IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 005915

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	RJ
Date of birth:	20 May 1986
Date of death:	14 October 2022
Cause of death:	1(a) Heroin toxicity
Place of death:	420 Swanston Street, Melbourne, Victoria

INTRODUCTION

1. On 14 October 2022, RJ was 36 years old when he died in a toilet block opposite the Melbourne City Baths. At the time, Mr RJ lived in South Melbourne although was known to regularly sleep rough around Melbourne.

2. Mr RJ was born in 1986 to CJ and had two siblings, and older brother, EJ, and younger sister, MJ. Mr RJ's father was incarcerated shortly prior to his birth and did not play an active role in his life thereafter.

3. Mr RJ was raised in public housing in the Wangaratta area and for a time lived with his mother and older brother in a women's shelter. From a young age Mr RJ displayed difficulties when separated from his mother. He started kindergarten when he was about four years old but was withdrawn from the program less than two months after due to aggressive behaviour.

4. He commenced primary school at a small school in Wangaratta where he struggled with learning, concentration, and controlling his behaviour. He was removed from school when he was in first grade due to violent outbursts. He was later diagnosed with attention deficit hyperactive disorder (**ADHD**) and was suspected to have an attachment disorder, autism, and schizophrenia. He made threats to harm himself from a young age.

5. When he was about 11 years old, his mother transferred custody of Mr RJ to the state due to his volatile behaviour. He lived in accommodation provided by Berry Street. He remained in contact with family until an incident when he was about 15 years old that destroyed the family home. After this, he had no contact with his family.

6. Mr RJ had a history of significant involvement with Victoria Police and was known to use intravenous heroin, methylamphetamine and other substances.

THE CORONIAL INVESTIGATION

7. Mr RJ's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

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

10. Victoria Police assigned Senior Constable Acacia Chapman to be the Coroner's Investigator for the investigation of Mr RJ's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of RJ including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Identity of the deceased

12. On 25 October 2022, Coroner Peterson made a formal determination (Form 8) identifying the deceased as RJ, born 20 May 1986, via fingerprint identification and the initial police report into the death.

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

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

Medical cause of death

14. Forensic Pathologist Dr Judith Fronczek, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination of Mr RJ's body in the mortuary on 19 October 2022 and provided a written report of her findings dated 29 November 2022.[2]

15. The post-mortem examination showed injuries consistent with the application of cardiopulmonary resuscitation (**CPR**). No injuries were observed which could have caused or contributed to death.

16. Routine toxicological analysis of post-mortem samples detected heroin[3] in blood samples. Methylamphetamine[4] and amphetamine[5] were detected in urine samples but not blood. Doxepin[6] and paracetamol[7] were also detected.

17. Toxicological analysis was also performed on a three small, white, opaque solid 'rock like' masses contained within a small zip-lock bag found on Mr RJ's person at the time of his death. Testing confirmed that the masses were heroin.

18. Dr Fronczek provided an opinion that the medical cause of death was *1(a) Heroin toxicity*.

19. I accept Dr Fronczek's opinion.

Circumstances in which the death occurred

20. Between 2018 and 2022, Mr RJ presented to the St Vincent's Hospital Emergency Department (**ED**) multiple times. The majority of his ED presentations were in the context of drug use and homelessness.[8]

21. His final presentation to the St Vincent's ED was on 25 February 2022. He had been found drowsy in the city following use of intravenous heroin. Mr RJ was assessed in the ED and

[2] An amended report superseding this report was signed by Dr Fronczek on 4 May 2023 updating Mr RJ's surname from 'X' to 'J.' Dr Fronczek's findings were otherwise the same.
[3] Heroin is an illegal drug produced from morphine obtained from the opium poppy. Within minutes of injection into a person, heroin is converted to morphine via the intermediate compound 6-acetyl morphine (6-AM). Morphine is the principal form detected in blood, although 6-AM may be detected in urine for about six hours of an injection and in blood only for a short time. 6-AM is not always present in urine of recent heroin users. The presence of a small amount of codeine in the blood, urine or other tissues of morphine-positive cases is consistent with its presence from the use of heroin, in which it is a contaminant. However, the use of codeine cannot be excluded.
[4] Methylamphetamine ("speed" or "ice") is a strong stimulant drug used recreationally.
[5] Amphetamines is a collective word to describe central nervous system (CNS) stimulants structurally related to dexamphetamine.
[6] Doxepin is an anti-depressant
[7] Paracetamol is an analgesic drug often known as 'Panadol.'
[8] Statement of Dr Jonathan Karro dated 5 August 2023.

disclosed daily intravenous drug use including heroin and methamphetamine. While in the ED, Mr RJ was seen by the Assessment Liaison and Early Referral Team (**ALERT**) and provided support and advice about his housing, substance dependence, and social isolation although was reluctant to engage with services.

22. On 24 August 2022, Mr RJ was arrested for outstanding warrants as well as possessing a drug of dependence. He was remanded into custody and spent time at the Metropolitan Remand Centre before being transferred to the Ravenhall Correctional Centre on 12 September 2022.

23. He remained in custody until 12 October 2022 when he was released and is believed to have been sleeping rough thereafter.

24. At about 7.30pm on 14 October 2022, Mr RJ was in a public toilet block on the corner of Victoria Street and Swanston Street in Melbourne, opposite the Melbourne City Baths, heard calling out for help. The evidence suggests he had recently used heroin intravenously.

25. Two witnesses, Mr Callum Neeve and Ms Kelly Fish, heard Mr RJ's calls for help and approached the toilet block. They found Mr RJ in an altered conscious state, slurring his words, and with a depressed syringe in his left arm. Mr Neeve contacted emergency services within 30 seconds of discovering Mr RJ. Records show that this call was made at 7.37 pm[9] (**the first call)**.

26. During the first call to emergency services, Mr Neeve reported to the ESTA[10] emergency call-taker (**the call-taker**) that he discovered Mr RJ on the floor asking for help with a needle sticking out of his arm.[11] When asked if Mr RJ was awake, Mr Neeve responded that he was breathing but that he was "*not really responding*."

27. The call-taker triaged the call and at 7.39 pm first recorded that the patient was in his 40s, conscious (awake) and breathing, not violent, not changing colour, not completely alert (not responding appropriately), and breathing normally based on the information provided by Mr Neeve.[12] The event was coded as a 'Priority 2 event'. Such a presentation is considered

[9] Statement of Andrew Keenan dated 14 November 2023.
[10] The 'Emergency Services Telecommunications Authority' (**ESTA**) was replaced by 'Triple Zero Victoria' as of 15 December 2023.
[11] ESTA audio recording – call 1.
[12] Statement of Andrew Keenan, Director of Patient Safety and Experience at Ambulance Victoria, dated 14 November 2023.

acute but not time critical; does not require a 'lights and sirens' response; and warrants a Paramedic response within 25 minutes.

28. Mr RJ did not respond when asked what he had taken by Mr Neeve. Moreover, Mr Neeve relayed to the emergency call-taker that he was unsure Mr RJ was even aware of that he (that is Mr Neeve) was there.

29. At 7.43 pm, the call-taker updated the event register to record that it was possible that Mr RJ was violent and combative. At around this time in the audio recording of the call, Mr RJ can be heard making noise in the background. Mr Neeve confirmed with the call-taker that Mr RJ said words to the effect of "*you fucking dog*".[13]

30. As Mr RJ was now considered possibly violent and combative, the call-taker subsequently changed the event type to '23C1V.' A 23C1V event type is a "*multi-agencies event*" and in this case required police assistance prior to paramedics attending the scene.

31. Despite the event type being changed to recognise Mr RJ was *possibly* violent and combative and that paramedics would not attend without police assistance, the call-taker asked Mr Neeve to remain with Mr RJ and "*watch him very closely*" so long as he felt comfortable to do so.

32. The first call ended at about 7.45 pm. The call-taker advised Mr Neeve that he would be contacted by responders within 60 minutes, instructed him to roll Mr RJ on his side if he vomited, and to call 000 if anything changed.

33. At 7.49 pm, Ambulance Victoria's (**AV**) Referral Secondary Triage Service's Triage Practitioner (**Triage Practitioner**) called Mr Neeve (**the second call**). At the start of the second call, Mr Neeve reported Mr RJ appeared a *"bit down,"* was making a snoring noise, was breathing, was slumped over with his head down moving up and down, and had dark fingertips.

34. On the instruction of the Triage Practitioner, Mr Neeve yelled at Mr RJ and kicked him on the foot to elicit a response. Mr RJ did not open his eyes after being yelled at or kicked on the foot multiple times but did make some noise after being kicked on the foot.

35. At 7.52 pm, the Triage Practitioner escalated Mr RJ's event type to Priority 1 as Mr RJ was not reported to be fully alert. Priority 1 events are for patients who require urgent

[13] ESTA audio recording – call 1.

paramedic assessment with a lights and sirens response[14] and paramedic arrival expected within 15 minutes.[15]

36. Seconds later, AV Advanced Life Support (**ALS**) crew SM6340 were dispatched. At the time, this crew was just 800 metres away however due to safety concerns, they were directed to head to a rendezvous location and wait for police assistance.

37. At 7.54 pm, the corner of Victoria and Bouverie Street in Carlton was nominated as the rendezvous location. This was one block from where Mr RJ was lying. Crew SM6340 arrived at the rendezvous location at 7.55 pm. The evidence suggests that police arrived at the rendezvous location at about 8.08 pm.

38. The second call with the Triage Practitioner lasted just over four minutes. Mr Neeve was reassured an ambulance was on its way and said he would stay at the scene with Mr RJ. The Triage Practitioner directed Mr Neeve to contact emergency services if Mr RJ's breathing became ineffective or his condition otherwise deteriorated.

39. <u>At no point during the second call was Mr Neeve asked whether Mr RJ was or remained possibly violent or combative.</u>

40. Mr Neeve remained with Mr RJ in the toilet blocks with paramedics a block away for 16 minutes. During this time Mr RJ's condition deteriorated which culminated in Mr Neeve again calling emergency services at 8.11 pm (**the third call**). Mr Neeve reported that Mr RJ was unconscious, was no longer making any noises and that it was hard to tell if he was breathing as he was slumped over.

41. The emergency call-taker updated the event register to recognise the primary complain was now "*cardiac or respiratory arrest/death*". The event was escalated to a 'Priority 0' which is the highest level of response.

42. At the same time, the emergency call-taker instructed Mr Neeve to commence cardiopulmonary resuscitation (**CPR**). As Mr Neeve commenced CPR, sirens can be heard in the background of the audio recording of the third call.

43. AV crew SM6340 departed the rendezvous location and were the first to arrive at Mr RJ's location at 8.15 pm. Attending paramedics continued resuscitation efforts with multiple other

[14] Statement of Andrew Keenan, dated 14 November 2023
[15] The 15-minute arrival time is expected for 85% of events state-wide.

crews, Victoria Police and Fire Rescue Victoria members converging on the scene a short time later. Despite all efforts, Mr RJ was unable to be resuscitated and was verified deceased at the scene at 8.20 pm.[16]

FURTHER INVESTIGATION

44. Having reviewed the brief and as part my investigation, I requested further information from Ambulance Victoria and Triple 000 Victoria (formerly ESTA) about the rationale for and use of rendezvous locations. Clarification was sought about why Mr RJ was assessed as possibly violent and combative resulting in a delayed attendance at the scene, despite Mr Neeve, a member of the public being encouraged to remain.

45. Subsequently, statements were received from:

    (a) Andrew Keenan, Director of Patient Safety and Experience at Ambulance Victoria, dated 14 November 2023.

    (b) A supplementary statement from Mr Keenan dated 3 September 2024; and

    (c) Jessica Taylor, Quality Improvement Investigator, Triple Zero Victoria dated 22 August 2024.

46. In his initial statement, Mr Keenan stated that it is AV's policy for paramedic crews not to enter violent or potentially violent situations unless police are in attendance and have the scene controlled. Once crew SM6340 arrived at the rendezvous location at 7.55 pm, Mr Keenan advised the crew were expected to remain at the rendezvous location until directed to proceed by police and/or an AV Duty Manager. In Mr RJ's case, this occurred when his condition deteriorated, and the event was escalated to a 'priority 0' during the third call.[17]

47. The AV 'Approach to a Scene' policy[18] (**the policy**) provides that "*the safety of staff is the number one priority*." The policy also allows for operational staff to exercise discretion on whether to proceed or withdraw from a scene, based on risk assessment of safety concerns.[19]

[16] Ambulance Victoria Verification of Death Form.
[17] Statement of Andrew Keenan, dated 14 November 2023, pg 8/9.
[18] WIN/OPS/070 v 14.0
[19] Ibid, pg 1/14.

48. The policy requires that when a scene has been identified as violent or dangerous, it is not to be entered by AV crews unless police are in attendance and have the scene controlled.[20]

49. Ms Taylor advised that Triple Zero Victoria emergency call-takers follow a structured call taking process with question-and-answer methodology protocols set by the International Academies of Emergency Dispatch. Answers provided to the emergency call-taker are entered into the dispatch software which provides key questions to ask the caller. Answers to the key questions allow the emergency call-taker to assign a particular event type. In Mr RJ's case, during the first call the event type was classified as 23C1V.

50. Once an event type has been determined, Ms Taylor reported that the call-taker does not have any discretion of the response or priority assigned to an event.

51. Ms Taylor confirmed during the first call with Mr Neeve, the emergency call-taker updated the key question 'is he violent?' from 'no' to 'possibly' when Mr RJ was heard yelling "*you fucking dog*" at 7.43 pm. This change to the key question 'is he violent?' reconfigured the event type to 23C1V which automatically assigned a Priority 2 response with assistance required from police.

52. Despite the change to key question 'is he violent?' being made, the audio recording from the first call indicates Mr Neeve was not asked this question at 7.43 pm when the change was made.

53. In relation to an alternative approach available to the emergency call-taker during the first call, Ms Taylor stated:

> *Based on the available information in relation to Call 1,* [the emergency call-taker] *could have included in the event remarks details of any perceived scene safety concerns, such as Mr RJ's swearing, without updating the answer to the Key Question 'Is he violent', and AV could have made their own assessment in relation to possible violence.*[21]

54. In his subsequent statement, Mr Keenan appeared to accept that information gathered by the AV Triage Practitioner during the second call[22] with Mr Neeve, namely that Mr RJ was now unresponsive, was not passed on to the crew at the rendezvous location. Moreover, Mr Keenan added:

[20] Ibid, '5.1 Violent Situations' pg 3 of 14.
[21] Statement of Jessica Taylor, Quality Improvement Investigator, Triple Zero Victoria dated 22 August 2024.
[22] Commencing at 7.49 pm.

It appears that they were waiting at the rendezvous point for some minutes because there was nothing to suggest to the crew on scene that the initial information that Mr RJ was possibly violent had in fact changed…

At times, it is competing interests to balance the safety of AV paramedics and timely ambulance attendance. While the safety concerns were warranted on the basis of the information gathered by the Triple Zero Victoria call-taker, it might have been preferable for the crews to be made aware of the new information gathered by the [Triage Practitioner]*, that Mr RJ had become "unresponsive", as they might have approached the scene some minutes sooner.* [23]

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments:

55. It is difficult to reconcile the fact that Mr RJ deteriorated in the presence of Mr Neeve, a member of the public who selflessly stopped to render assistance, while AV paramedics waited for police at a rendezvous location around the corner due to safety concerns.

56. When Mr Neeve first called emergency services he was asked "is he violent?" to which he answered 'no'. He was not asked this question again during any of his three calls with emergency services and never provided an answer or otherwise an indication to suggest Mr RJ was potentially violent.

57. Moreover, the evidence suggests that Mr Neeve was unaware Mr RJ had been categorised as 'possibly violent or combative' and that paramedics would be utilising a rendezvous location while he remained alone at the scene.

58. When Mr RJ said words to the effect of "*you fucking dog*" during the first call, the emergency call-taker changed the event type to 23C1V setting in motion a series of events which resulted in a rendezvous location being utilised. When cautioned about his own safety, Mr Neeve replied that he *"was not even sure if Mr RJ's comments were directed at him."*[24]

59. Mr Neeve was cautioned about his own safety and asked to remain at the scene only if he felt comfortable to do so. During the second call with the Triage Practitioner, he was asked to shout at Mr RJ and kick him on the foot to try and rouse him, again, if he felt safe to do so.

[23] Subsequent statement of Mr Keenan dated 3 September 2024.
[24] ESTA audio recording – call 1.

60. The contemporaneous ESTA event chronology described Mr Neeve as a "*reliable 2nd party remaining on scene*" at 7.55pm. Review of the audio of each of the three calls lends credence to this assessment. However, as the situation unfolded and Mr RJ's condition deteriorated, there is no evidence that Mr Neeve was utilised to assist emergency responders assess what type of threat Mr RJ posed, if one at all.

61. The evidence suggests paramedic crew SM6340 arrived at the rendezvous location at 7.55 pm. At this time, Mr Neeve remained with Mr RJ and had just provided information to the AV Triage Practitioner that Mr RJ was slumped over, snoring, and unresponsive. Paramedics did not attend upon Mr RJ until 8.15 pm at which point his condition had markedly deteriorated and he was in cardiac arrest. This reflects a 20-minute period where paramedics were waiting on standby at a rendezvous location just a single city block away.

62. Had paramedics attended the scene earlier to render assistance instead of waiting at a rendezvous location, it is possible Mr RJ would have survived.

FINDINGS/CONCLUSIONS

63. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    (a) The identity of the deceased was RJ, born 20 May 1986;

    (b) The death occurred on 14 October 2022 at 420 Swanston Street, Melbourne, Victoria;

    (c) The cause of Mr RJ's death was heroin toxicity;

    (d) Mr RJ's death resulted from an inadvertent or accidental overdose, that is he died from the unintended consequences of his deliberate ingestion of heroin.

64. While I make no criticism of the individual paramedics, emergency call-takers or AV Triage Practitioner, it is possible that earlier attendance by paramedics could have prevented Mr RJ's death.

65. The available evidence highlights the difficult balance to be struck between the unarguable need to ensure the safety of AV paramedics and the need to respond to patients who are acutely unwell where there may be a risk to the safety of AV paramedics.

66. The emergency response to Mr RJ indicates that there is the potential for the emergency response to be delayed where an assessment of that risk is not well-founded or where the risk is not updated as circumstances change.

67. Clearer communication between call-takers and Mr Neeve who was a lay person in a good Samaritan role and recognised by call-takers as a reliable person at the scene could potentially have indicated that Mr RJ was not violent or combative or, rather more to the point, that he was in such as a state that he was incapable of being so.

68. I acknowledge the brave response of Mr Neeve who selflessly answered Mr RJ's call for help and stayed with him until first responders attended the scene.

69. I convey my sincere condolences to Mr RJ's family and friends for their loss.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

CJ, senior next of kin
Ambulance Victoria
Triple Zero Victoria (formerly ESTA)
Senior Constable Acacia Chapman, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 05 September 2025

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 investigation. 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.