IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005749

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF REECE PULLEN

Findings of:	Coroner David Ryan
Delivered on:	1 December 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria, 3006
Inquest Hearing Dates:	30 November 2022
Counsel Assisting:	Katrina Sonneveld, Coroner's Solicitor, Coroners Court of Victoria
Chief Commissioner of Police:	Darren McGee, Victorian Government Solicitor's Office
NorthWestern Mental Health:	Jan Moffatt, DTCH Lawyers
Keywords:	Death in custody, police contact, mental health, suicide

I, Coroner David Ryan, having investigated the death of Reece John Pullen, and having held an inquest in relation to this death on 30 November 2022 at Melbourne, find that:

- the identity of the deceased was Reece John Pullen, born 30 August 1994; and
- the death occurred on 27 October 2021 from multiple injuries sustained in a fall from height.

I find, under section 67(1)(c) of the *Coroners Act 2008* (Vic) (**the Act**) that the death occurred in the following circumstances:

BACKGROUND

1. Reece grew up in Tasmania with his parents, Ricky and Melissa Pullen, and his four siblings.

2. Reece's father took his life in 2009. Melissa stated that "*Reece had struggled with his sexuality*" around this time which had led to some issues with his father prior to his suicide. Reece left school after he had completed Year 10 as a result of being bullied in relation to his sexuality. Melissa recalled that he "*started locking himself in his room and would only come out to shower and eat*". Reece was subsequently diagnosed with anxiety and depression and prescribed medication.

3. Between 2012 and 2017, Reece was employed at the RACV Hotel in Hobart. During this period, "*Reece seemed happy and enjoyed work and the social life that came with it*".

4. In May 2017, Reece decided to move to Melbourne as he considered that it would be a place more accepting of his sexuality. Soon after arriving in Melbourne, Reece consumed some ice[1] with a friend and subsequently experienced a drug-induced psychotic episode. He was admitted to the inpatient unit at Orygen Youth Health (**OYH**) in Footscray for treatment. About a week later, Reece returned to Tasmania with his mother.[2]

[1] Methamphetamines.
[2] Statement of Melissa Pullen dated 2 November 2021; Orygen Youth Health medical records.

5. Reece later returned to Melbourne in 2017 where he lived with extended family in Footscray. Unfortunately he suffered another drug induced psychotic episode and underwent a further admission to OYH between 10 and 14 October 2017 before returning to Tasmania to live with his grandmother.

6. Reece successfully moved to Melbourne on a permanent basis at the end of 2017 and secured employment with Melbourne Pathology. He moved into apartment 717 at 145 Queensberry Street in Carlton where he lived until his death. At the time of his death, he was living with two housemates.

7. Between 23 and 27 July 2018, Reece had a further admission to OYH. He had not been taking any antipsychotic medication since his last admission and was suffering from paranoia. After his discharge, he continued to receive treatment through NorthWestern Mental Health (**NWMH**) which included the administration of antipsychotic medication via depot injection.[3]

8. On 6 March 2021, Reece's housemates contacted Victoria Police and reported that he was behaving strangely. Police attended his apartment and observed that he appeared paranoid, and he advised them that he carried a knife to protect himself from groups of people who were going to "*slaughter*" him. He further informed police that he had consumed GHB[4] and ice a couple of weeks ago and expressed suicidal ideation. Police seized the knife and Reece subsequently agreed to be escorted by police to the Emergency Department at Royal Melbourne Hospital **(RMH**), where he was compulsorily admitted for treatment under the *Mental Health Act 2014* (Vic) (**MHA**). He was prescribed paliperidone during his admission and discharged on 9 March 2021 with follow-up from NWMH.[5]

9. Reece was voluntarily admitted to RMH between 20 and 25 March 2021 after ceasing his medication, consuming GHB and not attending appointments with NWMH. He became paranoid and had planned to jump from the 15th floor of his apartment building. Reece was reported to settle quicky in hospital with improved insight into his illness. His dose of

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[3] Statement of Melissa Pullen dated 2 November 2021. Orygen Youth Health medical records
[4] Gamma hydroxybutyrate.
[5] Statement of Constable Hugh O'Donnell dated 1 November 2021: Royal Melbourne Hospital medical records.

paliperidone was increased and he was assessed to have no acute risk of self-harm at the time of discharge. He was referred to NWMH for follow-up.[6]

10. Reece left his employment with Melbourne Pathology in March 2021 and then only had sporadic employment until his death. He had received some payments from Centrelink relating to restrictions on his employment opportunities as a result of the Covid-19 pandemic.[7]

11. Reece had a further voluntary admission at RMH between 19 and 30 August 2021 after experiencing paranoid delusions and suicidal ideation (planning to take an overdose of GHB). Reece's insight and judgment improved during his admission, and he was discharged on quetiapine and escitalopram with follow-up from NWMH.[8] During his admission, Reece reported that he was feeling down and spent most of his time in his room and did not speak to his housemates. He reported that he was worried about his lack of employment but was concerned about the impact of his psychotic symptoms.[9]

12. Melissa last spoke with Reece on his birthday on 30 August 2021. He told his mother that "*he had been struggling a bit and had been in hospital*" and was "*feeling suicidal*". He stated that "*he would spend the next couple of weeks trying to feel good before he started to look for a new job*". After 30 August 2021, Melissa tried on a couple of occasions to contact Reece on the phone, but he did not answer, and they exchanged a couple of text messages.[10]

13. Reece had a review with his psychiatrist from NWMH on 6 October 2021 where he reported feeling much better after his last admission to hospital. He denied any psychotic symptoms and reported that he remained abstinent from illicit drugs. It was planned to reduce his dose of quetiapine because he found it to be too sedating and to commence him

[6] Royal Melbourne Hospital medical records, Transition Discharge Summary dated 24 March 2021.
[7] Statement from Melissa Pullen dated 2 November 2021.
[8] Royal Melbourne Hospital medical records, Transition Discharge Summary dated 30 August 2021
[9] Royal Melbourne Hospital medical records, NorthWestern Mental Health Comprehensive Assessment dated 19 August 2021.
[10] Statement from Melissa Pullen dated 2 November 2021.

on aripiprazole. He was referred to a psychologist and agreed to contact the service if he experienced any psychosis or his anxiety worsened.[11]

14. Reece did not attend a scheduled appointment with NWMH on 17 October 2021. They reported that Reece's last contact with his treating team was on 21 October 2021, at which time there were no acute concerns for his mental health.[12]

THE CORONIAL INVESTIGATION

15. Reece's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as Reece resided in Victoria and his death was unnatural and arose from an accident or injury.[13] I infer from the evidence that, immediately before his death, Victoria Police were in the process of taking Reece into custody for the purpose of having him medically assessed[14] and I was therefore satisfied that an inquest into his death was required pursuant to section 52 of the Act. In the circumstances, I considered it appropriate to hold a summary inquest which occurred on 30 November 2022.

16. At the hearing, a summary of the evidence was provided to the Court by Coroner's Solicitor, Katrina Sonneveld. The individual witnesses who provided statements in the brief were not required to give evidence at the inquest as, after carefully considering all of the material in the brief, I was satisfied that there were no factual disputes or controversies which remained unresolved. The Chief Commissioner of Police and NorthWestern Mental Health were also given an opportunity to make submissions in relation to the evidence.

17. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[15] The role of the Coroner is to independently investigate reportable deaths to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[16]

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[11] Letter from Sally Cansdale to Rashmi Saluja dated 6 October 2021.
[12] Royal Melbourne Hospital Medical Records.
[13] *Coroners Act 2008*, section 4.
[14] *Coroners Act 2008*, section 4(2)(c); section 351 of the *Mental Health Act 2014.*
[15] *Coroners Act 2008*, section 89(4).
[16] *Coroners Act 2008*, preamble and section 67.

Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

18. It is not the role of the Coroner to lay or apportion blame, but to establish the facts.[17] It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation,[18] or to determine disciplinary matters.

19. The expression "cause *of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

20. For coronial purposes, the phrase "*circumstances in which death occurred*,"[19] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

21. 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 Court's "*prevention*" mandate.

22. Coroners are also empowered:

    a. to report to the Attorney-General on a death;

    b. to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    c. to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.

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[17] *Keown v Khan* (1999) 1 VR 69.
[18] *Coroners Act 2008*, section 69 (1).
[19] *Coroners Act 2008*, section 67(1)(c).

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

24. A directions hearing was held on 18 November 2021 at which it was confirmed that Victoria Police had assigned Sergeant Thomas McGowan to be the Coroner's Investigator for the investigation into Reece's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence which included relevant footage from the Body Worn Cameras (**BWC**) of members of Victoria Police.

25. This Finding draws on the totality of the material obtained in the coronial investigation of Reece's death, that is, the Court File, the Coronial Brief prepared by the Coroner's Investigator and further material obtained by the Court, together with a transcript of the Inquest hearing.[20]

26. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[21] 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.[22]

27. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[23] 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.

28. 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.[24] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs,

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[20] From the commencement of the Act, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the *Coroners Act 2008*.
[21] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[22] *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 section 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.
[23] (1938) 60 CLR 336.
[24] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

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.[25]

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

Identity

29. On 1 November 2021, Aaron McGuire visually identified the deceased as his cousin, Reece John Pullen, born 30 August 1994.

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

Medical Cause of Death

31. Forensic Pathology Fellow Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 28 October 2021 and provided a written report of her findings dated 4 November 2021.

32. Dr Zhou reviewed a post-mortem computed tomography (**CT**) scan, which revealed blunt force trauma to the skull and ribs, including multiple traumatic fractures, air within the cranial and chest cavities, and blood within the chest cavity.

33. Toxicological analysis of post-mortem samples identified the presence of aripiprazole,[26] paliperidone,[27] and quetiapine.[28] No alcohol or illicit drugs were detected.

34. Dr Zhou provided an opinion that the cause of Reece's death was 1(a) Multiple injuries sustained in a fall from height.

35. I accept Dr Zhou's opinion.

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[25] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.

[26] Ariprazole is an antipsychotic drug sold under the trade names Abilify, Abyraz and Tevaripiprazole, and can be taken as a tablet, oral solution, or intramuscular injection.

[27] Paliperidone is used in the treatment of schizophrenia and is supplied in extended-release tablets or intramuscular injections.

[28] Quetiapine is an antipsychotic available in normal- and extended-release tablets.

Circumstances in which the death occurred

36. On 27 October 2021 at about 10.29pm, Jye Todorov was inside his apartment at 77 Cardigan Street in Carlton. He looked across to the building at 145 Queensbury Street through his window and observed Reece standing on the balcony railing of his apartment. Mr Todorov called out to Reece and inquired "*Hey man, all good?*". Reece responded "*All good don't stress about it*". Mr Todorov went back into his apartment and contacted emergency services at 10.30pm to report his concern about Reece's behaviour.[29]

37. At around 10.44pm, Constables Alena Bazarkaia and Claire McCasker (Melbourne West 310) and Constables James Mioch and Caitlyn Matthews (Melbourne North 311) attended the scene and entered the laneway between the apartment buildings at 145 Queensbury Street and 77 Cardigan Street. The police members observed Reece seated on the balcony railing of his apartment on the seventh floor.[30]

38. Constable Mioch sought to engage with Reece and was able to obtain his name, date of birth and apartment number. Given the distance between them, communication was difficult but he "*gathered from what he said that he was struggling and wanted to kill himself*". Constable Mioch used his radio to inquire if police negotiators were available to attend and obtained Reece's agreement for police to go up to his apartment to speak with him.[31]

39. Constables Bazarkaia and McCasker gained entry to Reece's building and made their way to his apartment on the seventh floor. Before entering the apartment, Constable Bazarkaia contacted their supervising Sergeant, Damien Higgins (Melbourne West 251) to seek further instructions. He joined them shortly afterwards having already requested the attendance of the Critical Incident Response Team (**CIRT**) and Fire Rescue Victoria. Ambulance Victoria were also called to attend. It was agreed between them that Constable Bazarkaia would attempt to engage with Reece when they entered the apartment

[29] Statement of Jye Todrov dated 28 October 2021.
[30] Statement of Alana Bazarkaia dated 11 November 2021; Statement of Constable Claire McCasker dated 1 November 2021.
[31] Statement of Constable James Mioch dated 28 October 2021; BWC footage of Constable Alena Bazarkaia.

to identify "*what's going on*" and "*why he is suicidal*" and what may have happened to "*trigger it*".[32]

40. At around 10.58pm, Sergeant Higgins and Constables Bazarkaia entered the apartment. Constable Bazarkaia introduced herself to Reece while Sergeant Higgins and Constable McCasker spoke with his two housemates. Constable Bazarkaia situated herself at the door to the balcony and at Reece's request, she agreed not to come any closer. There was a distance of about three metres between them. Reece remained seated precariously on the railing of the balcony with a blanket wrapped around his shoulders and headphones around his neck.[33]

41. Reece told Constable Bazarkaia that he had been "*off and on*" his medication although he had taken a dose the previous evening but had not slept since the previous afternoon. He stated that he had not had any illicit drugs for the last six months although ice had "*ruined his life*". He also disclosed that his father had taken his own life. Further, he said that he was due to start a new job on Monday as a cleaner in a hotel, but there had been no particular trigger for his behaviour and that he had "*been feeling like this for a long time*". He said "*I know exactly what is going to happen. You guys will take me to the hospital and I'll be admitted to a psych ward and it doesn't help*" and later "*the doctors say its psychosis but I don't believe it is*".

42. Constable Bazarkaia established a compassionate rapport with Reece and asked him about his medical history, family and employment. She also sought to divert Reece from fixating on suicidal thoughts by inquiring about his interests, including music and travel, and encouraging him to focus on the future.[34]

43. At around 11.13pm, while Constable Bazarkaia was engaging with Reece, Senior Constables Mark McConnell and Jeffrey Nickel from CIRT arrived at the apartment building. They are specially trained negotiators. On route, Senior Constable Nickel contacted NWMH and received a summary of Reece's mental health history. They also

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[32] Statement of Sergeant Damien Higgins; BWC footage of Constable Alena Bazarkaia.
[33] BWC footage of Constables Alena Bazarkaia and Claire McCasker and Sergeant Damien Higgins.
[34] BWC footage of Constable Alena Bazarkaia.

received a briefing from Sergeant Higgins and agreed that Senior Constable McConnell would be the primary negotiator. Upon arriving at Reece's apartment, Senior Constable McConnell observed that Constable Bazarkaia was communicating with Reece in an effective way and was talking with him about his future.[35]

44. At around 11.26pm, after Constable Bazarkaia had been calmly and patiently engaging with Reece for about 28 minutes, Senior Constable McConnell introduced himself to Reece during a "*lull in conversation*" and took over the negotiation. He spoke with Reece for about 22 minutes.

45. Reece explained to Senior Constable McConnell that he was "*bipolar*" and had been experiencing a relapse in his psychosis and that he did not want to talk about his feelings. Reece said that he was seeking "*peace*" from the "*hurting*" and "*pain*" and his "*mental illness, hospitalisation cycles, medications*". He also expressed frustration at the side effects he experienced from his medication and said that "*I feel like the only way for my pain to stop is to die*". Further, Reece asked that a message be passed onto his mother that he loved her.

46. Senior Constable McConnell sought to engage with Reece by sharing some of his own personal experiences. He encouraged Reece to "*keep fighting*" and to "*go that extra day*". After about ten minutes, Senior Constable Nickel also joined the conversation and sought to divert Reece with a discussion about music and then encouraged him to consider the impact of his actions on his family. He also sought to establish an authentic connection with Reece by sharing some of his own personal experiences.[36]

47. At about 11.48pm, Reece put his headphones over his ears and stood up on the balcony railing. Senior Constable McConnell raised his voice in an attempt to maintain communication with him. Reece then "*began to verbally count down '3…2….1'*" before jumping from the balcony railing. Paramedic Christopher Meertens observed Reece fall

[35] Statement of Senior Constable Mark McConnell dated 1 November 2021; Statement of Senior Constable Jeffrey Nickel dated 1 November 2021.
[36] BWC footage of Senior Constable Mark McConnell.

and hit the ground in Queensberry Place. He immediately attended to him and observed that he was unresponsive with no signs of life. He was pronounced deceased at 11.55pm.[37]

Victoria Police Operational Safety Critical Incident Review

48. In accordance with Victoria Police policy, an Operational Safety Critical Incident Review (**OSCIR**) was conducted to assess the adequacy of and compliance with Victoria Police policies, procedures, guidelines, and training relevant to the incident, such as those relating to operational duties and apprehension of people pursuant to the MHA, and the conduct of officers who responded to the incident.

49. During the formal debrief, several officers expressed a belief that they could have benefited from further training in communicating with people suffering from mental health issues and suicidal thoughts. Notwithstanding, the review identified three Victoria Police training modules regarding effective communication, responding to mental health incidents, and managing incidents involving mental health. The review concluded that the available training was sufficient and had been available to officers since 2018, and therefore made no recommendations in this regard.

50. The review determined that the decision-making of officers involved in the incident was supported by appropriate risk planning in line with Victoria Police policy relating to operational response and safety, and incident command and control. The review considered that officers escalated the emergency response and requested further support from other emergency services, namely Ambulance Victoria and Fire Rescue Victoria, at the earliest available opportunity.

51. Having examined the clear and comprehensive BWC footage, the review concluded that these officers acted appropriately and in accordance with Victoria Police policies, procedures and guidelines, which were assessed by the review as fit for purpose.

[37] Statement of Senior Constable Mark McConnell dated 1 November 2021; Ambulance Victoria, Electronic Patient Care Record dated 27 October 2021.

CONCLUSION

52. Reece was clearly struggling with a deterioration in his mental health in the context of increased isolation throughout the Covid-19 pandemic. He demonstrated increasingly paranoid behaviour subsequent to experiencing a number of episodes of drug-induced psychosis after moving to Melbourne from Tasmania in 2017. I am satisfied that the care provided to Reece by his treating team at NWMH in the period proximate to his death was both reasonable and appropriate. Despite their active efforts, Reece became increasingly desperate. After reviewing all of the evidence, I am satisfied that Reece intended to take his own life when he jumped from the balcony railing of his apartment.

53. I have viewed the BWC footage of the police negotiations with Reece on the evening of 27 October 2021. Constable Bazarkaia and Senior Constables McConnell and Nickel engaged with Reece in a calm, compassionate and empathetic manner. They were obviously invested in securing his safety and demonstrated significant professionalism and humanity in the way they sought to assist Reece and dissuade him from taking his life. They were clearly and understandably distressed by the outcome. I echo the observations of the OSCIR and find that these officers acted reasonably and appropriately in accordance with Victoria Police procedures and their training. I consider that they should be commended for their actions.

FINDINGS

54. Having held an inquest into the death of Reece's death, I make the following findings, pursuant to section 67(1) of the Act:

    a. the identity of the deceased was Reece John Pullen, born 30 August 1994;

    b. the death occurred on 27 October 2021 at Queensberry Place, Carlton, Victoria, 3053, from multiple injuries sustained in a fall from height; and

    c. that the death occurred in the circumstances set out above.

I convey my sincerest sympathy to Reece’s family.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Melissa Pullen, Senior Next of Kin

Chief Commissioner of Police, c/- Darren McGee, Victorian Government Solicitor’s Office

NorthWestern Mental Health

Royal Melbourne Health

Sergeant Thomas McGowan, Coroner’s Investigator

Signature:

Coroner David Ryan

Date: 01 December 2022

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.