IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 654

FINDINGS INTO DEATH WITH INQUEST

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

Inquest into the Death of: Robert Ferrier

Delivered On:	1 July 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria 3006
Hearing Dates:	31 March, 1, 2 and 3 April 2014
Findings of:	Coroner Paresa Antoniadis Spanos
Representation:	Ms Sara Hinchey of Counsel, instructed by Lander and Rogers, appeared on behalf of Ambulance Victoria Mr Sebastian Reid of Counsel, instructed by the Victorian Government Solicitor, appeared on behalf of the Chief Commissioner of Police
Counsel Assisting the Coroner	Ms Rachel Ellyard of Counsel, instructed by the Ms Sarah Gebert from the Coroners Court In-House Solicitors Service.

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of ROBERT PETER FERRIER

AND having held an inquest in relation to the death on 31 March, 1, 2 and 3 April 2014

in the Coroners Court of Victoria at Southbank

find that the identity of the deceased was ROBERT PETER FERRIER

born on 4 July 1965

and the death occurred on 13 February 2013

at Martin St, Brighton, Victoria

from:

1 (a) DRUG TOXICITY IN THE SETTING OF RESTRAINT

in the following circumstances:

1. Robert Peter Ferrier[1], aged 45 years resided with his partner, Cheree Smith and her adult son, Jake at the time of his death. Rob was the son of John and Pat, was the youngest of three children and had a sister, Julie Muldoon and brother, Michael.

2. Rob was born and grew up in Canberra. He was skilled in the area of information technology and had worked for Australian Customs in the past.

3. Rob had a history of depression and was at the time of his death being treated by Dr Christine Harvey of Brighton Medical Clinic. He was prescribed Efexor and Seroquel and was last seen by his doctor on the day of his death.

4. Rob had recently been playing online poker, and was becoming aggressive in the setting of his family life with Cheree and her son.

5. On 13 February 2013, following a suspected ingestion of excessive prescription medication, and calls from Cheree and Julie to emergency services, Rob died in the back of an ambulance en route to the Alfred Hospital. He died in the presence of police officers who had been requested by ambulance paramedics to assist with Rob's management. Despite all efforts to resuscitate him, Rob was unable to be revived. Midazolam was administered twice by paramedics shortly before his death. In addition, handcuffs were fitted by the police shortly before his death, in an effort to restrain him.

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[1] Referred to in this finding as Rob at his family's request

Medical Examinations

6. A post-mortem examination was conducted by forensic pathologist Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine[2], who determined the cause of death to be 'Drug Toxicity in the Setting of Restraint'.

7. Routine post-mortem toxicological analysis showed low levels of ethanol (alcohol) within the blood and vitreous humour. Other medications identified within blood and stomach contents were amitripyline, venlafaxine and tramadol. In particular, there was a high dose of amitriptyline being 0.4mg in post-mortem blood and 115mg in a sample of stomach contents. The toxicologist noted that recommended daily doses of amitriptyline should not exceed 50-300mg and the use of high doses or the use of higher than recommended doses may result in the development of toxicity as a result of accumulation of the drug within body tissue. Dr Baber noted that midazolam was not detected, however as it was administered via intramuscular injection, the rate of absorption would have been slow.

8. Dr Baber advised there was clear evidence of tricyclic antidepressant toxicity in the heart but it was difficult to determine if Rob had experienced "serotonin syndrome" given the combination of tramadol and venlafaxine, both of which can lead to raised serotonin levels in the brain.

9. Dr Baber further noted that restraint was applied in the period leading up to death and its contribution to the cause of death remains impossible to determine. However, equally the possibility that restraint contributed to death could not be entirely excluded.

10. Cardiologist, Associate Professor Neil Strathmore, provided an opinion interpreting the ECG strip provided by Ambulance Victoria. He advised that '*the findings on the ECG are consistent with tricyclic antidepressant overdose. However, it should be pointed out that the first ECG of sinus tachycardia could also be consistent with extreme agitation*'.

11. These matters were the subject of further investigation and exploration at the inquest.

Purpose of the Coronial Investigation

12. The primary purpose of the coronial investigation of a reportable death[3] is to ascertain, if possible, the identity of the deceased person, the cause of death (interpreted as the medical

[2] Conducted on 14 February 2013
[3] Section 4 of the Act requires certain deaths to be reported to the coroner for investigation.

cause of death) and the circumstances in which the death occurred.[4] An investigation is conducted pursuant to the *Coroners Act 2008* (the Act). The practice is to refer to the medical cause of death incorporating, where appropriate, the mode or mechanism of death, and to limit investigation to circumstances sufficiently proximate and causally relevant to the death.

13. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter *connected with the death*, including recommendations relating to public health and safety or the administration of justice.[5] This is generally referred to as the prevention role of the coroner.

14. Coronial findings must be made on the basis of proof of relevant facts on the balance of probabilities.[6]

THE EVIDENCE

15. This finding is based on the entirety of the investigative material comprising the coronial brief of evidence, compiled by the Coroner's Investigator, Detective Senior Sergeant Gerard Clanchy including material obtained after the provision of the brief, the statements and testimony of those witnesses who gave evidence at the inquest (listed in paragraph 17) and any documents tendered through them, other documents tendered by counsel and the written and oral submissions of counsel following the conclusion of the inquest. All this material, together with the inquest transcript, will remain on the coronial file and comprises the coronial investigation of Rob's deaths. I do not purport to summarise all the material/evidence in this finding, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of clarity.

16. I further note that I received, and was assisted greatly by, the oral and written submissions from counsel assisting me, and from counsel representing Ambulance Victoria and the Chief Commissioner of Police (CCP).

17. The following witnesses gave evidence at the inquest:

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[4] Section 67 of the Act.
[5] Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.
[6] A coroner should give effect to the principles enunciated in *Briginshaw* v *Briginshaw* [(1938) 60 CLR 336]

- Dr Yeliena Baber, Dr Dimitri Gerostamoulos, Dr Neil Strathmore and Professor Andis Gaudrins who comprised an expert panel brought together to give concurrent evidence
- Constable Gareth Dorsey
- Senior Constable Glenn Vosbergen
- Jake Donovan, Ambulance Victoria
- Ross Wood, Ambulance Victoria
- Samuel Marshall, MICA Paramedic, Ambulance Victoria
- David Natoli, Ambulance Victoria

18. As a result of police being present at the time of Rob's death, the incident was attended by members of the Homicide Squad and Professional Standards Command (PSC), the latter oversighting the police investigation in accordance with the *Victoria Police Oversight Investigation Framework.*

SECTION 67 FINDINGS

19. Prior to the commencement of the inquest, it was apparent that most of the facts about Rob's death are known and were not in dispute. These include his identity, the medical cause of the death, although aspects of the cause of death were elucidated at inquest, and most of the circumstances surrounding the death including the place and date/time of death.

20. A number of discrete matters were sought to be resolved by the conduct of an inquest including, clarification of the precise cause of death; the appropriateness of the medical care provided; and the appropriateness of the restraint applied immediately before Rob's death.

Circumstances of the Death

21. On 13 February 2013, Rob went to a medical appointment in the morning accompanied by Cheree. His GP, Dr Harvey noticed nothing untoward in his presentation at that consultation.

22. After returning home, an argument ensued between Rob and Cheree, following which Rob left the house at about 2.00pm. He appears to have caught the train to the city and to have drunk a significant amount of alcohol over the next 4 hours, at an unknown location. He sent numerous text messages to Cheree during the afternoon, concerning his views on the state of their relationship.

23. As Cheree, her son and a friend returned home, she received a call from Rob during which he told her that he didn't want her at the house. In response, Cheree told him that she would return home, pick up some clothes and stay at a hotel.

24. As they approached their home on foot, Cheree sighted Rob from afar, walking away from the house. Once inside the house, Cheree ascertained that Rob had taken with him (and potentially ingested) all his anti-depressant medication and most of hers.

25. Cheree called Rob's sister Julie, who went searching for her brother and then called the police at about 8.06pm.

26. A short time later, Julie located Rob in Martin Street, Brighton, and called the police, confirming his location. According to Julie, Rob appeared a bit drowsy but willingly got into her vehicle.

27. At 20.25 hours Constable Garreth Dorsey and Senior Constable Glenn Vosbergen who were already searching for Rob, arrived at the scene. The ambulance arrived at 20:34 hours (having been dispatched at 20.26 hours as a Code 1). Paramedics, Jake Donovan and Ross Wood, assessed Rob's condition. In the meantime, a MICA paramedic had also been despatched (at 20.32.28 hours as a Code 2). Rob admitted to taking an excess of medication and attempted to vomit at that time. The attending ambulance paramedics were aware prior to arriving at the scene that the case involved a polypharmacy overdose with the possibility that a large number of tri-cyclic anti-depressants (**TCA**) were involved.

28. The attending paramedics concluded that Rob required urgent treatment and transport to hospital and intended for him to be transported to the Alfred Hospital. In addition, it was also recognised that a MICA paramedic would be needed in the event that Rob required sodium bicarbonate.

29. To affect this plan, it was arranged that the ambulance and the MICA paramedic (which was already en route) would rendezvous on the way to the hospital.

30. Prior to departure from Martin St, Rob was observed to become more and more agitated, so the paramedics requested that a police member travel in the back of the ambulance (Constable Dorsey) with a further police officer travelling behind the ambulance in a police car (Senior Constable Vosbergen). They left the scene at approximately 8.39pm.

31. At approximately 8.45pm, the MICA unit (Samuel Marshall), met with the ambulance on the side of Nepean Highway (50 metres north of Gardenvale Road, Gardenvale). He had

upgraded his status to Code 1 at 20.42.11 hours, following assessment of the patient by Mr Ross and Mr Donovan. By this time Rob had become severely agitated, physically aggressive, abusive and eventually, violent. In particular, he was trying to get up and out of the ambulance. He was described by Mr Donovan as being '*very violent and very intense in the small confines*' of the rear of the ambulance.

32. In an attempt to calm their patient to enable medical treatment through insertion of an IV cannula, all three paramedics and police, attempted to restrain him to the bed inside the ambulance using handcuffs, a waist strap and foot straps. A somewhat protracted struggle ensued within the confines of the ambulance. At 8.50pm, the MICA paramedic administered a dose of midazolam to Rob's right thigh.

33. As the struggle was happening a second police unit was requested.

34. A further dose of midazolam was administered approximately eight minutes later and Rob became quiet and was positioned on the bed. As soon as the monitoring equipment was re-attached, the paramedics observed that Rob had lost consciousness and was not breathing.

35. The paramedics immediately began resuscitation and medical treatment under the direction of the MICA paramedic, using the police to assist with CPR. A second MICA unit was called and also provided assistance.

36. After about 36 minutes of CPR, resuscitation attempts were ceased and Rob was declared deceased at 21.38 hours.

Concurrent Evidence

37. I convened a panel of experts to give concurrent evidence at the inquest, and to answer a set of directed questions. Those experts were Dr Yeliena Baber, forensic toxicologist and manager of the VIFM toxicology laboratory Dr Dimitri Gerostamoulos, cardiologist Neil Strathmore and clinical toxicologist and emergency physician Professor Andis Gaudrins.

38. I have outlined the questions posed and answers given below:

(1) Can the following drugs cause death and if so, what are regarded as fatal amounts, ante mortem compared to post mortem: Amitriptyline; Venlafaxine; Quetiapine; Tramadol.

The panel members agreed that each drug had the potential to be toxic and can be regarded as fatal but there are no specific toxic levels that are considered fatal for each of these drugs in isolation, in the post-mortem setting.

(2) *Assuming post mortem amounts, what would be the likely effect(s) of the following drugs in Mr Ferrier's system, singularly and in combination? a. Amitriptyline (0.4 mg/L); b. Venlafaxine (1.1 mg/L); c. Quetiapine (0.2 mg/L); d. Tramadol (0.4 mg/L).*

Professor Graudins noted that amitriptyline is a cyclic antidepressant and in overdoses tends to cause a stepwise toxicity. That is, early on in toxicity, patients may present with signs of a very fast heart rate, a dry mouth, a little drowsiness and exhibit signs of what is referred to as anticholinergic toxicity. He said that normally in significant overdoses of amitriptyline, toxicity progresses relatively quickly over a period of one to two hours from that early phase to gradual reduction in level of consciousness which then continues and may be associated with decreased respiration which is then often associated with low blood pressure and may be associated with seizures. In cases where treatment is not administered, this may be associated with death.

With respect to venlafaxine, another type of antidepressant, which in large doses Professor Graudins said can also initially cause a fast heart rate. He said it may cause high blood pressure and, as blood concentrations increase, it can cause seizures. He also said that it can cause serotonin syndrome on its own as well as in synergistic interaction with other drugs. The level of venlafaxine found in Rob was considered above therapeutic levels with a consistent with a degree of toxicity.

Quetiapine is an atypical antipsychotic drug which also causes a fast heart rate in overdose. Professor Graudins said it can cause low blood pressure and a delirium or confusion as well as agitation. The concentration in this case was however was relatively low but still above the therapeutic range.

Professor Graudins said that tramadol is a pain relieving medication which acts on similar receptors to morphine, but it also has other effects on serotonin receptors. It can result in depression of the respiratory drive, depression of level of consciousness and seizures, and also has the potential to cause serotonin syndrome, particularly in combination with other drugs such as venlafaxine. The level of tramadol in this case was low.

(3) *What do the Ambulance Victoria ECG/rhythm strips demonstrate about Mr Ferrier's presentation and its likely causes: a. in the period 20.38 to 20.59; and b. in the period from 21.00 to 21:39?*

Professor Strathmore observed that in the first period represented on the ECG strips, the cause of the observed cardiac rhythms was not completely clear. It could be a 'normal rhythm that one would see if a person without cardiac illness had been running or exercising, or if you they were particularly anxious or particularly agitated. He said that the rhythm would also be consistent with tricyclic antidepressant overdose, particularly in the presence of amitriptyline. With respect to ECG strips from 21.13 to 21.22 and then 21.30 to 21.38, Professor Strathmore said that they show changes and/or artefact changes that would be consistent with the performance of cardiopulmonary resuscitation.

(4) *What are the symptoms of, and was Mr Ferrier's clinical presentation consistent with, amitriptyline intoxication (or tricyclic antidepressant overdose)?*

See question 2. It was agreed by the panel members that Rob exhibited all those symptoms.

(5) *How long does it take for the onset of symptoms following amitriptyline intoxication (or tricyclic antidepressant overdose)?*

See question 2.

(6) *What is the appropriate field treatment of amitriptyline intoxication (tricyclic antidepressant overdose)?*

Professor Graudins said that this depends on the phase of toxicity the patient is in. In the early phase, where a patient may just be mildly agitated and drowsy, it would be appropriate to get that person to hospital relatively quickly, if transport times would be relatively short. If however, the patient was to present with significant signs of toxicity, such as particularly low level of consciousness or low blood pressure, it would be appropriate to protect the patient's airway, to intubate them and to ventilate them. Then to be guided in clinical management by their ECG and blood pressure. If they have a widened ECG, particularly a widenced QRS interval on ECG, they may need intravenous sodium bicarbonate. If they have a low blood pressure, that may respond to intravenous fluids or may need to be treated

with catecholamines such as adrenalin, or noradrenalin, and if they have seizures they may need intravenous midazolam and/or other anti-convulsants.

(7) *What are the symptoms of, and was Mr Ferrier's clinical presentation consistent with, serotonin toxicity (syndrome)?*

(8) *How long does it take for the onset of symptoms following the occurrence of serotonin toxicity (syndrome)?*

(9) *What is the appropriate field treatment of serotonin toxicity (syndrome)?*

The Panel noted that typical symptoms of serotonin toxicity syndrome include neuromuscular effects of which clonus (repeated jerking movements) is the most reliable. Other are hyper-reflexia and muscle rigidity, autonomic nervous system effects such as sweating; dilated pupils and central nervous system effects – none of which were noted in Rob's case. Other symptoms such as delirium and agitation could however be said to have been present. However, despite the presence of the latter, the panel agreed that serotonin syndrome wasn't a feature of this case.

It was noted by panel members that serotonin toxicity syndrome is an idiosyncratic syndrome and as such it is very hard to predict how it will happen or when it will happen, but when it does happen, it was agreed that supportive treatment is indicated.

(10) *Was Mr Ferrier's condition survivable? If so, (a) At what time? (b) in what clinical or treatment circumstances?*

The response to this would depend on the point of time (or phase of toxicity) that Rob had presented to a hospital, and in particular, if he had arrived in hospital prior to going into cardiac arrest, survival would have been possible.

(11) *How long should attempts to resuscitate Mr Ferrier have continued?*

Professor Graudins noted that in cases of cardiac arrest caused by reversible drug overdose, "prolonged" CPR (two hours not being unreasonable) and other resuscitative measures can be of benefit, since the drug can effectively be metabolised out of the heart, allowing drugs that have been administered to counter the effects of the toxicity (such as sodium bicarbonate), an opportunity to take effect.

However, Professor Graudins acknowledged that the longer CPR progresses, the greater the risk of brain hypoxia being suffered by the patient. In addition, this aspect of his evidence

was primarily directed to the hospital setting, where effective CPR can be provided over a prolonged period. However, he also maintained that it would have been desirable in a *perfect world*, for CPR to continue in the back of the ambulance, while Rob was transferred to hospital for ongoing management.

(12) What part, if any, did the use of restraints play in Mr Ferrier's death?

The evidence was unclear as to precisely what role the restraint played in Rob's death, although it was sufficiently manifest for Dr Baber not to extricate it from the cause of death.

(13) Apart from the four drugs already referred to and the use of restraints, were there any other factors which can be said to have played a part in Mr Ferrier's death?

No other factors were identified.

(14) What was Mr Ferrier's medical cause of death?

The panel of medical experts all agreed that the medical cause of death was appropriately formulated by Dr Baber as drug toxicity in a setting of restraint.

The appropriateness and affect of Rob's restraint in the context of his death

39. A statement was provided by Acting Inspector Daniel Baynes regarding the use of force and he noted that, whilst the existing Victorian procedures contemplate the use of force in the context of criminal and mental health responses, rather than medical emergencies, *Victoria Police Manual – Policy Rules – Operational safety and equipment*[7] provides that '*Police members are to protect themselves and the public while fulfilling their duties and, to do this effectively, they may need to use force.*' He further noted that the use of physical force should be seen as a last resort to contain the situation and to ensure the safety of the person concerned and any the other people present.

40. Having considered all the evidence, I am satisfied that the circumstances required that Rob be restrained and that the manner in which he was restrained by both Victoria Police members and Ambulance Victoria officers, was reasonable and proportionate in all the circumstances.

41. I accept the submissions made on behalf of Ambulance Victoria that matters relevant to the determination of this issue are that:

(a) Rob suddenly became very violent;

[7] 21 January 2013

(b) Mr Donovan and Senior Constable Vosbergen both feared for their own and each other's safety at that time;

(c) Rob was of large build (weighing some 106 kgs) and he and the ambulance paramedics and a police officer were all struggling in the very cramped space which comprised the back of an ambulance vehicle;

(d) The location where Rob was attempted to be restrained in the ambulance was very close to the Nepean Hwy, a busy, high speed road. I note Mr Marshall's evidence in this regard – *'At the time I thought we're on Nepean Highway, the speed zone is - speed limit is 80 kilometres an hour. We've got high speed moving traffic. If he exits the vehicle he's going to exit into - I'm familiar with the area - he would have been exiting into a dark - a dark reserve. And in his state I imagine he would probably want to head for the light, which is the road. So the road is well lit. The reserve to the side of the ambulance is dark. I pictured him not heading to the safety of the reserve but rather into the - the roadway. And I just thought I cannot let him leave that ambulance.'* and

(e) The police officers and the paramedics all realised that Rob was very unwell and required medical treatment as soon as possible.

The provision of medical care to Mr Ferrier

42. Further, I accept the submission made on behalf of Ambulance Victoria that the medical care provided to Rob was appropriate. In particular, Counsel noted that the following evidence was unchallenged:

(a) Having received the reports of a drug overdose prior to their arrival at the scene, it was essential for the paramedics to asses Rob, prior to deciding on a plan of treatment for him;

(b) Each of the paramedics who attended recognised the potential urgency of the situation that faced him, in particular, the potential for cardiac complications from the overdose of tri-cylcic anti-depressants;

(c) Once ECG changes were noted, those findings along with Rob's vital signs were communicated as a "sit rep" *via* the ESTA communications centre. The MICA paramedic immediately became aware of those findings. The MICA 2 responder had already been dispatched Code 2 at this time, was subsequently upgraded to Code 1

and was at the rendezvous point within minutes of the initial ambulance departing the scene. At all relevant times, all of the paramedics treated Rob as if he had taken an overdose of TCA medication;

(d) All paramedics recognised the desirability of inserting an IV cannular, in anticipation of the need to administer sodium bicarbonate and other drugs to reverse the toxicity. However, all present said that by reason of Rob's increasing agitation, at no stage from when the assessment commenced, until the rendezvous with the MICA 2 responder, did paramedic Donovan have an opportunity to insert an IV cannula;

(d) Within minutes of the rendezvous with the MICA paramedic, Mr Marshall, Rob became increasingly aggressive and ultimately violent, leading to the struggle that ensued. The evidence indicated that from that point, the focus was, appropriately, on calming or sedating Rob in order to treat him and ultimately, to transport him to hospital as quickly as possible;

(e) At no stage from when he first saw and began to assess Rob, until he collapsed, did Mr Marshall have an opportunity to insert an IV cannula;

(f) Once Rob went first into respiratory and then into cardiac arrest, the paramedics appropriately focussed on resuscitation and stabilisation. This included performing CPR and ventilating Rob, insertion of an IV cannula, calling for an additional MICA paramedic "Code 1", administering drugs to assist with the cardiac arrest (sodium bicarbonate, saline and adrenaline) and ultimately, intubating Rob to protect his airway;

(g) CPR and ventilation continued for a total of 36 minutes. The paramedics all realised that in certain cases (including drug overdose), Ambulance Victoria protocols provided for resuscitation to be continued beyond the 30 minutes usually stipulated. For that reason, they continued resuscitation for about six more minutes;

(h) During the entire period of the cardiac arrest, Rob had been in pulseless electric activity (PEA) or asystole. This meant that the only distribution of oxygen his brain and other organs, was *via* cardiac compressions; and

(i) At present, ambulance paramedics' training as to when further resuscitation may be futile, includes a consideration of the likely brain hypoxia which may result from prolonged CPR in a setting of PEA or asystole. In those circumstances, after 36

minutes of resuscitation, the MICA officers at the scene determined that Rob was deceased and that further resuscitation efforts would be futile.

Extended CPR

45. It is clear from the evidence (particularly of Professor Graudins) that, wherever possible, CPR should be ongoing as the patient is transported to hospital by ambulance.

46. In the circumstances of this case, extreme conditions existed which made administering CPR in the back the moving ambulance extremely difficult, if not impossible. I note there are risks to the safety of the patient and other occupants of the ambulance from unrestrained personnel, should a sudden stop or manoeuvre occur. There are risks to unrestrained personnel from falling against equipment or other people within the ambulance, in the same circumstances (in addition, potential for an unrestrained person to fly through the windscreen of an ambulance in the event of an accident or sudden stop). There is difficulty of co-ordinating the rotation of persons giving compressions in order to guard against fatigue, thus interfering with the efficacy of the CPR as well as the less than ideal position that the person giving compressions would occupy within the ambulance, meaning that CPR would be less effective. In addition, CPR carried out on an ambulance stretcher is less effective because the stretcher is a soft surface.

47. Professor Graudins agreed that each of these matters presented difficulties for the paramedics involved in the circumstances of this case.

The CHEER trial

48. Evidence arose during the course of the inquest regarding the existence of the CHEER trial. This trial, conducted at the Alfred Hospital, involved the use of a mechanical CPR device known as an "e-CPR". There was however no evidence to suggest that this device ought to have been used in Rob's case on 13 February 2013.[8]

49. I note that the efficacy of the e-CPR and its use in future remains to be assessed and this is a matter that will be considered by the appropriate bodies in accordance with the trial objectives and evaluative process.

[8] A criteria, at the time, was that the heart rhythm is ventricular which never occurred in this case. I note that consideration was given to using the device by the attending MICA paramedics but the situation was considered 'futile'.

Was Mr Ferrier's death a death in care or custody?

50. Proximate to this death, Rob was being restrained by the use of handcuffs applied by Victoria Police and leg restraints and waist strap applied by Ambulance Victoria. These restraints were clearly not for the purpose of arrest, but to facilitate urgent medical treatment. Nonetheless, his freedom of movement was effectively restricted.

51. A mandatory inquest is required pursuant to section 52(2)(b) of the Act if a death occurs *in care or custody* as defined by section 3 (eg. *a person in the custody of a police officer*). There is a broader discretionary power to hold an inquest into any death that a coroner is investigating.[9] In this case, as there was no controversy regarding the need for an inquest, I do not propose to determine whether the inquest was mandatory or discretionary by making a formal determination or ruling as to Rob's status immediately before he died.[10]

Mental Health History

52. In early December 2009, Cheree said that Rob suffered a 'complete medical breakdown' which she said had been building up for some time. She said: *'Thinking back I think this is the time that I lost Robert as a partner and event though I continued to love and support Robert he just never fully recovered and returned to the man I fell in love with.'*

53. In December 2010, Dr Carolyn Simms, Consultant Psychiatrist said: *'Psychologically Robert has struggled since being bullied at school and also in the context of his family of origin and the high expectations placed upon male members of the family.'*

54. Rob was subsequently referred to Dr Belinda Jude, Clinical Psychologist who said in April 2011, he *'is likely to have an underlying depressive personality...Rob has had a fixed negative belief system about himself which has centred on feelings of shame and worthlessness. We are slowly picking this apart and challenging the basis of his beliefs. He has come to realise his beliefs are actually based on nothing of substance but have served to punish and undermine his self-confidence and self-worth.'*

55. He was described by his medical practitioners as an attentive patient, who displayed insight and followed all of their recommendations.

56. I note that on and off during this period, Rob did suffer suicidal ideation but said that he would never act on those thoughts because of his family and partner.

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[9] See section 52(1) of the Act.

[10] Or alternatively within the meaning of custody at common law.

57. On 7 February 2013, Rob saw Dr Harvey and whilst he presented as 'flat', she said he totally dismissed any suicidal thoughts and whilst he felt flat but he was 'not that bad.'

58. There is nothing in the evidence before me that on 13 February 2013, it was Rob's intention to end his life.[11]

General comment

59. It should be stressed that both police and ambulance officers who responded to calls for assistance were attending a medical emergency. Before their involvement had even been contemplated, Rob had ingested an excessive quantity of prescription medication and set in train a series of events that placed his life in danger and would culminate in his death.

60. The evidence supports a finding that the police and attending paramedics treated Rob with dignity and that the paramedics applied their significant skills towards saving his life.

61. Both Cheree and Julie were present during the course of the inquest into Rob's death. They also thanked participants for all their efforts to try and save Rob.

62. Cheree said at the conclusion of the evidence:

'The behaviour of the man Your Honour has heard discussed over the past two days was atypical and bears very little resemblance to the man we knew and love. You've seen a picture of Rob experiencing a mental health crisis whilst in a chemically altered state on the worst moment of the worst day of his life but this is not representative of the life he led as a loving and supportive partner, father, son, uncle, brother, friend and a St Kilda supporter.'

CONCLUSIONS

63. Having considered all the evidence, I find that Robert Peter Ferrier born on 4 July 1965, died in Martin Street, Brighton, on the 13 February 2013 of drug toxicity in the setting of restraint. Whilst I find that he ingested the drugs as an act of deliberate self-harm, I am not prepared to find that he did so with the intention of taking his own life.

64. I further find that the evidence supports a finding that the responding police officers and paramedics acted professionally towards Rob and in accordance with the standards of their respective professions. To the extent that restraint or force was used, they did no more than was reasonable and proportionate in all the circumstances, and are to be commended for the

[11] In fact the evidence is that he tried to vomit the drugs he had ingested.

manner in which they conducted themselves in difficult circumstances, and also at the inquest.

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

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

- Ms Cheree Smith
- Ms Julie Muldoon
- Ambulance Victoria, c/o their solicitors Lander & Rogers
- The Chief Commissioner of Police, c/o the Victorian Government Solicitor
- Detective Senior Sergeant Gerard Clanchy, c/o O.I.C. Homicide Squad, Victoria Police
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Signature:

PARESA ANTONIADIS SPANOS
Coroner

Date: **1 July 2015**