IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 5778

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: Paul Bermingham

Delivered On:	18 December 2015
Delivered At:	Melbourne
Hearing Dates:	2 December 2015
Findings of:	Coroner Audrey Jamieson
Counsel Assisting the Coroner	Jessica Wilby, Principal In-House Solicitor

I, Audrey Jamieson, Coroner, having investigated the death of Paul Bermingham

AND having held an inquest in relation to this death on 2 December 2015
at the Coroners Court, Melbourne
find that the identity of the deceased was Paul Bermingham
born on 15 November 1975
and the death occurred on 16 December 2013
at the Alfred Hospital, Commercial Road, Prahran 3181
from:

1 (a) Toxicity to methylamphetamine

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

1. Mr Paul Bermingham (referred to in my finding as Paul) was the only son of Mrs Lesley Asquith and stepson of Mr Terry Asquith, who had raised Paul as his own son for the last twenty six years of his life.

2. Paul's biological father, Mr Brian Bermingham, resides in Queensland and Paul has one younger sister, Sarah.

3. Paul was 38 years old at the time of his death, he was single and had worked several jobs since leaving high school part way through Year 10.

4. Paul was a known drug-user and Paul's mother believes Paul began using marijuana when he was approximately 23 to 24 years of age. Paul relocated between Queensland, Seymour and Melbourne and it is during this time he is believed to have started using heavier drugs.

5. In 2010 Paul returned to Seymour and resided in a room in his grandmother's house. In the two years prior to his death Paul was unemployed and stayed at home making speakers and jewellery.

6. In the twelve months prior to his death Paul purchased a laptop and became obsessed with researching conspiracy theories. Paul was using drugs intermittently and his family describe Paul as becoming increasingly argumentative, secretive and private, spending a lot of time alone in his room.

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 Paul's death have been the subject of investigation by Victoria Police on my behalf.

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

12. It was apparent that most of the facts about Paul's death were clear including his identity and aspects of the circumstances, including the place and time of his death.

13. After considering all of the material contained within the coronial brief I determined to conduct further inquiries to assist me in the investigation of Paul's death.

14. Once these further inquiries had been completed it became evident that there was no utility in conducting a lengthy inquest to assist my investigation further, and so a summary inquest was conducted.

15. This finding is based on the entirety of the investigation material including the file, coronial

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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

brief of evidence, and the additional statements and reports obtained.

The events of 15 December 2013

16. On 15 December 2013, at approximately 11:00am, Paul went to Mr Craig Harmer's residence. Craig lives with Paul's aunt, Ms Barbara McCarthy.

17. Paul arrived at the house in a maroon Ford Telstar and Craig got into the car with Paul and they both went to the bottle shop. Paul then asked Craig if he wanted to visit some friends of his.

18. At one point while they were travelling towards Shepparton Craig got out of the car to open some cattle gates. When he got back into the car Craig found Paul's behaviour to be strange and that what Paul was saying was difficult to follow. Paul referred to Craig being a member of a secret organisation and accused him of being in possession of information.

19. Craig continued to talk to Paul in an effort to calm him down, but Paul started behaving more intensely and aggressively towards Craig. Paul accused Craig of planting seeds and electronic machinery. Craig became increasingly concerned for his own safety and so got out of the car.

20. Later that day, sometime after 1:00pm, Craig met up with Paul's aunt, Barbara McCarthy, in town and told her of Paul's bizarre behaviour. Between them they decided they needed to get Paul some assistance. Barbara rang Paul's mother, informing her of Paul's behaviour and that it appeared he was affected by drugs.

21. Lesley was with Paul at the time and had observed that he was acting in a bizarre fashion. Paul had asked Lesley if they could go for a drive to Goulburn Park, which she did. When they got there Paul began saying things that did not make sense to Lesley so she told him they needed to go home.

22. At approximately 2:30pm Lesley drove Paul to the Seymour McDonald's store and tried to calm him down as he was continuing to act in a confused state.

23. Lesley then contacted Barbara McCarthy again, who said she would send another friend around to check on Paul.

24. Mr Anthony Byrne, the family friend, went around to where Paul was living about an hour later and found him on the veranda painting stars and moons on a board. Paul was talking but Anthony found it difficult to keep up with him.

25. Paul kept repeating he had to finish the painting by 5 o'clock, before he killed himself. Paul was very specific about the 5 o'clock, and that he had to do it at the crow's nest at the river.

26. As Paul was detailing this to Anthony Byrne his behaviour markedly deteriorated. While Anthony was in the process of asking Lesley to call the police Paul became very erratic, squeezing paint out of the paint tubes very fast and removing all of his clothing.

27. Paul then climbed onto a maroon bicycle and rode out of the driveway, naked, with red paint all over his body.

Calls to police

28. Barbara McCarthy called the Seymour Police Station at 3:39pm that afternoon. During this call she reported Paul's bizarre behaviour to Sergeant Scott Mills, saying that Paul was suicidal, that he had been taking 'ice' and had not slept for three days. Barbara requested police attendance at Paul's grandmother's house.

29. Lesley also called police at 3:52pm.

30. Barbara then made another call to Seymour Police Station at 3:53pm, reporting that Paul had left the address and that he was riding his bicycle naked and she believed he was headed towards Goulburn Park/River.

31. There were a number of civilian witnesses at Goulburn Park in the vicinity of the boat ramp and Seymour Tourist Caravan Park who reported seeing a naked man covered in red paint yelling out to himself and walking quickly through the park.

32. Witnesses reported that the male appeared to be affected by drugs or mentally unstable and that he jumped into the Goulburn River to swim across.

33. Witnesses' accounts varied in that some said Paul appeared to have trouble while swimming, while others said he did not appear to be struggling at all.

34. Witnesses reported that the male was last seen climbing up a steep embankment to a vacant area of land.

Police attendance

35. Sergeant Mills was performing section Sergeant duties at Seymour Police station when the calls regarding Paul were received. He recorded the first call in the telephone message book, and was about to call police communications to request a divisional van to attend

when he received the second call from Barbara McCarthy indicating that Paul was heading towards Goulburn Park.

36. Sergeant Mills requested that the Seymour divisional van with police members Senior Constable Malane and Constable Kirk attend at Goulburn Park.

37. Sergeant Mills communicated the situation to police communications (D24) via the police radio, and was the first officer to arrive at Goulburn Park arriving at the boat ramp at 4:00pm.

38. When Sergeant Mills arrived Paul was in the river about three quarters of the way across.

39. Once at the scene Sergeant Mills took charge and made a request for assistance through SES attendance.

Risk assessment

40. Sergeant Mills determined that it would take some time for SES to arrive, and in assessing the risks and that Paul had indicated an intention to commit suicide, Sergeant Mills declared him an immediate risk and requested a local boat owner, Mr Robert Cook, transport him and Senior Constable Jethro Malane to the south side of the river.

41. Sergeant Mills made the decision to take with him a pair of handcuffs and OC spray as the OTST options in the event they were required to arrest Paul. Sergeant Mills indicated to Senior Constable Malane that the OC foam would be the first option. [5]

42. Upon arrival at the other side of the river Sergeant Mills and Senior Constable Malane climbed the embankment and saw Paul approximately 100 metres away on the ground on his hands and knees.

43. Senior Constable Malane estimated Paul to be about 190cm tall, with reddish paint on his body and saw that Paul had scratches on his torso and arms, that were fresh and appeared to be from brushing past scrub.

44. Sergeant Mills and Senior Constable Malane proceeded to walk towards Paul, telling him that they were there to help.

45. Once Paul became aware of their presence he jumped to his feet and walked away, saying he could not talk to them. Sergeant Mills continued to request for Paul to stop and speak to

[5] This refers to operational safety equipment in which police have received Operational Tactics Safety Training. Both officers involved had undertaken the relevant training.

him and as he was concerned that Paul would continue walking towards the river he positioned himself in front of him.

46. Sergeant Mills then placed his hand out in front of him however Paul ignored the requests and walked into Sergeant Mills' outstretched hand. On the third attempt Paul swatted Sergeant Mills' hand aside.

47. At this point Sergeant Mills concluded that the negotiations with Paul had failed and he made a decision to arrest Paul under section 10 of the *Mental Health Act 1986.*[6]

48. When Paul swatted Sergeant Mills' hand Senior Constable Malane moved in and took hold of Paul's right hand and Sergeant Mills took hold of Paul's left arm with the intention of placing handcuffs on him.

49. As Paul was resisting and tensing his arms there was a short struggle and all three of the men fell forward with Sergeant Mills losing grip of Paul's arm. Paul then fell to the ground face down, tucked his hands under his body and refused to give up his hands to be handcuffed.

50. Paul was fiercely non-compliant in continuing to resist, refusing to put his hands up stating they were 'Australian property' and that it was the police's job to get them.

51. Sergeant Mills placed his left knee on Paul's shoulder while Senior Constable Malane attempted to extract Paul's right arm from under him.

52. At this point Paul was fully conscious and talking to police.

53. Senior Constable Malane managed to obtain hold of Paul's right arm and placed one handcuff on his wrist, which he described as incredibly difficult and that Paul was displaying extreme strength and resistance.

54. Police radio transmissions captured Sergeant Mills stating they were just trying to handcuff Paul at 4:14pm.

55. Sergeant Mills moved and had his right knee on Paul's shoulder in what he described as a 3 point hold, stating that he maintained sufficient pressure to overcome Paul's efforts at getting back up while Senior Constable Malane attempted to extract Paul's left arm and place the second handcuff on his wrist. Paul continued to resist, saying 'I can't, I can't'.

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[6] Section 10 of the *Mental Health Act 1986* sets out the powers of a police officer to apprehend a person where they have a mental illness and may harm themselves or others. This has now been replaced by s351 of the *Mental Health Act 2014*.

56. A few seconds later Sergeant Mills noticed that Paul's body had gone limp and that he was not responding. Sergeant Mills immediately removed his knee and saw Paul's eyes had rolled back in his head.

57. Sergeant Mills requested urgent medical assistance and an air ambulance due to their location.

58. The police communications transcript indicates this request was transmitted at 4:15pm. The transcript also indicates that Sergeant Mills said that Paul has passed out while they were struggling with him.

59. Shortly after the request for medical assistance two police members from Euroa, Sergeant Hughes and Senior Constable Willis, arrived and Senior Constable Willis commenced cardiopulmonary resuscitation (CPR) and delivering chest compressions after finding that Paul had no pulse.

60. A local off duty nurse, Ms Amy Cook, also assisted police in performing first aid and CPR.

61. Ambulance paramedics arrived at 4:27pm and continued CPR and treatment and Mobile Intensive Care Ambulance paramedics and the air ambulance attendant arrived at 5:05pm

62. Paul was treated at the park until approximately 6:00pm, when he was transferred to the Alfred Hospital by Air Ambulance.

63. At no point from the time that paramedics arrived until he reached the Alfred Hospital at approximately 6:05pm did Paul regain consciousness. Paul was admitted to the Intensive Care Unit (ICU) in a critical condition after sustaining a cardiac arrest.

Treatment

64. Dr Steven Philpot detailed that observations and examinations in the ICU were consistent with Paul having had a recent cardiac arrest. Dr Philpot noted that the likely reason for Paul's condition was hypoxic-ischaemic encephalopathy resulting from his cardiac arrest.

65. Paul received CPR and adrenaline out of hospital and required an adrenaline infusion to maintain blood pressure on arrival to the Alfred Emergency Department. Paul was intubated and ventilated and a CT scan showed widespread hypoxic injuries including oedema, cerebellar herniation and progressive swelling of the entire brain.

66. At 10:50pm on 15 December 2013 the ventilator assisting Paul was switched off and clinical examination on 16 December 2013 confirmed the absence of brain reflexes. Paul was

declared deceased by a consultant neurologist at 15:30pm.

67. A toxicological screen taken at the hospital showed a positive test for amphetamines.

68. Mr Robert Cook, who had assisted transporting police across the Goulburn River in his boat, had reported seeing a large brown snake on the river bank near where Paul had exited the river. Samples were taken for toxicological testing for snake venom, which was not found.

Police conduct

69. As Paul's death resulted from an incident involving police attempting to take Paul into custody under section 10 of the *Mental Health Act* it was declared a critical incident, and on 15 December 2013 an independent officer, Inspector Dan Trimble from the Mitchell Shire, attended the scene and took charge. Inspector Trimble directed the four involved officers undergo drug and alcohol tests, all of which returned a negative result.

70. The two primary police officers involved in the incident, Sergeant Mills and Senior Constable Malane, had their statements obtained by Homicide Squad members, and the investigation was overseen by Sergeant Josh Chadwick from Professional Standards Command.

71. As referred to previously Sergeant Mills and Senior Constable Malane were acting under s10 of the *Mental Health Act* when attempting to arrest Paul, taking into consideration the information they received from family members Lesley Asquith and Barbara McCarthy that Paul had made comments indicating he was going to commit suicide. From their own observations of Paul's behaviour they formed the belief on reasonable grounds that Paul was affected by drugs, appeared to be mentally ill and needed to be taken into custody for his own safety.

72. Following my assessment of all of the material gathered during this investigation I am satisfied that there is no indication that any of the police officers involved in the incident did anything improper. An amount of force was clearly applied when Sergeant Mills and Senior Constable Malane were attempting to handcuff Paul when he was refusing to produce his arms, but there is no evidence to suggest this was excessive. The timing of the incident is also notable, with Paul falling into unconsciousness almost immediately and the police moving quickly to administer CPR.

73. I believe that the risk assessment Sergeant Mills conducted was appropriate in the circumstances.

Police inquiries

74. Mitchell Shire Criminal Investigation Unit attended and searched Paul's room at his grandmother's house, finding no items of interest. The motor vehicle used by Paul on that day was located and searched, but no drugs were located in the vehicle.

75. Investigators have been unable to determine when and where Paul obtained the drugs that were later found in his blood.

76. Leading Senior Constable Know measured distances and co-ordinates of the park and the Goulburn River, and the distance between the top of the embankment and the area in the paddock where Paul was first approached by police is approximately 91 metres.

77. Leading Senior Constable Know also took GPS co-ordinates from the north side to the south side of the river where Paul had swum, and found it to be approximately 131 metres.

78. Detective Sergeant Ross investigated Paul's psychiatric history and ascertained that no records were held with Seymour Health regarding either CAT or psychiatric services. Detective Sergeant Ross also examined Victoria Police LEAP records, which showed no notations of any warning or mental impairment concerns.

Forensic Pathology

79. Dr Michael Burke, forensic pathologist from the Victorian Institute of Forensic Medicine (VIFM), performed a post mortem examination on 18 December 2013, and a reasonable cause of death was given as 1(a) Toxicity to Methylamphetamine.

80. Dr Burke noted the Paul resisted police with some force, and that when police had one of Paul's wrists handcuffed Paul became unconscious and his condition deteriorated rapidly.

81. Dr Burke says '*...it is my understanding that at no time was Mr Bermingham restrained such that officers placed weight over the deceased's back while he was being restrained...Furthermore, it is my understanding that at no time was any force applied to the deceased's head or neck.*'

82. The post mortem examination showed no evidence of any injury that would have led directly to death, and Dr Burke notes in particular that there was no evidence of head or neck injury.

83. The post mortem examination confirmed a hypoxic ischaemic brain injury, and showed no evidence of any underlying disease process that would have led to such cardiac arrest.

84. Dr Burke concluded that it would appear reasonable to suggest Paul suffered toxicity to methylamphetamine, including marked agitation. Paul has then suffered a lethal cardiac arrhythmia, also secondary to the effects of the drug.

85. The toxicological examination detected methylamphetamine at 0.4mg/L, amphetamine at 0.03mg/L, morphine and midazolam.

86. Toxicity associated with amphetamine use includes agitation, hyperthermia, hallucinations leading to convulsions, unconsciousness and respiratory and/or cardiac failure.

87. Dr Burke prepared a secondary report stating that it should be added that the 'emotional response' associated with being held by the officers during the incident could have caused a surge of adrenaline, a further risk factor to a sudden cardiac arrhythmia.

88. Following this a further supplementary report was sought from Dr Burke, requesting he specifically canvas the possible interactive effects of the methylamphetamine, adrenalin and restraint by police. The request highlighted Paul's irrational and strange behaviour prior to his death, and his activities including stripping off all his clothing and swimming approximately 131 metres across the Goulburn River after riding his bicycle naked through the streets of Seymour.

89. A further expert toxicological report was also sought, as was further information from Victoria Police regarding the utilisation of the three point hold by police.

90. Sergeant Jarrod Ross from the Victorian Police Centre for Operational Safety provided an additional statement detailing the three point hold, and relevant training. Sergeant Ross outlined the three point hold is the most commonly known restraint position that is suitable for controlling a person who is face down so that handcuffs can be applied safely.

91. Sergeant Ross indicated the three point hold is a transitional position, with no emphasis on holding an individual down. Once handcuffs are applied any pressure should be removed from the individual's back to reduce the potential of Positional Asphyxia Disorder.

92. Dr Burke, in his additional supplementary report, commented that he understood that Paul was not being restrained in such a way that his breathing was compromised, and that there were no injuries at the post mortem examination to suggest this.

93. Dr Burke noted that any designation of cardiac arrest while being arrested is problematic as it implies that unreasonable restraint was a significant factor when there is no objective supporting evidence that this was the case here.

94. Dr Burke concluded that it would be reasonable to suggest that the additional physical exertion by Paul and the 'stress' and physical activity associated with the arrest attempt may well have contributed to a surge of additional endogenous catecholamines[7] and subsequent cardiac death.

95. Dr Gerostamoulas, Chief Toxicologist from VIFM, was asked to provide a further expert opinion as to what the effects of consuming methylamphetamine and other drugs can have on an individual when they have been involved in a number of strenuous activities such as those Paul was engaged in prior to falling into an unconscious state, with particular focus on the level of methylamphetamine in Paul's body.

96. In his report in respect to Paul, Dr Gerostamoulas commented that amphetamines stimulate the central nervous system causing persons to become hyperactive, more aroused and euphoric, with an increase in heart rate and blood pressure.

97. At higher doses the effects of methylamphetamine are quite marked, and would be expected to produce high heart rates and blood pressure, excessive hyperactivity and marked personality changes, often coupled with aggression and paranoid behaviour.

98. Dr Gerostamoulos indicated that the stimulation lasts as long as the drug is in an individual's body, with more intense effects soon after administration and that the concentration of methylamphetamine detected in Paul's blood is consistent with recent use within 12-24 hours. The amount of the drug consumed was unable to be estimated.

99. Dr Gerostamoulos outlined that death from methlyamphetamine is not common, but that '*...irregular heart rate (arrhythmias) is possible at high concentrations, particularly on exertion or in times of stress which can lead to death.*'

Conclusions

100. I find that Paul Bermingham died on 16 December 2013 from toxicity to methyl amphetamine in the circumstances described above.

101. Whilst Paul indicated verbally to friends and family that he wanted to commit suicide based on the entirety of the evidence I am not satisfied that Paul intended to take his own life.

102. I further find that although Sergeant Scott Mills and Senior Constable Jethro Malane were present at the time of Paul's cardiac arrest they did not directly contribute to his death.

[7] Neurotransmitters and hormones including dopamine, noradrenaline and adrenaline

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

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

- Mrs Lesley Asquith and Mr Terry Asquith
- Victorian Government Solicitor's Office on behalf of the Chief Commissioner of Police
- Ms Sarah Larwill, Alfred Hospital
- Detective Sergeant Graham Ross, Coroner's Investigator

Signature:

AUDREY JAMIESON
Coroner
Date: **18 December 2015**