IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 1057

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

Inquest into the Death of: DAVID SCROFANO

Delivered On:	5 May 2016
Delivered At:	Coroners Court of Victoria at Melbourne 65 Kavanagh Street Southbank, Victoria 3004
Hearing Dates:	15, 16, 17 and 18 June 2015
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Ms Diana COSTARAS, instructed by Corrs Chambers Westgarth for the family Mr Andrew IMRIE, instructed by Ms Leveasque Peterson of Landers & Rogers for the Chief Commissioner of Police Mr Daniel WALLIS instructed by Meridian Lawyers for Ambulance Victoria Mr Peter ROZEN, instructed by Mr Fatmir Badali of Gadens Lawyers for the Emergency Services Telecommunications Authority
Counsel Assisting the Coroner	Ms Naomi HODGSON, instructed by Ms Jessica WILBY, Principal In-House Solicitor

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of DAVID SCROFANO
and having held an inquest in relation to this death on 15, 16, 17 and 18 June 2015
at the Coroners Court of Victoria at Melbourne
find that the identity of the deceased was DAVID SCROFANO
born on 10 February 1972
and that the death occurred on 12 March 2013
at 991 High Street, Reservoir, Victoria 3073
from:

1 (a) PHENIRAMINE TOXICITY

in the following circumstances:

Background and Personal Circumstances

1. Mr David Scrofano (referred to in this finding as David) was the 41 year old only son and middle child of Rosemary Zappulla and Carrado Scrofano. David was born in Melbourne and had an older sister, Gabrielle, and a younger sister, Elizabeth. When David was eight years old the family moved to Mount Gambier in South Australia. He was a happy and healthy child who required very strong prescription glasses due to his short sightedness, his mother describing him as being close to legally blind.

2. In May 1987 the family were involved in car accident in Mount Gambier, when a drunk driver crossed onto the wrong side of the ride and collided with the family's car, killing David's father. David was 15 years old at the time and sustained an acquired brain injury as a result of the car accident. He spent three days in a coma. After the accident David began having hallucinations and exhibiting paranoid behaviour. According to David's mother he began smoking cannabis and drinking alcohol in the years after the accident.

3. In about 1989 David, his mother and his younger sister moved back to Melbourne.

4. In 1990 David was diagnosed with Schizophrenia and poly-substance abuse and was prescribed varying anti-psychotic medications. After his diagnosis David spent periods of time in the psychiatric section of Maroondah Hospital and lived at various addresses throughout the years, including numerous care facilities where he received psychological, medical and psycho-social treatment.

5. At the time of his death David had been residing at Reservoir Lodge, a supported residential care facility since November 2012. David was known for his sense of humour, liking to

dance and joke with those around him when he was in a good mood. He was reasonably independent and was able to use public transport by himself, however only tended to go out with his mother or his Aunt when they visited him at the Lodge. David often slept in, leaving his room in the afternoon or evening for meals and was known to get up in the middle of the night and ask other residents for food and/or cigarettes

6. David's prescribed medication was given to him in single doses by Reservoir Lodge staff and self-administered, including Lexapro (escitalopram) at breakfast, Zyprexa Zydis wafer (olanzapine) at dinner and Paxam (clonazepam) and Olanzapine at bedtime.

Purposes of the Coronial Investigation

7. The purpose of a coronial investigation into a reportable death[1] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[2] In the context of a coronial investigation it is the medical cause of death together with the context of background and the surrounding circumstances of death, which are proximate and causally relevant to the death. An investigation is conducted pursuant to the *Coroners Act 2008* (the Act).

8. Coroners are empowered to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice and to make recommendations to any Minister, public statutory body or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[3] This is generally referred to as the prevention role.

9. A coroner's findings made on the factual matters are to the requisite standard of proof, the balance of probabilities.[4]

10. The circumstances of David's death have been the subject of investigation by Victoria Police on behalf of the Coroner.

11. The Coroner's Investigator, Detective Sergeant Mark Hatt, prepared a comprehensive coronial brief of evidence comprising a range of evidentiary material including witness statements and visual material.

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[1] Section 4 of the *Coroners Act 2008* requires certain deaths to be reported to the coroner including all deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury.
[2] Section 67(1) of the *Coroners Act 2008*
[3] Sections 72(1), 72(2) and 67(3) of the Act
[4] As per the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336

12. After considering the material contained within the coronial brief I determined to obtain additional material and conduct an inquest to assist me further in the investigation of David's death.

13. The inquest focussed primarily on the following issues:

a) Any known substance abuse by David including his use of personal 'concoctions;'

b) David's use and abuse of medication such as pheniramine;

c) Ambulance Victoria's response on the night of David's death;

d) ESTA call times and Sergeant Zeeher's direct multiple contacts with ESTA and his understanding that a call had been Code 1 when it had not; and

e) Whether David's death was preventable if ambulance officers had arrived earlier and the effects of pheniramine toxicity were reversed.

14. The following witnesses gave evidence at the inquest:

- Dr Jacqueline Lee, Forensic Pathologist,VIFM
- Dr Linda Iles, Forensic Pathologist / Neuropathologist, VIFM
- Professor Olaf Drummer, Toxicologist, VIFM
- Dr Morris O'Dell, Forensic Physician, VIFM
- Mrs Rosemary Zappulla, David's mother
- Ms Sarah Kuila, Care Co-ordinator Reservoir Lodge
- Constable Lauren Dri
- Senior Constable Penny Lekakis
- Sergeant Craig Zeeher
- First Constable Jethro Carbines
- Constable Vincent Kirkpatrick
- Mr Brian Hicks, MICA Paramedic
- Mr Paul Felicetti, MICA Paramedic
- Mr Anthony Balm, Manager, Quality Review, Ambulance Victoria
- Mr Mark Richards, Quality Improvement Manager, ESTA

15. This finding is based on the entirety of the investigation material including the file, coronial brief of evidence, the statements and evidence of those witnesses who appeared at the inquest.

The circumstances of David's death

16. At 7:30am on 11 March 2013 David was woken by Ms Sarah Kuila, a care coordinator at Reservoir Lodge. He had his breakfast and his morning medication and stayed at the Lodge until lunchtime.

17. David had lunch and was given his medication at about 2pm. According to Ms Kuila he was happy and in a good mood, joking with the other residents.

18. At 6:30pm Sarah Kuila noticed that David did not attend for dinner, which was somewhat unusual. Another staff member checked David's room, but he wasn't there. Another room check was conducted at 7:30pm before a search of the entire facility was conducted. Further checks were made at 8:30pm and 9:30pm.

19. At 10:00pm Sarah Kuila attempted to contact David's mother, but was unable to get through and left a message.

20. Meanwhile, at about 10:00pm David arrived at 991 High Street in Reservoir, a small block of three residential units. He removed a fly wire screen from the window of Unit 1 and attempted to open it prior to making attempts to open the front door. The occupants of Unit 1 called '000' at 10:13pm and requested police assistance, fearful that David was trying to break into the premises. During the '000' call David walked to the front door and started banging on it.

21. A short time later David walked to Unit 3 and started banging on the front window and door. The occupants of this unit were home and observed David pacing unsteadily up and down outside of their unit, mumbling to himself. They also called '000' and requested police assistance.

22. At 10:22pm D24 police communications contacted the Preston 303 divisional van and they responded, arriving at the units a short time later. Preston 303 members spoke to the residents of Unit 1 and then found David sitting on the front veranda of Unit 3 and talking to himself. He told police he was thirsty, and they arranged a drink of water for him.

23. The Preston 303 members were Senior Constable Lekakis and Constable Dri. They were able to get David's Health Care Card from him and by conducting LEAP checks established that David resided nearby at Reservoir Lodge.

24. An additional three police members arrived (Transit 253[5] and Reservoir 311[6]) to assist the Preston members dealing with David. As one of the members approached David to assist him to stand up and walk, he reacted angrily and began flailing his arms. While this was occurring David fell backwards onto a wooden shoe box on the veranda of Unit 3 that he had been sitting on before standing up again.

25. Police intended to assist David up the driveway and drive him back to Reservoir Lodge. However, he was unsteady on his feet and still flailing his arms. As David moved away from Unit 3 he fell forward, hitting his head on the concrete path.

26. Police immediately went to David's assistance, rolling him into a recovery position, and observing that he was still conscious and talking.

27. At 11:08pm police requested Ambulance Victoria to attend. While they were waiting for the ambulance attendance David's condition declined rapidly and CPR was performed by police members.

28. At 11:15pm Sergeant Zeeher spoke to D24 and requested Ambulance Victoria to hurry as David was deteriorating. Shortly afterwards David sat up and then fell backwards and started seizing. Police members again placed him in the recovery position and put a blanket under his head. Sergeant Zeeher made two more contacts requesting an ambulance.

29. When a MICA Unit arrived at 11:49pm further resuscitation was attempted but David was unable to be revived and he was pronounced deceased at 12:20am on 12 March 2013.

30. Together with Dr Lee, Forensic Pathologist at VIFM, I attended the scene on the night of David's death. The environmental temperature on the night was very hot and humid.

Post Mortem examination

31. Dr Lee performed an autopsy on David on 12 March 2013 that revealed superficial abrasions to David's face, elbows, forearms and knees. There were no acute injuries to any of David's organs and there was no evidence of any physical injuries which may have caused or contributed to his death. Fractures were identified to David's ribs, consistent with chest compressions during his attempted resuscitation.

32. There was no evidence of natural disease which may have caused or contributed to David's death.

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[5] Sergeant Craig Zeeher
[6] Constables Vincent Kirkpatrick and Jethro Carbines

33. A neuropathological examination conducted by Dr Isles, VIFM forensic pathologist, found a mild generalised reduction in the white matter volume of David's brain.[7]

34. Noting the results of toxicological analysis, Dr Lee attributed David's death to pheniramine toxicity.

Toxicology

35. Toxicological analysis of post-mortem blood samples conducted by Dr Gerostamoulos found the presence of Citalopram[8], Olanzapine[9] and Clonazepam[10], David's prescribed medications, and paracetamol. No alcohol was detected.

36. Dr Gerostamoulos' analysis revealed that 14.7mg/L of pheniramine was detected in David's blood, pheniramine was detected in David's urine, 5 mg of pheniramine was detected in his stomach contents and 40mg/kg of pheniramine was detected in his liver.[11] Pheniramine is an over the counter antihistamine which may be found in syrup or table form.

37. Dr Gerostamoulos advised that the pharmacokinetic half-life of pheniramine is generally between 8 to 19 hours and that blood concentrations in cases of fatal pheniramine overdose range from 1.9 to 30 mg/L. Manifestations of pheniramine toxicity in overdose include agitation, hallucinations, disorientation, delirium, cardiac arrhythmias, coma and death.[12] Adverse effects of pheniramine include dryness of mucous membranes, drowsiness and dizziness.[13]

38. Professor Olaf Drummer gave an expert toxicological opinion in relation to pheniramine toxicity, and made the following general observations:

- Liver concentrations in fatalities attributed to pheniramine range from approximately 7mg/kg; and
- When used in excess pheniramine can cause a mixture of stimulation and CNS depression producing symptoms such as agitation, convulsions, disorientation and hallucinations. [14]

39. Professor Drummer concluded that:

- The dose or time of ingestion cannot be predicted however overdose ingestions of

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[7] Report of Dr Isles, p 143 of coronial brief, Exhibit C
[8] An antidepressant
[9] Prescribed for the treatment of schizophrenia and mood stabilization
[10] A benzodiazepine
[11] Amended VIFM toxicology report, p 134 of coronial brief
[12] Ibid
[13] Report of Dr Lee, p 131 of coronial brief
[14] Expert toxicological opinion, Appendix AI to coronial brief, Exhibit B

pheniramine would be expected to lead to substantial adverse effects within an hour of ingestion;

- That concentration in the tissue cannot determine if the levels are the result of chronic use or one large ingestion; and
- The symptoms described by those who witnessed David, including strange and confusing behaviour, high body temperature and seizures are consistent with pheniramine toxicity.[15]

40. Professor Drummer gave further evidence at the inquest that it is unable to be determined in this case whether the level of pheniramine is due to a single dose or larger doses consumed over a few days.[16] As there was only a fraction of a tablet in David's stomach contents but a high level in the blood Professor Drummer was of the opinion that a single overdose or an accumulation over a short period of time was likely and that death probably occurred within hours of ingestion.[17]

41. Professor Drummer outlined that David likely experienced the symptoms of toxicity for two to three hours, presumably getting worse as more of the drug was absorbed.[18] He concluded that the toxicology results are unable to specifically distinguish David's drug taking behaviour.

42. Dr O'Dell provided expert clinical forensic opinion outlining that death in pheniramine toxicity occurs from complication of hyperthermia, dehydration, seizures, cardiac arrhythmia and coma and there is no specific antidote for antihistamine overdose.[19]

43. Dr O'Dell was asked had paramedics arrived earlier, given their training, could David's death have been prevented, or was his only chance an urgent transfer to the emergency department. He highlighted that David had taken a large amount of pheniramine and was suffering serious and life threatening effects by the time both police and paramedics attended as he was hot, dry, confused and agitated.

44. Dr O'Dell further indicated that after David became unconscious a serious cardiac arrhythmia had developed by the time the ambulance arrived and that this type of heart rhythm disturbance carries an uncertain prognosis even with prompt treatment.

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[15] Ibid
[16] Inquest transcript, p 20
[17] Ibid
[18] Inquest transcript, p 21
[19] Appendix AJ of coronial brief, Exhibit D

45. During the inquest Counsel Assisting asked Dr O'Dell whether David's life would have been prolonged or saved if all supportive treatment had been available when police first saw David. Dr O'Dell responded '*...I think it's very hard to tell...He had a very high level of this drug on board so the continued action of the drug would have been going all the time.*'[20]

46. Dr O'Dell was also of the opinion that given the small amount of pheniramine found in David's stomach and the high amount in his blood and liver it was most likely that consumption had occurred more than an hour or two before David's death, and possibly earlier that day. The levels of pheniramine detected in David's body was well in excess of the lower range for fatal overdoses.[21]

47. The difficulty in delineating David's condition was highlighted by Dr O'Dell: '*..to somebody that didn't know the difference it would be impossible to tell whether this person was just suffering from some severe mental derangement or whether it was a drug effect.*'[22]

48. Dr O'Dell concluded that it was not possible to determine whether David would have survived any longer had treatment been initiated earlier: '*I think as a general rule the earlier treatment could have been initiated the better but as to whether or not he would've survived any longer or any differently is impossible to say.*'[23]

David's history of drug-taking and making 'concoctions'

49. Eastern Health Records obtained during the investigation show that David had a marked history of poly-substance abuse and actively sought other drugs and medications to ingest. David was known to have smoked, swallowed and injected concoctions of medications and other materials. Records from Box Hill Hospital show that David had injected dirt, sugar, aspirin and coffee and had admitted to taking five Avil tablets at a time for the 'buzz' and a bit of a high.[24]

50. During the time David was in residential care he would occasionally find his way back to his mother's house. On some of these visits David appeared to be affected by drugs or alcohol and it was necessary for David's mother to call for the police, or an ambulance.

51. David's mother believes that David was frustrated by his condition, and would try to self-medicate. On occasion she saw him collecting lavender and other plants and mixing his own medicine. When David visited on special occasions the family would hide medications to prevent David from taking them.

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[20] Inquest transcript, p 52
[21] Inquest transcript, p 62
[22] Ibid
[23] Ibid
[24] Ibid, p 12

52. David's financial management was provided by State Trustees. David was in receipt of a Disability Support Pension and his Treatment and Individual Recovery Plan from his residential care indicates that he was not to have an allowance as he was known to spend money on illicit substances and over the counter drugs.[25]

53. Counsel Assisting indicated to Professor Drummer at the inquest that upon admission to Box Hill Hospital in 2008 David had self-reported to clinicians that he had taken 50 Avil tablets, querying the likelihood of David surviving this previous ingestion, to which Professor Drummer outlined: *'a response to a drug is very much dependant on the circumstances, they vary from one day to the next...if you take a number of tablets you are risking your life.'*[26] That said, Professor Drummer expressed the opinion that if David had previously taken 50 Avil tablets he certainly would have experienced severe effects and was lucky to have survived.

54. At the time of his death David had in his possession a wallet, two Medicare cards, two heath cards, an empty plastic box, a pen, a notebook containing handwritten notes, a piece of paper containing handwritten notes, a Met travel card and a Priceline receipt dated 27 December 2012 for 50 x AVIL (antihistamine) tablets. However, David had no money or drugs on him at the time of his death.

55. On 14 March 2013, investigators searched David's room at Reservoir Lodge and located numerous pages of handwritten notes consisting of various drug names, and a box of Avil (50) tablets with most of the contents missing.

Police contact with David

56. The officers who attended the unit block in Reservoir on 11 March 2013 described David as being erratic and unsteady on his feet, and then falling and hitting his head at least once. There were differing initial observations from the police as to whether David's presentation was due to drunkenness, mental health or intellectual disability.

57. Police attempted to ascertain as much information as they could about David and his possible condition. The members received information from David's LEAP records that he had a propensity for violence if he felt he was being forced or pushed. Constable Dri deduced from this that David did not like to be touched, or as Sergeant Zeeher described, he could become aggressive if cornered.[27]

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[25] Additional material: Extracts from David's medical records, p 2
[26] Inquest transcript, p 24
[27] Inquest transcript p 149

58. Senior Constable Lekakis noted that David became aggressive when approached and thought that David would not have allowed them to get close enough to assist him.[28] Senior Constable Lekakis, having experience in the area, correctly identified that it was likely that David resided in one of the nearby lodges. Senior Constable Lekakis was concerned for David's welfare and was of the belief that he shouldn't be on the street. [29]

59. Constable Dri went to considerable lengths to attempt to ascertain the proper whereabouts for David gathering information from police communications, David's previous carer and also then contacted his carer at Reservoir Lodge.[30]

60. Senior Constable Lekakis thought that staff who knew David would be better placed to assist him, if he needed any medication.[31]

61. Both Constable Dri and Senior Constable Lekakis did not believe it was necessary to arrest David under the Mental Health Act and it was determined they would take him back to Reservoir Lodge. As they had determined it was necessary to give David space the members who were present effectively 'corralled' David and attempted to guide him up the driveway to Sergeant Zeeher's vehicle. However, David was only able to walk a few steps before he collapsed or fell.

The observations of police as to David's condition.

62. With the benefit of hindsight whilst it is identifiable that the negative effects of pheniramine toxicity were displayed by David that evening, there was nothing about David's presentation that suggested drug overdose to the officers who were present.

63. Constable Dri did not consider that David was either intoxicated or drug affected based on her initial observations of him. Senior Constable Lekakis had had a lot of experience during her time with the police of dealing with drug-affected people, and individuals suffering from drug overdoses. In their time with him neither Constable Dri nor Senior Constable Lekakis viewed David's behaviour as being linked to drug use, or potential overdose.

64. Constables Kirkpatrick and Carbines, who arrived at the scene later to assist had only been there for about one minute before David fell and in that time had both formed the opinion that he may be drunk, but not drug affected.

65. The most senior and experienced officer there, Sergeant Zeeher, gave evidence at the inquest that there was nothing from his presentation that made him think David was alcohol

[28] Inquest transcript p 140
[29] Inquest transcript p 130
[30] Inquest transcript pp 117-118
[31] Inquest transcript p 130

or drug affected, and Sergeant Zeeher formed the belief that David's actions were the result of an intellectual disability or mental illness.[32]

66. Constable Dri, Senior Constable Lekakis and Sergeant Zeeher were all of the opinion that David did not initially require medical attention, prior to his fall.

67. In light of all of the circumstances Sergeant Zeeher determined that the most appropriate course was to transport David to his residential lodge and his carers, who would be able to identify any inconsistencies from David's normal behaviour.[33]

68. In the totality of the observations Sergeant Zeeher made on the evening of David's death, even with the benefit of hindsight, there was nothing about David's presentation that suggested he was drug affected: '*And I stress that at the time when I spoke to David at the time that I was with him until the time that he fell over there was no deterioration of his fine motor skills from what I saw and clearly he wasn't perfectly walking, nor his cognitive skills so I wouldn't have – I would not have made that jump to a drug overdose.* '[34]

The observation of Ambulance Victoria attendees

69. Just as they were arriving at the scene paramedics received information that David was pulseless and that police had commenced CPR. The initial observations of the MICA attendees were that David's mouth, nose and eyes were all very dry.

70. MICA Ambulance attendee Mr Paul Felicetti observed that David was hot to touch and took David's temperature, which was well above the normal body temperature of 37 degrees and described it as 'way above the expected' at 41.9 degrees.[35]

71. With the symptoms they observed paramedics believed that David may have been suffering from an infective disease, and despite their experience drug toxicity or overdose was not contemplated.[36]

The police approach to dealing with David

72. This case highlights the differing spectrum of behaviour that can be displayed by an individual as a result of mental illness, intellectual disability and/or utilisation of different types of drugs, and the subsequent interaction they may have with police. As Sergeant Zeeher explained: '*There's no one glove fits all, each situation is different. You might take them home, I've taken many people home, provided that they have someone that they can be*

[32] Inquest transcript, p 160
[33] Inquest transcript, p 179
[34] Inquest transcript, pp 158-159
[35] Inquest transcript, p 228
[36] Ibid

left with who is a responsible person. I have taken people back to carers as in this situation. I've taken people to hospital. If I've determined that they fit section 10 or section 351 then I've enacted that. So there's a myriad of things that can be done but it will depend on the situation and the information that you receive at the scene to make that decision.'[37]

73. As was submitted by Counsel representing the Chief Commissioner of Police, police officers responding to incidents involving members of the public must assess the situation they are confronted with, gather as much information as they can and formulate an appropriate response accordingly.

74. Any police member's action is governed by their discretion, enhanced by training and experience. Sergeant Zeeher comprehensively outlined the approach to dealing with vulnerable individuals: *'I've been taught that it's a matter of keeping your distance, establishing a rapport, making the person feel comfortable, making them feel safe and then hopefully taking them to whatever treatment they need or you know, getting them the help they deserve.'*[38]

75. When police first came into contact with David he did not have any obvious injuries, he was able to communicate and he was conscious. There was a marked absence of clear indication that David's condition was deteriorating to the officers who were present and each officer who gave evidence identified an inconsistency between David's behaviour that night and other drug overdoses the police members had previously observed while on duty.

76. Having regard to David's displayed behaviour on that evening and the identified possibility for him to react negatively if approached or touched the police took understandable and sensible action in their attempts to engage with David and return him to Reservoir Lodge.

Calls to ESTA

77. ESTA is responsible for emergency communications including emergency call-taking, dispatch and information transfer services for fire services, ambulance and police.

78. ESTA utilises a computer aided dispatch (CAD) system which allows operators to record all call details. CAD details and recordings of the relevant calls were obtained during the investigation.

79. These confirmed that Sergeant Zeeher called '000' at 23:23pm. During this third call Sergeant Zeeher stated that David was 'now unconscious and going downhill pretty

[37] Inquest transcript p 160
[38] Inquest transcript p 159

quickly.'[39] Sergeant Zeeher told the ESTA call-taker that David had stopped fitting and as a result of this the call-taker re-coded the event.

80. Mr Mark Richards, Quality Improvement Manager at ESTA, gave evidence that the ESTA computer system automatically downgraded the event from Priority 1 to Priority 2.

81. Mr Tony Balm, Manager of the Quality Review Team at Ambulance Victoria, was of the opinion that this was an appropriate re-coding. Mr Richards also agreed it was an appropriate recoding and the call-taker re-coding the event based on the information that David had stopped fitting and was still breathing was correct.

82. Mr Richards however identified an error was made by the call-taker within the standing ESTA guidelines as they were at the time. Mr Richards' was of the view that the call-taker had incorrectly characterised the event because although David had stopped fitting and was breathing, he had not regained consciousness.[40] I note that feedback was provided to the call-taker involved, and that she is no longer working at ESTA.

83. Representatives for ESTA have conceded that if the ambulance priority had not automatically been downgraded to a priority 2 event one of the ambulances would have continued to the scene, arriving approximately ten minutes earlier that the MICA unit that arrived at 23:49pm.[41]

84. As a result of the circumstances in which David's death occurred, ESTA reviewed its process regarding the handling of patients reported to be convulsing as the result of a traumatic injury, prior to ESTA knowing that drug toxicity was involved.[42] As ESTA have accepted there may now be cause to review the seizure protocol in respect to possible drug poisoning I make no further comment in respect to this.

Ambulance attendance

85. All ambulances are dispatched in accordance with a priority system and ambulance response time is determined by priority levels designed to triage emergency calls.[43] The police first called for an ambulance at 23:10pm, with an ambulance arriving at 23:49, a total response time of 39 minutes.

86. Evidence at the inquest focussed on the ambulance response time, with the following being an agreed summarised chronology:

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[39] Exhibit X
[40] Inquest transcript, p 320
[41] Submissions on behalf of ESTA, p 5 and reply submissions, p 1
[42] Submissions on behalf of ESTA, p 11 and reply submissions, p 4
[43] Inquest transcript p 258

- 23:10pm – a call was made reporting that David was involved in a fall and was conscious and breathing (ambulance code priority 2)
- 23:19pm – second call made for an ambulance, reporting that David was having a seizure (the event was upgraded to Priority 1, requiring a Code 1 response)
- 23:24pm – third call made advising that David was unconscious and 'going downhill pretty quickly.' It was confirmed that David was breathing and had stopped fitting (downgraded to Priority 2)
- 23:38pm – fourth call indicating that David had lost consciousness. Clinician consulted (priority coding upgraded to Priority 1 requiring a Code 1 response)
- 23:47pm – fifth call indicating that David had stopped breathing (upgraded to Priority 0 due to apparent cardiac arrest)
- 23:49 – ambulance arrives at scene

87. As identified by Ambulance Victoria representatives all ambulances on the evening were dispatched in accordance with the priority system.[44] The alteration from Priority 1 to Priority 2 at 23:19pm resulted in two different ambulances being dispatched, both being cancelled at 23:21pm and a different ambulance, that was closer to the scene, was dispatched on a Code 1 response.[45] The first ambulance dispatched was upgraded to Priority 1 when a call was diverted to a clinician.

88. While Sergeant Zeeher called again to emphasise the heightened need for ambulance attendance, unfortunately the information he provided resulted in the Priority level being downgraded as David's fitting had stopped. As such the ambulance that had been dispatched to attend to David was diverted to another event.[46]

89. The initial trigger for the police calling the ambulance was David falling or collapsing and striking his head on the pavement.

90. Dr Lee expressed the opinion that David more likely collapsed, rather than fell, as he did not place his hands out to break his fall, suggesting a loss of consciousness and that the collapse was likely to have been from the effect of the drugs.[47]

91. There was no evidence from the attending police of a need to call an ambulance earlier as no medical cause for concern presented outwardly in David's behaviour.[48]

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[44] Inquest transcript p 280
[45] Statement of Tony Balm Appendix AK, Exhibit T
[46] Ibid
[47] Inquest transcript, p 8, p 11

David's whereabouts on the day of his death

92. The last known sighting of David prior to him arriving at units at 991 High Street, Reservoir at approximately 10:00pm was at about 2pm at Reservoir Lodge. Comprehensive investigation has been unable to establish where David was between these times.

93. As Ms Kuila explained residents of the Lodge were free to come and go as they lived independently and on that day David did not tell his carers he was going anywhere.[49] As it was a public holiday, David participated in a group BBQ at Reservoir Lodge that afternoon and after that most probably left out of the back gate of the Lodge. He said goodbye to Ms Kuila at 2pm and said he was going to his room. According to Ms Kuila David was not exhibiting any signs of being unbalanced when she last saw him.[50]

94. David told Senior Constable Lekakis that he had had a couple of beers with a friend, but this 'friend' has been unable to be located and an analysis of David's travel cards found no identifiable travel on the day of his death.

95. There is no CCTV available from Reservoir Lodge or its surrounds to show David's movements that day.

Conclusions

96. David was described as being a 'very very sick man', illustrated through the level of drugs in his body, his seizing and the loss of consciousness. [51]

97. It is clear from the evidence that David's death was caused by pheniramine toxicity, with nothing else found at autopsy that was likely to have caused or contributed to death. [52] The level of pheniramine in post-mortem samples taken from David's body was fifty times the upper limit of the usual therapeutic range and well in excess of the lower range for fatal overdoses as evidenced in the literature.[53]

98. It has been submitted on behalf of both Ambulance Victoria and Victoria Police that I am unable to conclude on the available evidence with the requisite degree of certainty if the arrival of ambulance paramedics at any earlier time from the time when the first police responders were at the scene, would have resulted in a different outcome for David, and I accept this submission.

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[48] Inquest transcript, p 145
[49] Inquest transcript, p 278
[50] Inquest transcript, p 279
[51] Ibid
[52] Inquest transcript, p 7
[53] Inquest transcript p 62

99. While the option of calling for an ambulance was open to police at any earlier time, I do not make any adverse comment in respect to this failure as the evidence of the police witnesses who were present, indicates that none of them distinguished drug toxicity as a possible cause of David's behaviour, and that it was not unreasonable for them not to do so.

100. The medical evidence available does not allow me to definitively conclude on the balance of probabilities that earlier intervention by police or ambulance paramedics would have prevented David's death, but the possibility has not been excluded. Similarly, the evidence does not support a finding that had paramedics arrived earlier they would have prevented David going into cardiac arrest, nor that David would have survived if he was admitted to hospital, but the possibility has not been excluded.

101. The weight of the evidence does support a finding that the pheniramine toxicity to which David succumbed resulted from an excessive quantity of pheniramine taken in the 24 hours or so before his death, rather than from chronic or long term use.

102. The representatives for the family submitted that those familiar with the effects of pheniramine toxicity would have identified David as suffering from those effects and sought urgent medical help.[54] They recognise that the police members who attended that evening were not equipped to diagnose David as suffering from pheniramine toxicity, however submit that clear steps should have been taken to determine his background.[55] Furthermore, they submitted that police members were too quick to attribute David's behaviour to a mental illness, and did too little to explore whether there was any alternative explanation for his behaviour.[56]

103. Representatives for the family have suggested a proposed finding that had paramedics arrived on scene sooner David would have had access to the supportive care he required and had a greater chance of survival.[57] As indicated above, while the possibility that David could have survived with earlier intervention, diagnosis and appropriate treatment is not excluded, the evidence gathered during the investigation and inquest into David's death does not support a finding that this was probable.

104. It is abundantly clear from the evidence before me that the police members who attended the Reservoir premises tried to assist David, particularly evidenced in their attempts to gather all the information they could about David and the care and concern expressed for him: '*...my*

[54] Closing submissions of the family of David Scrofano, p 5
[55] Ibid, p 16
[56] Ibid, p 17
[57] Ibid, p 11

only concern for him or highlight of my concern for him was to get him off the street, get him home as soon as possible so he can be treated by the people who knew him at the residential unit. So whether or not he needed medication I didn't know, whether he'd taken it I didn't know but I assumed being from the lodge he would be looked after there with medication.'[58]

105. In my view the police who attended on the evening of David's death went to considerable lengths to assist David in the best way they saw fit in the circumstances they were presented with. They commendably attempted to gather information, being particularly sensitive in their approach to David noting that he did not like to be touched, determining the best approach was to take him to Reservoir Lodge where people who knew him better could assist. Police also made numerous contacts for assistance continuing through to commencing CPR when David collapsed and lost consciousness.

Findings

106. Having considered all the available evidence, I find that David Scrofano born on 10 February 1972 died on 12 March 2013 from pheniramine toxicity in the circumstances described above.

107. I further find that the police actions did not cause or contribute to David's death and that the actions of police and Ambulance Victoria attendees that evening were reasonable and appropriate and in keeping with their professional obligations. In particular, the police members who were present did everything that could be expected of them in the situation and they are commended for the way they undertook their duties on the night.

108. I further find that although the incorrect characterisation of the event by the ESTA call-taker that resulted in the event being downgraded from a Priority 1 to a Priority 2 event was conceded, the evidence does not support a finding that this caused or contributed to David's death.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that a copy of this finding be published on the Internet.

[58] Inquest transcript, p 137

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

- Mrs Rosemary Zappulla
- Ms Leveasque Peterson, Landers & Rogers on behalf of the Chief Commissioner of Police
- Mr Colin Grant on behalf of Ambulance Victoria
- Mr Fatmir Badali, Gadens Lawyers on behalf of the Emergency Services Telecommunication Authority
- Detective Sergeant Mark Hatt, Coroner's Investigator

Signature:

PARESA ANTONIADIS SPANOS
Coroner
Date: 5 May 2016