IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 002178

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Jarryd Robert Liddicoat

Findings of:	Coroner Kate Despot
Hearing Dates:	1 February 2023
Delivered on:	13 October 2023
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006

Representation

Counsel Assisting	Lindsay Spence Principal In-House Solicitor Coroners Court of Victoria
Chief Commissioner of Police	Kathleen Crennan of Counsel instructed by MinterEllison
Keywords:	Police operational safety and use of force, police operation safety equipment, police statutory power

BACKGROUND

1. Jarryd Robert Liddicoat was born 14 October 1988 and passed away on 27 April 2021, aged 32 years, at the United Petroleum Service Station, Cranbourne during Victoria Police Officers apprehending and handcuffing him. Officers had observed Jarryd walking into the path of oncoming traffic on High Street and held concerns in respect of Jarryd's erratic behaviour and presentation, causing them to apply handcuff restraints following concerns for his, theirs, and the safety of the general public.

2. Jarryd and his long-term partner, Carolyn Miller, had been in a relationship for the past fourteen years and had three children together. At the time of his passing, Jarryd was living in Wonthaggi and Inverloch. Within her coronial impact statement, Carolyn described Jarryd as '*so many things to so many people. A loving son, a brother, a partner, a devoted father and an incredible friend … … Jarryd was passionate about cars, a passion that he passed onto our two sons. Our daughter was an angel in his eyes, they were the best of friends. I've heard you only have one true love in life, Jarryd was mine. He guided me for so many years, teaching me to always be strong*'.

3. Approximately fifteen months prior to his passing, Jarryd started using 'ice' (methylamphetamine) resulting in him becoming '*increasingly paranoid*'.

CORONIAL INVESTIGATION

Jurisdiction

4. Jarryd's death constituted a 'reportable death' pursuant to s 4(2)(c) of the *Coroners Act 2008* (Vic) (**Coroners Act**), as his death occurred in Victoria and immediately before his death, Jarryd was a person placed in custody (being a person in the custody of a police officer). Accordingly, pursuant to s 52(2)(b) of the Coroners Act, an inquest was mandatory.

Purpose of the Coronial jurisdiction

5. The jurisdiction of the Coroners Court of Victoria (Coroners Court) is inquisitorial.[1] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[2]

6. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

7. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

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

9. Coroners are empowered to:
   - 9.1. report to the Attorney-General on a death;
   - 9.2. comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and
   - 9.3. make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[3]

   These powers are the vehicles by which the prevention role may be advanced.

10. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of

[1] Section 89(4) Coroners Act.
[2] Preamble and s 67 Coroners Act.
[3] Sections 67(3), 72(1) and (2) of the Coroners Act.

an offence.[4] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[5] However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death.[6]

Standard of proof

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[7] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[8]

12. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[9] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

13. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[10] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[11]

Inquest

14. The inquest was conducted on 1 February 2023 with the Chief Commissioner of Police represented by counsel. Jarryd's family attended the inquest remotely and Jarryd's partner, Carolyn Miller made a Coronial Impact Statement at the conclusion of the hearing. This

[4] Section 69(1) of the Coroners Act.
[5] *Keown v Khan* (1999) 1 VR 69.
[6] See ss 69(2) and 49(1) of the Coroners Act.
[7] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[8] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to s 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[9] (1938) 60 CLR 336.
[10] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[11] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

statement was deeply moving and emphasised the significant and ongoing impact this tragic event has had on the family. I acknowledge and thank Jarryd's family for their attendance at the inquest, in what were very challenging and difficult circumstances.

15. This finding draws on the totality of the material obtained in the coronial investigation of Jarryd's death: the coronial brief prepared by Detective Sergeant Brendan Devenish of the Homicide Squad; further material obtained by the Court; transcript of the evidence and submissions adduced at the inquest; and the written submissions of counsel filed on behalf of the Chief Commissioner of Police.

16. In addition to the statements of the Victoria Police Officers involved in the circumstances of Jarryd's passing, I also have available numerous multimedia sources including Body Worn Camera recordings from both First Constable Harris and First Constable Rollo; dashcam footage of a fuel tanker that was stationary within the United Service Station; and dashcam footage of a taxi that was exiting the United Service Station. Having carefully evaluated all of these sources of evidence, I am satisfied there is an internal consistency between the statements of the Officers and the multimedia recordings. There were no significant factual conflicts within the evidence and upon that basis, I was satisfied this matter could proceed to inquest, without the calling of witnesses.

17. In writing this finding, I do not purport to summarise all the material evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased: s 67(1)(a) of the Coroners Act

18. On 29 April 2021, Jarryd's identity was confirmed through fingerprint identification undertaken by the Forensic Services Department, Victoria Police.

19. Identity is not in dispute and requires no further investigation.

Cause of death: s 67(1)(b) of the Coroners Act

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20. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine **(VIFM)**, conducted an autopsy on Jarryd's body and provided a written report of her findings. Postmortem examination revealed:
    20.1. Multiple fractured ribs (consistent with CPR).
    20.2. Catecholamine-induced inflammation in the heart.
    20.3. No significant trauma identified.
    20.4. Neuropathology found no evidence of established significant traumatic brain injury.

21. Toxicological analysis identified the presence of amphetamine and methamphetamine at toxic levels.

22. Dr Parsons within her report made the following relevant comments:
    22.1. The deceased was acting erratically prior to police arrival, likely due to the very high level of methamphetamine in the blood. Life threatening reactions to methamphetamine can occur. These include agitation, fever, aggression and violence, these can rapidly lead to very high body temperatures with elevated heart rate and blood pressures. Irregular heart rate (arrhythmia) is possible at high concentrations particularly on exertion or in times of stress.

    22.2. Excessive stimulation through violent behaviour, excessive exertion (such as running) or stress will also release noradrenaline in the heart and also adrenaline from the adrenal glands. Adrenaline is a catecholamine related closely to noradrenaline. The combined effects of these situations can lead to arrhythmias and cardiac arrest.

    22.3. At autopsy the deceased had evidence of significant coronary artery disease and myocardial fibrosis. This is in keeping with a diagnosis of ischaemic heart disease.

22.4. Ischaemic heart disease is the generic definition of a group of closely related disorders resulting in myocardial ischaemia. Myocardial ischaemia is the imbalance between supply (perfusion) and demand of the heart for oxygenated blood. In the vast majority of cases this is due to coronary artery disease as we see here. People with ischaemic heart disease are at an increased risk of sudden death usually due to cardiac arrhythmia.

22.5. Recent reviews of prone positioning in police arrest have postulated that prone positioning in agitated people can lead to metabolic acidosis and a decrease in cardiac output leading to a cardiac arrest. A contribution of restraint to the cause of death can therefore not be excluded. However, given the short duration of the prone positioning (less than a minute), the toxic levels of methamphetamine in his blood and the significant heart disease are considered to be the cause of death/arrythmia in this case.

22.6. The information received suggests that the deceased has staggered and fallen forwards into a prone position just prior to his death. On the video footage he appears to stagger forward into a prone position, he does not appear to hit his head. At autopsy there was no evidence of significant head injury or any other injury that would have caused or contributed to death.

23. Dr Parsons concluded that the cause of death was:

1(a) METHAMPHETAMINE TOXICITY IN A MAN WITH ISCHAEMIC HEART DISEASE.

Circumstances in which the death occurred: s 67(1)(c) of the Coroners Act

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24. On Tuesday 27 April 2021, approximately 9.10pm, Jarryd was driving a white Holden Commodore south along High Street towards the South Gippsland Highway when, at the intersection with Sladen Street, he entered the intersection against a red traffic control signal

and impacted a white Mitsubishi Outlander that was travelling west. Minor front-end damage was occasioned to the Mitsubishi Outlander however the Holden Commodore post-collision has collided with a light signal pole causing major damage to the rear of the vehicle and rendering it undriveable.

25. Approximately 9.16pm Senior Constable Davies and Constable Ford (Endeavour Hills 303) received a tasking to attend the motor vehicle collision, arriving at 9.24pm. Upon their arrival they spoke with the driver of the Mitsubishi Outlander who informed them Jarryd had not exchanged details with her. Witnesses then identified Jarryd as the driver of the other vehicle who at that time was standing outside the entrance to the Cranbourne Police Station.

26. Constable Ford approached Jarryd and asked him if he was the other driver involved in the motor vehicle collision with Jarryd saying '*I've already self-reported to the police in here*' and has then started walking away from Constable Ford and has entered the Police Station. The subsequent interaction with Constable Ford is captured on CCTV within Cranbourne Police Station (Exhibit 27) and identifies no concerns, at that time, in respect of how Jarryd was presenting.

27. Constable Ford confirmed with First Constable Gopalan who was on watchhouse duties at the time that he was in the process of taking a report from Jarryd. In further discussions Jarryd then informed First Constable Gopalan that he was at fault as he had run a red traffic control signal. Jarryd provided First Constable Gopalan his driver's licence and then made a number of telephone calls walking out of the Police Station. A preliminary breath test was administered with Jarryd returning a negative result. A preliminary oral fluid test for illicit drugs was not undertaken. Following this Jarryd returned outside of the Police Station and First Constable Gopalan returned to watchhouse duties.

28. During this interaction in First Constable Gopalan's opinion '*I had no concerns for his physical or mental health, LIDDICOAT had no visible injuries and was not showing any signs of distress. He seemed a little heightened, but I thought it was due his recent car accident*'. By that time Constable Ford had returned to the collision scene and organised tows for both vehicles involved. As they were driving away from the scene after clearing

the incident, they sighted Jarryd and pulled up alongside to have a conversation with him. At that time '*Jarryd threw his arms up and said 'If you're not going to help me you can fuck off, why'd you tow my car?*' with Constable Ford explaining it had to be removed as it was undriveable and a traffic hazard. Jarryd then walked off.

29. At 9.52pm Jarryd called Triple Zero to report the collision that had previously occurred. When asked by the operator '*So are police there at the moment?*', Jarryd replied '*Yeah, but I don't wanna talk to 'em*'. Jarryd was then informed by the operator '*I'm not able to contact the police station on your behalf. If you're there at the moment, can you go and talk to the police who are there*'.

30. Approximately 10.00pm Jarryd rang long-time friend and associate, Daniel Egan, and said '*he was stuck in Cranbourne and couldn't find anyone to come pick him up*'. Within that telephone call Jarryd indicated to Daniel to meet him on High Street between the Red Rooster restaurant and the United Petroleum Service Station. Daniel left his house and commenced to drive into Cranbourne however was at least half-an-hour away.

31. Approximately 10.05pm Jarryd is captured on CCTV walking north along High Street on the western side outside the Cranbourne Shopping Centre. Ten minutes later approximately 10.15pm Jarryd entered the United Petroleum Service Station, walked straight up to the front counter and said to the console operator '*Call the Dandenong cops, call the Dandenong cops*'. When the console operator questioned why, Jarryd replied '*there was a major accident in Cranbourne*'.

32. The console operator wrote down the phone number for the Dandenong Police Station on a piece of paper and gave it to Jarryd who picked up a silver chocolate bowl located on the front counter and threw it in the console operator's direction. Jarryd then started swearing at the console operator, told him to '*fuck off*' and then walked out of the premises.

33. At 11.00pm Jarryd is next captured on CCTV walking further north along High Street outside Red Rooster. At 11.25pm he is then captured on CCTV at the YPA Real Estate Agency running hard west along the adjacent Walter Street.

34. First Constables Harris and Rollo were rostered from 6pm on the Narre Warren divisional van (callsign Narre Warren 306). That shift First Constable Harris was the driver and First Constable Rollo was the observer.

35. Approximately 11.30pm First Constables Harris and Rollo were patrolling High Street, Cranbourne in their vehicle when they observed Jarryd '*stumbling along High Street on the side of the road in Cranbourne. When I say side of the road, I mean he was on the road, on the white edge line. The male appeared drug affected, appeared aggressive, and armed with a metal bottom of a road or street sign. The male appeared heavily agitated, swinging the metal pole around, mumbling, talking to himself*'.

36. Due to concerns that either Jarryd would stumble into oncoming traffic and get hit, or alternatively throw the pole at a passing vehicle, First Constable Harris conducted a u-turn and approached Jarryd whilst remaining within their vehicle. As they approached First Constable Harris observed that Jarryd was sweating heavily. In First Constable Rollo's opinion '*he appeared to be severely drug or alcohol affected. I formed this opinion because his movements were erratic, he was swinging his arms in an unpredictable manner. He was stumbling and staggering on his feet, he struggled to walk in a straight line*'.

37. Upon sighting the Victoria Police members approaching, Jarryd dropped the pole on the ground and said something similar to '*fuck off pigs*'. First Constable Harris engaged Jarryd in conversation and asked him to walk up onto the footpath and to stay away from the road and traffic. This appeared to have some result, Jarryd walked down the slip lane and along there for a short distance, mumbling and swinging his arms around.

38. First Constable Harris followed in the divisional van and asked Jarryd for his name which he provided as 'Jarryd'. When asked for his surname he replied '*whatever you want it to be*'. Jarryd then walked away from the slip lane, straight back onto the roadway. At this point the Police members were just north of the United Petroleum Service Station on High

Street. Jarryd '*continued walking in the middle of the road, very agitated, and walking into oncoming vehicles, mumbling and yelling things*'.

39. First Constable Harris at this time was driving behind Jarryd and had the red and blue lights of the divisional van activated. First Constable Harris '*saw a vehicle approaching from the south towards us and the male walked straight towards the vehicle. The vehicle stopped and went around the male and continued travelling north and didn't stop*'. Jarryd appeared to be ignoring all requests from First Constables Harris and Rollo to remove himself from the road and at one stage First Constable Harris activated a short burst of the siren in an attempt to get Jarryd's attention.

40. First Constable Harris observed that '*the male started to stumble worse and became very unsteady on his feet. He attempted to run from us into the United Service Station*'. First Constable Harris parked the divisional van to the left of the service station driveway and exited the vehicle.

41. Within her statement, First Constable Harris stated the following then occurred:

> *Upon exiting the vehicle , I observed the male stumble over the speed hump and land belly first. I said numerous times to the male, "stay on the fucking ground".*
>
> *The male was attempting to get up and making really loud grunting noises, which I thought were out of aggression. I told him more times to stay on the ground. The male continued to be aggressive in our presence and making lots of noises. I told the male to stay on the ground or I would gas him. I had my MK9 in my left hand.*
>
> *At this point the male kept reaching for pebbles from the garden bed for what I thought he was going to throw at us. The male got up and took a couple of steps before falling again to the ground in a garden bed with a couple of bushes and*

white pebbles. When the male fell to the ground, I said to FC ROLLO to cuff him. The male was still making a lot of noises on the ground and grabbing handfuls of pebbles. FC ROLLO went to his right and I went to his left and attempted to make a three-point hold and hand cuff him for his and our safety. When I say three-point hold, I mean a technique of placing a knee on their back/shoulder area and holding their arm behind their back to restrain them. My concern was that he was a risk to himself and the public due to the way he was presenting to police.

When the male fell into the garden bed he was on his belly and I don't believe he hit his head. In our attempt to three-point hold the male to cuff him, the male, to what I believe, was resisting and clenching his arms and fist. We asked the male to stop resisting and give us his hands. FC ROLLO requested on the radio for some backup. The male said to us to call the ambulance. I said, "yeah, we'll call you an ambulance". I thought he was requesting one because he was on drugs.

The male continued clenching his arms and fist to what I believed was resisting. The male was still making noises and talking to us at this time.

The male then grabbed numerous rocks in his hands which I thought he was going to flick at us. FC ROLLO had his right arm in the three-point hold. I managed to get his left arm and hand out and put it behind his back.

I said to FC ROLLO, "have you got him", as I handed him the wrist of the left arm. FC ROLLO held both of his arms while I got my handcuffs out of my pouch to handcuff him. As soon as he was handcuffed I said we'd get him into the recovery position, as that's what I do with everyone to avoid positional asphyxia.

He was handcuffed in a few seconds and turned onto his right side in the recovery position. At this point it appeared as though his eyes were closed and the male had stopped talking. I bent over and had a look at his face. I couldn't see him chest moving. FC ROLLO did a pulse check on his neck. We were talking to him with no response.

After a couple of checks I made the observation that the male appeared no longer responsive.

I came up on air and requested an ambulance as he had become unresponsive. This all happened very quickly.

I then noticed the male's legs go stiff whilst I was trying to hold him in the recovery position. FC ROLLO was checking for a pulse and if the male was breathing. I noticed that the male's face turned purple and red and FC ROLLO said "I don't think he' s breathing".

I then said "let's get the cuffs off' and we started to immediately do that. Whilst we were removing the cuffs, the Cranbourne 306 unit arrived and I very briefly told the Cranboume unit what had happened as we continued to check for a pulse and if the male was breathing.
We were giving lots of updates on the radio. As I was giving updates, the four of us tried to roll him onto his back so we could commence CPR. It took us some time to roll him over due to his size, but we were trying our best. His head was near a pole and I was very conscious and cautious of that and made sure that we weren't forcing his head onto the pole or anything like that.

Once we made sure he was on his back, a Senior Constable from the Cranbourne unit commenced CPR.

42. The above events were captured from numerous sources including the dashcam of a fuel tanker that was stationary within the service station, the dashcam of a taxi that was exiting the service station, and the Body Worn Cameras of both First Constables Harris and Rollo. During my investigation, and in making these findings, I have extensively reviewed all of this multimedia footage, in addition to considering the statements from the Officers involved.

43. First Constable Harris ran into the United Petroleum Service Station and asked the console operator for the location of a defibrillator however was informed the service station didn't have one. A short time later Fire Rescue Victoria arrived on scene and assisted with CPR and attempted defibrillation followed by Ambulance Victoria. Despite extensive efforts from all emergency services on scene, Jarryd was unable to be revived and was declared deceased at the scene.

44. A Critical Incident was immediately declared, and crime scene established with both First Constables Harris and Rollo undergoing mandatory critical incident drug and alcohol testing. An investigation into Jarryd's death was commenced by the Victoria Police Homicide Squad overseen by the Professional Standards Command.

COMMENTS

I make the following comments connected with the death under section 67(3) of the Act:

Was the application of handcuffs lawful, proportionate and reasonable in the circumstances?

45. Given the proximity of the application of handcuffs to Jarryd's passing, I formed the opinion it was necessary for me to consider the precise basis upon which they were applied, and further whether their application was lawful and reasonable in all the circumstances.

46. The *Victoria Police Manual – Operational Safety Equipment* states the following (in part):

    46.1. *Members and PCOs are expected to protect themselves and the public while fulfilling their duties. To do this effectively, they may need to use force*.

46.2. *The use of force, including the use of OSE, must be in accordance with specific legal requirements (eg. legislative provisions or common law).*

46.3. In respect of handcuffs specifically, the VPM states that *members and PCO must comply with the following instructions – Handcuffs – any person arrested or taken into custody should be handcuffed* ***if it is reasonably believed to be necessary in the circumstances*** (my emphasis).

47. Firstly there is no evidence from either First Constables Harris or Rollo that Jarryd was ever placed under arrest. Their statements are silent in respect of whether they ultimately intended to arrest him. However what there was, was a clear concern for the welfare of Jarryd, themselves and the general public:

47.1. First Constable Harris within her statement indicates '*the male continued walking in the middle of the road, very agitated, and walking into oncoming vehicles, mumbling and yelling things. I saw a vehicle approaching from the south towards us and the male walked straight towards the vehicle. The vehicle stopped and went around the male and continued travelling north and didn't stop. The male started to stumble worse and become very unsteady on his feet*'. I note the First Constable's observations are captured on the relevant dashcam footage referred to previously.

47.2. First Constable Harris then makes reference to Jarryd '*attempting to get up and making really loud grunting noises, which I thought were out of aggression. I told him more times to stay on the ground. The male continued to be aggressive in our presence and making lots of noises … … the male kept reaching for pebbles from the garden bed for what I thought he was going to throw at us*'. Ultimately First Constable Harris expressed the view '*my concern was that he was a risk to himself and the public due to the way he was presenting to police*'.

47.3. First Constable Rollo likewise expressed in his statement that he had formed the opinion that he held welfare concerns for Jarryd, that he was '*likely on drugs, this was causing him to be aggressive and walk on the road'*. First Constable Rollo formed the belief that handcuffing Jarryd was necessary on the basis of three identified factors:

(a) His physical size; and

(b) His erratic behaviour, speech and movements; and

(c) His level of aggression.

47.4. Further First Constable Rollo stated that '*I believe that the restraint of this male was required to allow ambulance to safely assess him, had we not taken action to restrain him he would have continued to walk on the roadway and endanger himself and others*'.

48. On this specific issue, and to assist my investigation, a response was sought from the Chief Commissioner of Police, in respect of both the applicable policies *and* law that were relevant to the decision to handcuff Jarryd.

49. In addition to the excerpts of the *Victoria Police Manual* previously referenced, I was also referred to the *Victoria Police Manual – Operational Safety and the Use of Force* that includes within its operational response principles, '***Safety*** *– while providing a policing service our members will, as far as practicable, identify hazards and mitigate risks to themselves and others. This is consistent with the requirements of the Occupational Health and Safety Act 2004'.*

50. The Chief Commissioner submitted ultimately that the handcuffing of Jarryd was lawful, proportionate and reasonable in all the circumstances, as:

50.1. Before Jarryd was handcuffed, he was observed by the First Constables to be drug affected and acting in a manner in which he presented as a danger to himself, members of the public and the Officers themselves; and

50.2. Prior to using handcuffs, the First Constables used lesser invasive measures, including verbal direction, to secure Jarryd's cooperation which were considered to be ineffective; and

50.3. The First Constables had the statutory power to handcuff Jarryd in the circumstances as a use of force contemplated under the *Crimes Act* or alternatively '*bodily restraint*' contemplated under the *Mental Health Act*.

51. The Chief Commissioner submitted that section 458 *Crimes Act* provides that any person, whether a police officer or not, may at any time without warrant apprehend and take before a bail justice or the Magistrates' Court, any person found to be committing any offence (whether an indictable offence or an offence punishable on summary conviction) where it is believed on reasonable grounds that the apprehension is necessary for either:

    51.1. To preserve public order; or

    51.2. To prevent the continuation of the offence; or

    51.3. For the safety or welfare of members of the public or of the offender.

52. It was further submitted that sections 13, 15 and 17A *Summary Offences Act 1966* (which were in force at the time of Jarryd's passing) provided a power of arrest (without warrant), in particular section 15 that provided '*any person drunk, or drunk and disorderly in a public place may be arrested by a police officer*'.

53. Finally the Chief Commissioner referred to s462A *Crimes Act* that authorises a person to use force to effect the lawful arrest of a person, however the force used must not be disproportionate to the objective as the person believed on reasonable grounds to be necessary.

54. Ultimately I am satisfied having considered the statements of First Constables Harris and Rollo, and viewed their Body Worn Cameras as well as the independent dashcam footage, that they reasonably believed it to be necessary to use force and apply handcuffs to Jarryd on the basis of his physical size, erratic behaviour and presentation and the level of aggression they perceived. I accept the submission of the Chief Commissioner that the handcuffing of Jarryd was lawful, proportionate and reasonable in all the circumstances.

55. Finally, it must also be noted that Dr Parsons, the Forensic Pathologist who conducted the autopsy upon Jarryd's body opined the following within her post-mortem report:

> *Recent reviews of prone positioning in police arrest have postulated that prone positioning in agitated people can lead to metabolic acidosis and a decrease in cardiac output leading to a cardiac arrest. A contribution of restraint to the cause*

of death can therefore not be excluded. However, given the short duration of the prone positioning (less than a minute), the toxic levels of methamphetamine in his blood and the significant heart disease are considered to be the cause of death/arrythmia in this case.

Positional asphyxia and the appropriateness of the Officers' observations

56. The *Victoria Police Manual – Operational safety equipment* states the following (in part) in respect of restraint techniques and positional asphyxia:

56.1. Keep any person who is physically restrained under close observation. Take care to ensure the person is placed in and maintains a position that allows unrestricted breathing. If any restriction or impairment to respiration is observed or suspected immediately seek medical assistance.

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

56.3. Positional asphyxia occurs when a person is restrained in a manner that interferes with their normal breathing.

56.4. Application of OC aerosols or handcuffs in the presence of the following factors may increase the likelihood of positional asphyxia:

(a) extreme physical exertion, as occurs in a violent struggle, combined with illicit drugs, prescribed medication or alcohol intoxication;

(b) obesity;

(c) the presence of demonstrable natural disease, including mental illness and acute behavioural disturbance.

56.5. When using OC aerosols or handcuffs, prevent the possibility of positional asphyxia by ensuring subjects:

(a) do not have their face covered;

(b) are not left lying face down with their hands restrained behind their back.

57. Reviewing the Body Worn Camera footage of both First Constables Harris and Rollo identifies the following timings:

57.1. From the commencement of the process to handcuff Jarryd, 52 seconds elapsed prior to Jarryd's left arm being placed behind his back due to a significant level of resistance that delayed the handcuffing process;

57.2. Within 7 seconds of the handcuffs being closed, Jarryd was placed into the recovery position;

57.3. Within 10 seconds of Jarryd being placed in the recovery position the First Constables were aware that he was non-responsive and potentially not breathing and within another 16 seconds a request for Ambulance Victoria was broadcast;

57.4. Within the next minute the process to remove the handcuffs had commenced and efforts were being made to move Jarryd into a position where CPR could be commenced.

58. Having considered the conduct of First Constables Harris and Rollo, specifically:

58.1. Their awareness of the possibility of positional asphyxia; and

58.2. Minimising the opportunity for positional asphyxia by placing Jarryd into the recovery position at the earliest opportunity; and

58.3. Keeping Jarryd who was physically restrained under close observation; and

58.4. Immediately seeking medical assistance

I am satisfied that First Constables Harris and Rollo complied with the requirements of the *Victoria Police Manual* in respect of restraint techniques and positional asphyxia and I identify no concerns in respect of their conduct managing Jarryd after the handcuffs were secured.

FINDING

59. I find that Jarryd Robert Liddicoat passed away on 27 April 2021 at the United Petroleum Service Station, High Street, Cranbourne from methamphetamine toxicity in a man with ischaemic heart disease.

60. I order that this finding be published on the Internet in accordance with section 73(1) *Coroners Act* and in accordance with the Rules.

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

Carolyn Miller, Senior Next of Kin

Shane Patton APM, Chief Commissioner of Police

Professional Standards Command, Victoria Police

A/Senior Sergeant Brendan Devenish, Coroner's Investigator

Signature:

Coroner Kate Despot

Date: 7 December 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.