IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 4328

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	**ROSEMARY CARLIN, CORONER**
Deceased:	**PHILLIP RICHARD ANDERSON**
Date of birth:	27 March 1983
Date of death:	25 August 2015
Cause of death:	1(a) COMPLICATIONS OF MIXED DRUG USE
Place of death:	Prahran, Victoria

HER HONOUR:

Background

1. Phillip Richard Anderson was born on 27 March 1983. He was 32 years old when he died from complications of mixed drug use.

2. Mr Anderson lived in Flemington at the time of his death. He was adopted as an eighteen month old by the King family. His birth parents both suffered schizophrenia and were unable to care for him.

3. Mr Anderson's adoptive mother Leonie King loved Mr Anderson as her own son. In her statement she said: *'Aside from his mental health issues [Phil] was very loving and very soft ... Phil brought so much love to our family'*. His relationship with Ms King sadly broke down when he was seventeen as a result of his severe mental health issues. From this time, he lived with his brother Ty, started using a range of illicit drugs, and was periodically employed by his brothers as a concreter, but would often go on 'walkabout' and not return to work.

4. Mr Anderson was diagnosed with schizoaffective disorder in 2002. He also struggled with poly-substance abuse, in relation to illicit and prescription medication. Mr Anderson attempted suicide twice: once by stabbing himself in response to hallucinations in 2006, and a second time by taking an olanzapine overdose in 2009.

5. In recent times Mr Anderson established a relationship with his biological father.

The coronial investigation

6. Mr Anderson's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**).

7. The role of a coroner is to independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and

causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

8. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Anderson's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses, and submitted a coronial brief of evidence.

11. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

12. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Identity of the deceased

13. Mr Anderson was visually identified by his biological father Richard Leslie Wilson on 28 August 2015. Identity was not in issue and required no further investigation.

Medical cause of death

14. On 29 August 2015, Dr Yeliena Baber, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an autopsy on the body of Mr Anderson. The autopsy revealed healed thrombophlebitis in the left wrist and antecubital fossa, moderate portal

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

triaditis throughout the liver, and gastric contents within some airways in the lungs, indicative of peri-mortem aspiration.

15. Toxicological analysis of post mortem specimens taken from Mr Anderson's blood identified zuclopenthixol, trifluoperazine, pregabalin, diazepam, nordiazepam (a metabolite of diazepam), hydroxyrisperidone (a metabolite of risperidone and a drug in its own right), benztropine, olazepine and paroxetine. Analysis of Mr Anderson's urine identified zuclopenthixol, trifluoperazine, buprenorphine, norbuprenorphine (a metabolite of buprenorphine), nordiazepam, oxazepam, temazepam, hydroxyrisperidone, benztropine, olanzapine, paroxetine, morphine and paracetamol.

16. After reviewing toxicology results, Dr Baber completed a report, dated 29 December 2015, in which she formulated the cause of death as '1(a) complications of mixed drug use'. She commented in her report that although the drugs detected were not at excessively high levels, they are capable of causing a degree of respiratory depression in combination. It was likely, she opined, that Mr Anderson had some airway compromise due to the presence of vomit and his physical position when he was discovered, being slumped forward in a train seat.

17. I accept Dr Baber's opinion as to the medical cause of death.

Circumstances in which the death occurred

18. On Tuesday 25 August 2015 Mr Anderson boarded a city-bound Sandringham train at 3.06pm at Balaclava Railway Station. He placed his backpack on the empty seat facing him. CCTV footage shows that approximately 20 seconds after boarding Mr Anderson lowered his head apparently onto his backpack and the seat in front of him.

19. CCTV footage reveals that Mr Anderson stayed on board the train in roughly the same position as it completed five full journeys, and two partial journeys, of the entire Sandringham line. No police officers, Protective Service Officers (**PSOs**), Authorised Officers, Metro staff or Metro train drivers walked through the carriage where Mr Anderson was slumped. Various passengers sat in the same group of seats as Mr Anderson and a number of passengers looked at him. Up to 25 passengers were in the same section of carriage as Mr Anderson at any one time. One passenger shook him by the shoulders, but

then left him. Another passenger looked at him and then abruptly turned around and sat somewhere else.

20. At approximately 6.30pm, a passenger saw Mr Anderson and thought he was asleep. He then noticed liquid at his feet and smelt vomit. That witness notified PSOs at Prahran Railway Station. The PSOs boarded the train and unsuccessfully tried to rouse Mr Anderson who fell forward. Mr Anderson was blue, not breathing and had no pulse. He had vomited all over his backpack and the floor.

21. An ambulance was called. Ambulance officers found no heart activity but performed cardio-pulmonary resuscitation to no avail. He was pronounced deceased at 7.13pm. Ambulance officers noted apparent signs of recent IV drug use on Mr Anderson's arms.

Response of Metro Trains Melbourne and the Coronial Investigator to Mr Anderson's death

22. On 7 June 2016, I caused letters to be sent to Metro Trains Melbourne (**MTM**)[2] and the Coroner's Investigator inviting comments on possible coronial recommendations to prevent similar deaths in the future.

23. In response the Coroner's Investigator suggested the following:

- At the end of the line the driver walks through the train to check no one is left behind or needs assistance;
- End of the line stations have Metro staff or Station Masters check on the trains as they arrive;
- A Metro customer welfare/awareness campaign that would encourage patrons to watch out for other patron's health and safety. This could be done by implementing posters at stations (similar to the 'Dumb Ways to Die' campaign), a pre-recorded message that plays in the carriage for other patrons to press the emergency intercom button if they see something not quite right, or radio/print advertisements;
- Signs/stickers (similar to the 'Terrorist Hotline' campaign) within the train carriages to encourage people to call triple-0 if something is not right;

[2] MTM operates the metropolitan rail network by agreement with the Victorian Government.

- PSOs/Police conducting 'walk-throughs' of trains on a regular basis; and
- Giving train drivers CCTV vision within the train to be able to monitor patrons during their journey.

24. In its response MTM set out the procedures currently used to detect and assist ill passengers on MTM trains. MTM places a large onus on its passengers to report ill passengers and emergency situations. Red emergency buttons and intercoms with emergency instructions are fitted in each train carriage, and the MTM website contains passenger safety information in relation to assisting ill passengers (this information is predominantly directed to passenger illness during 'flu season'). MTM also responds to customer tweets on Twitter in relation to ill passengers.

25. According to MTM, the large number of scheduled passenger services and limited employee resources curtail its capacity to have employees check each train at the end of each service.

26. Aside from procedures which place the onus on passengers to report incidents, internal procedures utilised by MTM in relation to passenger safety include the following:

- MTM employees check to clear trains of passengers prior to going out of service each day (for example at the last station prior to entering a siding);
- Authorised officers (**AOs**) are deployed across the network to patrol and check in-service trains for ill passengers, among other duties. MTM notes that due to the number of AOs it is not possible to deploy AOs in all in–service train carriages at all times;
- During morning peak periods, trained paramedics are located at critical locations across the network to provide any assistance; and
- Protective Service Officers (**PSOs**) are based at stations from 6.00pm onwards and provide assistance to ill passengers when notified by other passengers or upon being notified by Metrol[3] or triple-0.

27. MTM submitted that its current procedures were appropriate. It knew of no other similar deaths to Mr Andersons. If any changes should be made, it suggested changes to emergency

[3] Metrol is the central control centre of the suburban rail network in Melbourne.

information directed to passengers, on the basis that passengers are more likely to first notice an ill passenger, rather than MTM employees, police officers, AOs or PSOs.

Findings

28. Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

    a. the identity of the deceased was Phillip Richard Anderson, born 27 March 1983;

    b. Mr Anderson died on 25 August 2015, in Victoria, from complications of mixed drug use;

    c. Mr Anderson's death was the unintended consequence of the deliberate ingestion of drugs; and

    d. the death occurred in the circumstances described above.

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

29. The cause and manner of death described by Dr Baber suggests that timely intervention may have prevented Mr Anderson's death. It is not clear from the CCTV footage when Mr Anderson vomited or became critically unwell. However, it is extraordinary that a young man spent almost three hours riding a train in an unwell or drug-affected state for at least part of that time, before authorities were finally alerted at 6.31pm by which time he was already blue, pulseless and not breathing. I am particularly disturbed by the fact that CCTV footage captures several passengers observing Mr Anderson throughout the journey. In particular, at 6.03pm, a passenger apparently peers closely at Mr Anderson for approximately 90 seconds, but does not alert authorities.

30. I consulted with the Coroners Prevention Unit (**CPU**) who confirmed that the circumstances of Mr Anderson's death were highly unusual. I accept that the ability of MTM to check trains is limited by resources. I also understand that commuters would be reluctant to disturb someone in Mr Anderson's position for a number of reasons. A reluctance to notify authorities is, perhaps, less understandable. In that regard a 'cultural change' to the sensibility of commuters may be desirable. In my view, however, it is unlikely that such a change could be achieved by MTM simply adjusting the information in relation to ill

passengers on its website. More effective would be appropriate signage in stations and carriages suggesting appropriate action if a commuter notices someone, (or something) that does not look right.

31. Due to the extraordinary nature of Mr Anderson's death and the complexities of any proposed measures to prevent similar deaths I do not think a formal recommendation is warranted. I would however urge MTM to consider ways to broaden its existing passenger information to include advice to commuters as to how to respond to passengers whose appearance is productive of concern.

32. As I consider it in the public interest to draw attention to this issue, pursuant to section 73(1A) of the *Coroners Act 2008* I direct that this finding be published on the internet.

I convey my sincere condolences to Mr Anderson's family.

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

Richard Wilson, Senior Next of Kin

Leonie King, adoptive mother of deceased

Metro Trains Melbourne

Office of the Chief Psychiatrist

Senior Constable Miranda Mullavey, Coroner's Investigator, Victoria Police

Signature:

ROSEMARY CARLIN
CORONER
Date: 29 November 2016