Mr Perry in circumstances where they were aware that he was a suspect in the attempted murder.

g. After carefully reviewing the video footage and statements of witnesses, I am satisfied the force used by attending police to effect the arrest was necessary, reasonable and proportionate. Mr Perry's resistance to the arrest was forceful and persistent, so much so that members of the public assisted police to make the arrest. The evidence demonstrated that the attending officers made significant efforts to de-escalate a volatile situation and sought to calm Mr Perry and seek his cooperation. In these circumstances, I'm satisfied that the use of OC spray, mechanical and physical restraint was reasonable.

h. With the benefit of hindsight, the attending police could have requested back up on their way to the incident. However, while additional police may have assisted the attending officers to control the chaotic and dangerous situation on the busy road and have reduced the reliance on non-police bystanders to assist, I cannot find that calling back-up would have changed the outcome of their interaction with Mr Perry.

i. After carefully reviewing the documentation provided by the Chief Commissioner of Police, including, *inter alia* the Victorian Police Manual, I am satisfied that Mr Perry's arrest conformed to police procedures and protocols regarding operational safety and the use of force.

j. The efforts of the attending ambulance officers were reasonable in difficult and chaotic conditions. They responded to his medical deterioration appropriately and promptly.

k. The restraint, including prone positioning could be excluded as contributor to Mr Perry's death, but it did not play a significant role in his death. The existence of significant natural cardiac disease and use of illicit drugs indicated that the medical cause of death was likely to be multifactorial and the relative contributing factors could not be isolated. Hence, the cause of death was unascertained.

l. Having regard to the environmental conditions, the injury to LSC Kearney's eye and Mr Perry's state, the length of time that Mr Perry was restrained in a prone position was reasonable.

115. Pursuant to section 73(1) of the *Coroners Act 2008,* I direct this finding be published on the Internet.

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

Mr Philip Perry, Senior Next of Kin

Ms Lea Perry, Senior Next of Kin

Commissioner of Police, C/- Victorian Government Solicitors Office

Ambulance Victoria

Signature:

KATHERINE LORENZ
CORONER
Date: 25 August 2021