IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 3425

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	Liaqat Ali Hamid KAYANI
Delivered on:	22 June 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	4,5,6,7, 8 and 9 May 2017
Findings of:	Coroner Paresa Antoniadis SPANOS
Counsel assisting the Coroner:	Ms Rachel ELLYARD of Counsel, instructed by Ms Sarah GEBERT from the Court's In-House Solicitors Service.
Representation	Ms Sophia KAYANI, one of the deceased's sisters, appeared on her own behalf. Ms Naomi HODGSON of Counsel instructed by Ben Lloyd of Russell Kennedy appeared on behalf of the Chief Commissioner of Police.
Catchwords	Hypoxic brain injury secondary to heroin and alcohol toxicity, role of police at the scene of a suspected overdose.

Table of Contents

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of LIAQAT ALI HAMID KAYANI

and having held an inquest into the death at Melbourne between 4 and 9 May 2017:

finding that the identity of the deceased was LIAQAT ALI HAMID KAYANI

born on 26 August 1969, aged 44

and that the death occurred on 5 July 2014

at the Western Hospital Melbourne, 160 Gordon Street, Footscray, Victoria 3012

from

1(a) HYPOXIC BRAIN INJURY

1(b) HEROIN AND ALCOHOL TOXITY

in the following circumstances:

INTRODUCTION

1. Liaqat Ali Hamid Kayani (Al)[1] was born in the United Kingdom. He was the second (but only surviving) son of his parents and had two older sisters and one younger sister.[2] Al grew up in Essex and moved to Australia in 1993. He maintained contact with his mother and sisters and some of them visited him in Australia or travelled to meet him in other locations over the succeeding two decades.
2. Al's area of business was property development and he owned at various times up to five properties in Queensland. By the time of his death all of these properties had either been sold or were at risk of being sold because of mounting unserviced debt secured against them.
3. Al was in a relationship from about 1997 with Sarah Davis. They lived together in NSW and then in Queensland. The relationship was marked by occasional separations and by drug and alcohol use, with Davis having a heroin addiction and Al being a heavy user of alcohol. At the time of his death they had been living apart for a number of months but were in very frequent contact by phone and text.
4. In January 2014 Al left Queensland and travelled first to New South Wales where he stayed with friends for several months. He then travelled on to Melbourne in May 2014 to stay with his friend Darren Hayward who lived in St Albans.

[1] This was the way in which family members asked that the deceased be referred to during the inquest.
[2] All three of Al's sisters travelled to Melbourne for the inquest. Al's mother was not able to attend but had contact with the Court through her daughters and by way of telephone contact with Counsel Assisting.

5. On 29 June 2014 Al collapsed at Mr Hayward's house after taking heroin. He was revived by paramedics and transported to the Western Hospital where he was diagnosed with a hypoxic brain injury. He was intubated for 6 days without improvement and died after his life support was removed.

INVESTIGATION AND SOURCES OF EVIDENCE

6. This finding is based on the totality of the material which has been produced by my investigation into Al's death. This includes -

   6.1. The brief of evidence complied by Acting Detective Sergeant Bec Stokes, including audio and audio visual material recovered from Al's phone;

   6.2. The submissions and materials received from members of Al's family, including materials submitted by Ms Sophia Kayani which contained an analysis of the phone call made to 000 by Mr Hayward;

   6.3. Documents and statements received from the Chief Commissioner of Police;

   6.4. The statements and testimony of those witnesses who gave evidence at the inquest together with exhibits tendered through them; and

   6.5. The final submissions and reply submissions of the interested parties and Counsel assisting.

7. All of this material, together with the transcripts of the inquest, will remain on the coronial file. In writing this finding I do not purport to summarise all of that material and evidence and will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

THE PURPOSE OF A CORONIAL INVESTIGATION

8. The purpose of a coronial investigation of a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred. Al's death was clearly a reportable death as defined in the *Coroners Act* 2008.

9. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which the death occurred refers to the context or background and surrounding circumstances. However, this is confined to that context, background

and circumstances sufficiently proximate, and causally relevant, to the death. It will not include all of those circumstances which form part of the narrative culminating in the death.

10. In the case of Al's death, the requirement that I confine my consideration to those circumstances that are sufficiently proximate and causally relevant to the death means that it is not necessary or appropriate for me to make findings about every aspect of Al's personal and professional life in the years before his death. Whilst those broader matters are, naturally, of great significance to those who knew and loved him, they do not fall within the reasonable scope of a coronial investigation of his death.

11. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners. This is generally referred to as the prevention role. In furtherance of this role, Coroners are empowered to -

    11.1. report to the Attorney-General in relation to a death;

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

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

12. It is important to stress that coroners are -

    12.1. not empowered to determine any civil or criminal liability arising from the investigation of a reportable death; and

    12.2. specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.

FINDINGS AS TO UNCONTENTIOUS MATTERS

13. Some of the matters I am required to ascertain are not contentious. Al's identity and the date and place of his death were not at issue in my investigation. I find, as a matter of formality, that Liaqat Ali Hamid Kayani, born 26 August 1969 and

aged 44 years, died at the Western Hospital, 160 Gordon Street, Footscray, on 5 July 2014.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

14. At a directions hearing held in advance of the inquest I indicated that the focus of my investigation and the inquest would be -

14.1. The medical cause of Al's death;

14.2. The circumstances of Al's collapse on 29 June, including both the events of that day and the events of the days and weeks preceding his collapse;

14.3. The attempts at resuscitation, first by Al's friends and then by MFB and AV members at the scene, and who was there;

14.4. The examination and processing of the scene where Al was found by police members and whether it complied with relevant policies, procedures and powers; and

14.5. The investigation which followed Al's death.

MEDICAL CAUSE OF DEATH

15. At the time of his death Al had been a patient at the Western Hospital since 29 June 2014 with a diagnosis of hypoxic brain injury, and he died after a decision to withdraw life support which was made by his family in consultation with doctors. There is nothing in my investigation which calls that diagnosis, or the decision to withdraw life support, into question.

16. The autopsy in this matter was performed by forensic pathologist Dr Paul Bedford of the Victorian Institute of Forensic Medicine (VIFM). Dr Bedford advised that hypoxic ischemic changes were observed in the brain, and there were no other signs of injury or illness that would explain Al's death. Having regard to his observations, the results of toxicology screens and his awareness, based on the Police Report of Death to the Coroner (Form 83) material, that Al was said to have taken heroin, Dr Bedford proposed the medical cause of death as *1(a) hypoxic brain injury – apparent heroin overdose.*

17. I also had access to the results of a subsequent autopsy undertaken in the United Kingdom after Al's body was taken there by his family. Dr Ian Maddison largely

accepted the results of Dr Bedford's autopsy but proposed a slightly different formulation of the cause of death as *1(a) Cardio-respiratory suppression 1(b) Alcohol and opioid intoxication.*

18. I have also reviewed a letter sent to Ms Sophia Kayani by Professor Stephen Leadbeater which commented on the two autopsies and noted that a key question was how the drugs came to be in Al's system.

19. At the inquest I received oral evidence both from Dr Bedford and from Associate Professor (A/Prof) David Ranson also of the VIFM. Dr Bedford explained that, having been made aware from the Form 83 materials that the death could be a drug-related death, he approached the autopsy looking for signs of any injury or other mechanism of death and any other explanation outside of a drug-related incident for the loss of oxygen to Al's brain. He said that it was that loss of oxygen which caused the brain injury and that the loss of oxygen in turn had been due to respiratory depression; a lack of drive to the lungs to keep breathing, which had eventually stopped the heart because too was starved of oxygen. The respiratory depression was most likely caused, Dr Bedford said, by some sort of drug, though he could not say for certain.

20. Dr Bedford was not able to identify the injection site, given subsequent medical intervention, or make any comment on whether any heroin was injected by Al or by another person.

21. A/Prof Ranson gave evidence about the role of a forensic pathologist and the extent to which it was proper for a pathologist to have regard to, or be influenced in their assessment by, sources of information other than the body of the deceased. He said that the primary focus should be on what was observable, but that in appropriate cases weight might be given to other available information about the circumstances in which the death occurred.

22. A/Prof Ranson said that the various causes of death posited by the pathologists in this case were all consistent in that they all identified that a narcotic drug caused the cardiac arrest and the resulting hypoxic brain injury, albeit that they used different words. He agreed with Dr Bedford that the observed hypoxic brain injury could have had one of several causes, and said that it was the toxicology results which gave a basis for the view that the injury was attributable to drug-induced respiratory depression and cardiac arrest.

23. A/Prof Ranson's evidence was that it was very difficult to make positive findings about how long a needle mark is visible on the skin and whether it is possible to tell from such a mark whether the dominant or non-dominant hand was used. He also said that it was not possible to determine from toxicology results the order in which the substances found in Al's blood had been ingested. On the question of alcohol readings, he said that a blood alcohol reading of 0.09% suggested several heavy drinks but that here too it was had to be definitive about how impaired a person would be at that level of intoxication.

24. I also heard evidence from Dr Linda Glowacki, Toxicology Manager at the VIFM, about the results of the toxicology tests conducted on samples taken after Al's death but also a sample taken on the night he was admitted to hospital. On the question of the blood alcohol level of 0.09%, Dr Glowacki testified that this level would suggest six standard drinks in the hour before the sample was taken, but that in circumstances where the sample was taken at least an hour after his last drink, there were a number of factors which might affect whether blood alcohol levels were increasing or decreasing in that hour. I note there is evidence that Al had been drinking heavily on the afternoon and evening of 29 June 2014.

25. In addition to alcohol, Dr Glowacki found evidence in the ante-mortem sample of olanzapine, codeine, morphine and midazolam, a benzodiazepine. As cannabis was found in the post-mortem sample (but not the ante-mortem sample), Dr Glowacki expressed the opinion that this was likely due to post-mortem redistribution. The ratio of codeine and morphine (a metabolite of codeine and of heroin as well as a drug in its own right) in the ante-mortem sample meant that the morphine could be entirely attributable to the metabolism of codeine.

26. The ante-mortem sample also revealed the presence of traces of 6-monacetylmprhone (6-MAM) which is a heroin specific metabolite. Dr Glowacki's evidence was that the presence of 6-MAM, albeit at a level lower than the laboratory's usual reportable limits, meant that Al had been exposed to heroin.

27. Both alcohol and heroin are central nervous system depressant drugs that can cause respiratory depression.

28. Ms Sophia Kayani strong submission was that the evidence did not permit a finding about the antecedent causes of Al's hypoxic brain injury.

29. In my view, the weight of the medical and other evidence, supports a finding about the context in which Al's hypoxic brain injury was sustained. I am satisfied that Al

suffered severe respiratory depression which led to cardiac arrest. During the cardiac arrest, Al suffered a hypoxic brain injury. Although his heart and breathing were later restored, the brain injury had already occurred and its sequelae were observable shortly after he arrived at hospital.

30. The presence of the trace of 6-MAM together with morphine in the ante-mortem sample, taken together with the other evidence from Mr Hayward and Mr Ostojic about Al's actions on the evening of his collapse, assists me to be comfortably satisfied that Al ingested heroin and that it was the heroin, combined with the alcohol he had drunk through the evening, which caused the respiratory depression.

31. I exclude the potential effects of the other substances found in the ante-mortem and post-mortem samples. The midazolam found in Al's body can be accounted for by it having been administered at the Western Hospital at 12:30am, shortly before the ante-mortem blood sample (later tested for the presence of drugs at VIFM) was taken at 12:50am. By that time Al had already suffered the respiratory depression and cardiac arrest and accordingly the midazolam was not the cause of that respiratory depression. The olanzapine was present at a very low level (.01 mg/L where therapeutic levels range up to approximately 0.5 mg/L).

32. Having regard to all of the available evidence, I find that the medical cause of Al's death is *1(a) Hypoxic brain injury 1(b) Heroin and alcohol toxicity.*

GENERAL COMMENTS ABOUT THE EVIDENCE AS TO CIRCUMSTANCES

33. I have the advantage in this investigation of access to information and evidence from a range of sources. The evidence includes written and oral evidence from the three people who were in the most frequent contact with Al, as well as evidence from other friends and associates, his family, records of Al's own words in text messages and audio recordings, documents relating to his business affairs, medical and hospital records, and reports prepared by counsellors who had treated Al for depression and alcohol abuse in the past.

34. In making my assessment of the witnesses, I kept in mind the potential for their memories to have been altered by time or grief by an unconscious desire to remember Al or their own conduct in a particular way. The reliability of a witness's evidence can also be affected by factors like intoxication or by the circumstances in which they came to witness an event.

35. In this case, the existence of contemporaneous records in the form of text messages and in reports written by treating counsellors assists me because they were -

35.1. prepared at the time rather than being recollections given years later; and

35.2. prepared without any expectation that they would be used in any court proceedings, meaning there is the absence of any motive or risk of fabrication, exaggeration, or minimisation.

36. The standard of proof in coronial proceedings is the civil standard of the balance of probabilities. Coroners must not speculate. If there is no evidence of a given fact, a coroner ought not speculate that the fact might exist or act on the basis that it does exist. Similarly, where there is evidence to support a finding of fact, a coroner should not rely on speculation to avoid making that finding.

EVENTS LEADING UP TO 29 JUNE 2014

37. At the time of his overdose and subsequent death Al had been staying for some weeks at Mr Hayward's home at 2/4 Branston Rd St Albans. Mr Hayward had previously been a friend of Ms Davis but by June 2014 his primary connection to the couple was as Al's friend. He had known Al for several years and had observed his relationship with Ms Davis, including their mutual drug use.

38. Until his arrival in Melbourne Al had been living largely in NSW and in Queensland where he owned investment properties which, it would seem, he had bought at the top of the market shortly before the global financial crisis reduced property values. He had been in a complicated relationship with Ms Davis and was displaying signs of depression.

39. Ms Davis and Al had first met in 1997 and had two short term relationships in the 3 years that followed before they separated and lost contact for several years. In 2008 they re-established contact and Ms Davis left her then husband to begin a new relationship with Al.

40. Al and Ms Davis lived together in NSW and then in Queensland in a property owned by Al. At some point their relationship became fraught and characterised by acrimony and accusations. In 2013 there were a number of contacts with police. In March 2013, a domestic violence order was made in Al's favour against Ms Davis, though Ms Davis's evidence was that she considered herself the victim of the incident. Later that year there was further police involvement regarding an

apparent theft of items from Al in which Ms Davis was implicated. That matter was never followed up because in January 2014 Al left Queensland and did not return. Ms Davis denied any theft.

41. In mid-2013 Al consulted a psychologist for treatment for anxiety and depression. He also reported major financial worries and the use of alcohol as a coping mechanism.

42. Although Al owed a number of properties, at the time of his death he was in a parlous financial state, owing more to the bank than most of the properties were worth and with limited income other than that which Ms Davis was earning in her role at a bank. Al's explanation to friends and family for how his finances had gone so wrong was that Ms Davis had being stealing money, including rental income, to pay for her drug habit. This was consistent with a general theme of his final years of life in which he blamed Ms Davis for both his financial and his personal difficulties, including accusing her of having incited two men to assault him.

43. Ms Davis said in her evidence that Al had suffered increasingly from depression for several years and that this, combined with alcohol use, had led to him increasingly failing to pay bills, organise tenants, and meet commitments on the investment properties he owned so that he fell increasingly behind in repayments.

44. The evidence of Mr Berger, a financial advisor who had been assisting Al to sell some of the properties or to refinance in early 2014, was that the properties were heavily mortgaged with little to no prospect of refinancing, and that he found it very hard to get Al's engagement and involvement in the process because of Al's apparent depression. Mr Berger described Al as a "in a very dark state" and "reliable to be unreliable."

45. Mr Matthew Towner was a friend of Al's for over 15 years. In his statement Mr Towner said that Al had told him he was in financial difficulty after the global financial crisis and that in his observation Al had made 'crazy' decisions like decisions to renovate properties where there would be no increase in the market value. He said that he was aware Al was drinking heavily and that he had become morbid and dark in the last year of his life.

46. After leaving Queensland Al stayed in New South Wales for some months. Whilst there he had six sessions with a counsellor for alcohol issues. During the sessions he disclosed past heroin use and discussed his financial problems. He also spoke

about his childhood and disclosed violence by his father towards himself and his mother.

47. In May 2014 Al drove to Melbourne and stayed at Mr Hayward's house. Mr Ostojic travelled with Al after being told there would be work available for both of them in Melbourne. Ms Davis remained in Queensland. The state of the relationship between her and Al was volatile but in evidence she insisted that though they were separated they were still in close contact and working towards being back together again.

48. Members of Al's family invited me to treat the evidence of Ms Davis with caution and, in the case of Ms Sophia Kayani, to conclude that they were not close at the time of his death and that Ms Davis had been largely responsible for the problems Al had experienced. Al's family also expressed concern about the role Ms Davis may have played in the disappearance of some of Al's possessions after his death and about statements she had made criticising their decision to turn off his life support.

49. Mr Hayward's evidence included evidence that Al was 'collecting evidence' about Ms Davis and that he was keeping records on his computer about her. The presence of some brief films involving Ms Davis found on Al's phone supports this evidence. Mr Ostojic did not know Ms Davis at all but gave evidence that as they pulled up at Mr Hayward's house Al told him that the true reason for their visit was to enable him to collect information or evidence about Ms Davis from Mr Hayward.

50. On or about 29 June 2014, Mr Towner had a conversation with Al in which Al spoke of Ms Davis breaking his heart and ripping him off, topics which Mr Towner said were themes of many conversations he had with Al in which he tried to tell Al to end the relationship, sell his properties and move on.

51. A theme in the submissions made by Ms Sophia Kayani was that Al was the victim of family violence at the hands of Ms Davis. In support of that argument she referred to statements Al made to friends about Ms Davis's conduct and to the existence of the intervention order taken out by police in favour of Al against Ms Davis.

52. Ms Davis gave an account which cast a different light on events which Al had reported to his sisters and friends as being instances of Ms Davis being violent or dishonest towards him and which instead suggested that it was Al who was violent

and controlling towards her. At inquest, Ms Davis presented as having cared deeply about Al whilst also regarding him as the cause of her past heroin habit and as someone who, as he sank into depression, became increasingly controlling and violent. Her account of the volatility and complexity of their relationship rang true, though she was also clearly motivated to defend herself against the accusation that she had stolen from Al or otherwise harmed him; accusations of which she was aware before being asked about them in cross examination.

53. For the purposes of my investigation and findings it suffices to say that the relationship between Al and Ms Davis was dysfunctional and characterised by family violence and drug and alcohol misuse. By June 2014 they had been living apart for several months and their communications ranged from loving and intimate messages to accusations and threats.

54. However, the best evidence of the role played by Ms Davis in Al's life in the final weeks of that life comes from the text messages recovered from his phone. Those messages indicate that he was in constant and frequent contact with Ms Davis in the days and weeks before his death. Whilst some of that communication was angry or accusatory in tone, there is also ample evidence of Al seeking, and receiving, emotional support and comfort from Ms Davis. This is particularly so in the final days of his life where the text messages corroborate the evidence of Mr Hayward and Ms Davis that Al was becoming more depressed.

55. I accept that Al told Mr Hayward that he was gathering evidence about Ms Davis, just as I accept that he told Mr Ostojic that they had come to Melbourne gather evidence about her. It is not now possible to determine what sort of evidence, and in relation to what sort of conduct, Al had in mind, or whether he had any proper basis to believe such evidence existed or was merely ruminating or obsessing on Ms Davis as part of his depression and anxiety.

56. However, whatever Al may have said to Mr Haywood, Mr Ostojic or others about Ms Davis and the suspicions he had of her, she was a significant person in his life. There is no evidence before me that she played any role in his decision to take heroin on 29 June 2014, that she directed the actions of Mr Hayward or Mr Ostojic or that she wished Al any harm at that time.

57. It is beyond the scope of my investigation to determine the precise causes of Al's financial situation. However, he had plainly hit rock bottom and was facing the

loss of all of his properties and a substantial blow to his sense of self-esteem and capacity to rebuild which was affecting his state of mind and his decision making.

EVENTS ON 29 JUNE 2014

58. On 29 June Al and Mr Ostojic were drinking together at the flat in St Albans. Over the course of the afternoon and evening they drank a bottle of tequila, a bottle of scotch and four full strength beers between them. Mr Hayward was also present.

59. Some of the interactions between the three men that night are available to me as recordings made by Al over the course of the evening and found on his mobile phone. There is no direct evidence of why Al decided to make the recordings and I do not speculate on what his reason may have been. However, the recordings give a sense of the dynamics of that night and in particular show Al's mood as being one of anger and accusations towards Mr Ostojic. The final recording was made within an hour of Al's collapse.

60. Ms Sophia Kayani submitted that the recordings showed that Al was not drunk and that he was instead angry and in fear. I listened carefully to the recordings and do not agree that Al sounds fearful. He seems in command of himself and dominant over both Mr Hayward and Mr Ostojic.

61. Mr Hayward gave clear evidence which included admissions about his own drug taking. I found Mr Hayward to be a witness of truth and I have largely accepted his evidence. He had a good memory of the events of the night and his evidence was consistent with other collateral evidence.

62. Mr Ostojic presented as having a very limited recollection of the events of 29 June 2014 because of his level of intoxication. That level of intoxication is corroborated by his voice and behaviour on the recordings Al made, as well as by the evidence of Mr Hayward and of attending police. I have accordingly placed little weight on his evidence of the events of the evening of 29 June save where it is corroborated by other evidence. However, I have been assisted by his evidence of his dealings with Al in the weeks and months prior to Al's death.

63. Towards the later part of the evening Al and Mr Ostojic quarrelled and then had a physical scuffle as a result of which Mr Ostojic left the flat. Al referred to a fight in a text he sent to Ms Davis at 10:15pm Melbourne time which indicates the fight had occurred by that point.

64. At some time after Mr Ostojic left the flat, Mr Haywood and Al each injected themselves or were injected with heroin. I am not able to make any definite finding about who owned the heroin or how it came to be in the house, though I note Mr Haywood says that the cover of the stereo (which he had purchased a year earlier) was broken in the scuffle between Al and Mr Ostojic and that behind that cover he found a tissue wrapped package which contained heroin. Mr Hayward's evidence was that he had injected speed with Al a few days earlier and that Al was happy to see the heroin and eager to use it. Mr Ostojic's evidence was that he believed the scuffle had been staged by Al to get him out of the house so that Al and Mr Hayward could use heroin.

65. At some point between the time he sent the text to Ms Davis and 11:10pm Melbourne time, Al was injected with at least one syringe of heroin. Mr Haywood's evidence was that he and Al both prepared and injected their own fit of heroin. Shortly after he saw Al collapse.

THE DECISION TO USE HEROIN

66. An issue in dispute at inquest was whether Al took heroin willingly. Al's family members invited me to reject the suggestion that he was a drug user or alcoholic. Ms Sophia Kayani submitted that there were grounds to suspect that Al had been injected with heroin against his will.

67. Whilst I accept that Al's mother and sisters knew a man who was healthy and active and who, as far as they knew, shunned drug use (I note Ms Kamall's statement indicates she did know of some drug use), the reality is that they had varying but limited direct contact with him in the final period of his life and were not in a position to know how far his life had changed course.

68. It is for this reason that I prefer the evidence of those most closely associated with Al in the final weeks of his life; that is, Ms Davis, Mr Hayward and Mr Ostojic -

    68.1. Ms Davis's assessment was that Al had been depressed for a long time and that in the final weeks of his life his mood, though fluctuating, was very low. She was aware he was drinking and said that he had had an increasing problem with alcohol over the course of their relationship. She knew him as a casual user of drugs, including heroin;

68.2. Mr Hayward also gave evidence that Al was depressed and that his days were spent drinking. He remembered Al saying "how can I be a property developer if I can't get a bank loan". Al had used drugs with him on other occasions.

68.3. Mr Ostojic, brought to Melbourne on a promise from Al that there would be work for them both, gave evidence that no work eventuated and that they spent their days drinking and doing nothing and that he had seen Al use drugs in the company of Mr Hayward.

69. That evidence is supported by the evidence of a number of other people who knew Al and whose statements were obtained during the investigation, to the effect that Al was drinking excessively, that he was worried about business and financial matters and that he was becoming more and more depressed about his circumstances. Although he had access to assets in the form of personal property, and through his family to further financial resources, his manner of living in the final weeks of his life was that of someone who was broke and having to struggle to afford telephone credit. He had no job and no immediate prospects of work and was spending his days largely in drinking and idleness.

70. It is clear that Al was not suicidal and that the text messages he exchanged with Ms Davis indicate that he had not given up hope of salvaging one or more of his properties and of improving his financial prospects. I accept too that he continued to have friends with whom he was in contact and that he had not lost contact with his family. He had not lost all hope but he was very depressed and was self-medicating with alcohol and drugs.

71. All of this evidence assists me to be comfortably satisfied that Al knowingly took heroin. Although some of Al's friends, like his family, believed he would never inject drugs, it is not surprising given his life circumstances in June 2014 that he made the decision to take heroin.

72. Attending paramedics noted a puncture mark on Al's right arm. As Al was right-handed, it might have been expected that he would have injected himself in the left arm. Mr Hayward's evidence was that he had showed Al a technique he himself (also right handed) used to inject in the left arm. Ms Davis considered the site of the puncture was evidence that Al had been injected by someone else, but that any

such injection would have been with Al's consent, something she said she was aware had occurred before. Mr Hayward denied injecting Al.

73. Ms Sophia Kayani submitted that Mr Hayward's past mental health issues and criminal history made him an unreliable witness whose evidence had changed over time and which should not be accepted. She contended that the evidence supported the view that Al had not injected himself and that he might have been drugged first and the heroin administered to him while he was unconscious.

74. There is simply no evidence, other than the location of the puncture mark, to suggest any external influence, whether by Mr Hayward or anyone else. The suggestion that Al was drugged first is mere speculation.

75. Mr Hayward made many other admissions against his own interest and there was no reason for him to deny injecting Al with heroin if in fact that is what occurred. I found him a credible witness, even acknowledging that he did not tell the truth to police who attended the scene about his own drug use. At the same time, on the evidence before me Al was not a frequent injecting drug user likely to have mastered a technique of injecting with his non-dominant hand.

76. In all of the circumstances I am not able to reach a state of comfortable satisfaction as to whether Al injected himself using the technique shown to him by Mr Hayward or whether he consented to be injected by Mr Hayward. Either way, I find that he willingly took the heroin and that the dose he took caused him to overdose and collapse. Whether this overdose was due to the strength of the heroin or to matters personal to Al's physiology and response to the drug I am not able to say.

THE IMMEDIATE AFTERMATH OF THE OVERDOSE

77. I am able to follow the events following Al's collapse by way of the recording made by ESTA of Mr Hayward's call to 000. The recording reveals Mr Hayward seeking advice on how to perform CPR and apparently trying to perform it, with some interruptions from Mr Ostojic who appears to have returned to the house during the call.

78. Ms Sophia Kayani submitted a report prepared by Iain McArthur, a Forensic Audio and Video Enhancement Specialist. Mr McArthur's report indicated that he had been instructed to review and enhance the ESTA emergency call made by Mr Hayward and to prepare a transcript. The transcript which he produced purported

to identify the voices of three males plus the Metropolitan Fire Brigade (MFB) officer who appears (and is heard) at the end of the call.

79. Ms Sophia Kayani relied on this transcript as evidence that there was a third male present in the house in or around the time Al was injected with heroin. She suggested that the presence of the third male was confirmed by the evidence of some of the MFB officers, particularly Mr Halasz, and consistent with the evidence of police officers that they had been asked to remove a male from the house and that it is not uncommon for persons to flee when police arrive at the scene of a drug overdose.

80. As I indicated during the inquest, I am not satisfied that Mr McArthur has the necessary expertise to give an expert opinion on the identity of the voices on the recording. His experience appears to be mainly in relation to visual images and in relation to the enhancement of images and sounds rather than the identification of persons on an audio recording.

81. Further, I have more direct evidence from those whose voices clearly appear on the recording.

    81.1. The Emergency Services Telecommunications Authority (ESTA) recording was played during the evidence of Mr Hayward. He denied there was a third male present at any stage and said that the words attributed to "male 3" by Mr McArthur were spoken by either him or by Mr Ostojic.

    81.2. Mr Ostojic also denied there was any third male present.

    81.3. Other than Mr Halasz no other person gave evidence that there were more than two men present with Al.

82. I have listened closely to the recording myself. The voices overlap and are sometimes hard to distinguish but there is no clearly identifiable third voice.

83. Mr Halasz made his statement a considerable time after his attendance at the scene of Al's overdose and in circumstances where he had attended many other such scenes since. In those circumstances, whilst I accept that he was doing his best to assist me, I prefer the evidence of Mr Hayward and Mr Ostojic, supported as it is by the evidence of the ESTA recording and the evidence of other emergency personnel attending the scene.

84. I am comfortably satisfied that there was no third male present at the time Mr Hayward rang for help or during the time he was trying to cardiopulmonary

resuscitation (CPR) with the assistance of the ESTA call taker. I am further comfortably satisfied that there was no one other than Al himself, Mr Hayward and Mr Ostojic at the house on the evening of 29 June prior to Al's collapse.

85. I also accept Mr Hayward's evidence that he rang for an ambulance as soon as he realised Al had collapsed. His concern and distress are apparent on the recording and are consistent with his written and oral evidence about his feelings for Al. I do not accept the suggestion that he had any motive or desire to harm Al. I place no weight on Mr Ostojic's apparent perception that Mr Hayward was not performing CPR correctly, given his intoxicated state.

86. MFB officers Dammous, Dunmore and Halasz were the first emergency personnel to arrive and their arrival is recorded on the 000 recording. Officer Dammous is heard to refer to the potential use of Narcan but no Narcan was ultimately administered because Al was in cardiac arrest and required resuscitation. Officer Dammous commenced CPR on Al who was on the floor in the living area, assisted by Officer Halasz.

87. Station Officer Dunmore called for police attendance after becoming concerned about the behaviour of one male who was agitated and making potential threats. I am satisfied that the male was Mr Ostojic.

88. When paramedics Lynch and Nyland arrived at 11:25pm, they found Al with no carotid pulse and cyanotic in colour. They took over Al's care from the MFB officers. After multiple administrations of adrenaline and continued chest compressions Al's heart started again.

89. Police officers Acting Sergeant Clinch and Senior Constable Sekoa[3] attended the scene at 11:27pm in response to Station Officer Dunmore's request for assistance in dealing with the agitated male. They had understood before arrival that there were issues with two males but on arrival were told by the MFB but that it was one male (Mr Ostojic) who was the concern. Senior Constable Sekoa escorted Mr Ostojic outside while Acting Sergeant Clinch spoke to Mr Hayward. Mr Hayward gave an account of the events of the evening that was largely consistent with his evidence to me save that he did not admit to his own heroin use that evening.

[3] At the time of the attendance both officers were First Constables of Police but I have used the ranks they held as at the date of their evidence before me.

90. Acting Sergeant Clinch and Senior Constable Sekoa found Mr Ostojic to be highly intoxicated and uncooperative. Their role at the scene was largely confined to keeping Mr Ostojic away from the scene of treatment as all the indications were that the scene was an accidental overdose and not a crime scene. The duty sergeant, Sergeant Penny Renden also attended the scene but did not remain after being satisfied that it did not require additional police resources.

91. Acting Sergeant Clinch and Senior Constable Sekoa remained at the scene until Al left in the ambulance. At Mr Hayward's request they directed Mr Ostojic to leave the property and he collected his belongings and left in a taxi. Acting Sergeant Clinch reviewed the lounge area but did not see any drugs or drug paraphernalia. They then left the scene.

92. Al was transported to the Western Hospital at Footscray. On route he began breathing spontaneously but he remained ventilated at the Western Hospital and a CT scan revealed the hypoxic brain injury later observed by Dr Bedford at autopsy.

93. He remained in hospital and his condition did not improve. His mother and sisters travelled from the United Kingdom to be by his side. Ms Davis and other friends also travelled to see him. Unfortunately it would appear that conflicts developed between Ms Davis and others and that rumours and second hand information began to circulate and be reported to Al's family suggesting that Al had been the victim of a crime and that Ms Davis and or Mr Hayward may have been involved. Although my investigation has revealed no basis for those rumours I accept that they caused great distress and concern for Al's mother and sisters at a time when they were already coping with the sudden and unexpected illness and impending death of their son and brother in a foreign land and in circumstances which were very alien to the their knowledge of him.

94. On 5 July 2014 after extensive investigations confirmed that Al would not recover, a decision was made to withdraw life support and Al died at 5:10pm.

THE ROLE OF THE POLICE AT THE SCENE

95. Neither Acting Sergeant Clinch nor Senior Constable Sekoa conducted any formal search of the scene or collected any evidence of the events of the evening. They said that from their perspective there were no suspicious circumstances and they were there to keep the peace and ensure Mr Ostojic did not interfere with the care being provided to Al by the MFB and paramedics. Acting Sergeant Clinch denied

that his failure to locate the heroin or obtain truthful answers from Mr Hayward about his own use of heroin suggested that there was any inadequacy in how he searched the premises or spoke to Mr Hayward.

96. Both Acting Sergeant Clinch and Senior Constable Sekoa said that police are not called to accidental overdoses as a matter of course and that the reason for this was to ensure that people are not dissuaded from calling for help after an overdose by the risk that they might be charged with drug use or possession. They said that nothing at the scene suggested to them that any offences other than drug possession and use offences may have been committed. In those circumstances they had no power to conduct a formal search and no basis to question Mr Hayward on any basis other than in the context of him having been present at a medical emergency.

97. Both officers were aware that Al's heart had been re-started at the scene and both believed he would recover. There was some dispute on the evidence about what precisely might have been said by paramedics that made the police officers think Al would live, but I accept that the officers did not have any reason to expect that Al would die, given that he was alive and apparently stable when he left in the ambulance.

98. The absence of any full search at the time meant that the spoon and needles used by Al were not located, nor the remaining heroin which Mr Hayward said was still on the kitchen bench during the police attendance. It also meant that no photographs were taken of the scene on 29 June 2014 or until after Al's death.

99. Ms Sophia Kayani submits that this represented a significant failure by police to investigate what may have been a crime. She invited me to find that the failure to search meant the potential loss of valuable evidence and that the conclusion by Senior Constable Sekoa and Acting Sergeant Clinch that Al had taken an accidental overdose had tainted all subsequent police action.

100. Assistant Commissioner of Police Rick Nugent conducted a review of police involvement in Al's case and gave evidence before me at the inquest. His evidence included the following -

100.1. Police cannot search private property without a search warrant;

100.2. The grant of a search warrant requires evidence on oath that a police officer reasonably believes that material relevant to the commission of an offence will be found; and

100.3. Victoria Police does not usually seek search warrants where the offences in question are use or possess drugs of dependence.

101. Assistant Commissioner Nugent gave evidence that Victoria Police's approach to addressing drug issues in the community is based on the principle of harm minimisation. Both in the Police Academy and by means of the Victoria Police Manual police officers are trained to give consideration to whether the prosecution of a person for use or possession at non-fatal overdoses is in the best interests of the community. The rationale for the approach is that removing the fear of prosecution will encourage persons present at overdoses to call for an ambulance without delay.

102. Assistant Commissioner Nugent's assessment of the conduct of Senior Constable Sekoa and Acting Sergeant Clinch was that they had acted in accordance with Victoria Police policy in deciding not to treat their attendance at Al's overdose as a suitable matter for investigation for drug offences. He also considered that on the information available to them there was no reason for them to suspect that any more serious offence had been committed, given the absence of any signs of a struggle or injury, and that absent such signs there would have been no basis to seek or obtain a warrant to permit a full search of the property.

103. I accept that Victoria Police has a policy of harm minimisation in relation to drug issues and that the policy is appropriately grounded in the aim of balancing health, social and economic outcomes for the community and for individuals.

104. I accept that it was consistent with this policy for Acting Sergeant Clinch and Senior Constable Sekoa, once they formed the view that Al had suffered an overdose, to refrain from conducting any formal investigation into his conduct. Were it not for the request by the MFB for assistance to contain Mr Ostojic, police would not have attended the scene at all.

105. I also find that it was reasonable in all of the circumstances for Acting Sergeant Clinch and Senior Constable Sekoa, once they did attend to assist with Mr Ostojic, to form the view that there were no suspicious circumstances associated with Al's overdose and collapse. He had been in the company of friends, there were no signs of injury or struggle, and Mr Hayward had called for help and appeared appropriately concerned about his friend's welfare.

106. I also accept that the officers had no basis or power to conduct a search or interview witnesses in relation to any offence of violence because there was no

evidence of an offence being committed against Al and there was no suggestion in their minds that Al was going to die such that a crime scene needed to be established to assist a coronial investigation.

107. My investigation has confirmed that the decision by police to regard the events of 29 June as an accidental overdose was the correct one. There were no offences committed other than the offence of use and possess heroin committed by Mr Hayward and by Al himself.

108. It follows that I am satisfied that the police response on 29 June 2014 was appropriate.

THE INVESTIGATION

109. As I have noted, at the Western Hospital both before and in the immediate aftermath of Al's death his family were told of rumours or suggestions that Ms Davis may have been involved in Al's overdose. There was also considerable acrimony developing over access to Al's possessions and to questions of who was his next of kin and whether his life support should be turned off. All of those property and personality related matters are outside the scope of my investigation, though I note they would have added to the distress being felt by Al's family.

110. Senior Constable Dewe received and investigated the concerns the family raised about the potential for Al to have been injected with heroin against his will. She attended at the St Albans flat and spoke to Mr Hayward who gave her the same account he has given me. She photographed the house after consulting with the divisional Crime Investigation Unit.

111. The investigation was otherwise carried out by Detective Stokes, assisted by Detective Clark and with the guidance of Detective Sergeant Mackender. The coronial brief represents the fruits of that investigation. It includes extensive material about Al's life in Queensland, statements from a number of his friends, and statements from emergency services and medical personnel who were involved in Al's care.

112. The investigation clarified, by way of additional statements some of the rumours which had circulated in the days following Al's death. It would appear that the combination of stress and confusion and a desire to be helpful may have led some friends of Al to draw, and express, conclusions or suspicions which did not have a proper foundation. This was most unfortunate for Al's family.

113. It is true that I do not have available to me the kind of evidence of the scene that I would have had if a crime scene had been established at the St Albans address on the night of Al's overdose. Had Al died at the scene, Victoria Police policy would have to establish a crime scene for the purposes of a coronial investigation and photographs of the scene would have been taken and the remainder of the heroin and drug paraphernalia might have been found. However, I am satisfied that those photographs and other pieces of evidence would not have pointed to anything other than an accidental overdose by Al.

114. I am satisfied that the investigation was sufficient to enable me to make the findings required of me under the Coroners Act and that there was no criminal involvement by any person in Al's ingesting of heroin or subsequent collapse.

CONCLUSIONS

115. Having considered all of the evidence and submissions received during the inquest and all of the other material contained in the investigation, I make the following findings about the circumstances of Al's death.

116. I find that Al injected himself, or was consensually injected by Mr Hayward, with heroin on 29 June 2014 at Mr Hayward's flat in St Albans. No person other than Mr Hayward was present at the time, though Mr Ostojic had been at the address earlier in the evening. Al's decision to take heroin occurred in the context of depression and anxiety about his professional and personal circumstances and in circumstances where he had previously used heroin and other drugs with (at least) Mr Hayward and Ms Davis. There is no evidence to support a finding that Al intended to take his own life.

117. I find that Mr Hayward called 000 in a timely fashion and that only he - and later Mr Ostojic whose return is recorded on the 000 recording - were present until the arrival of emergency services personnel. I am satisfied that the 000 recording confirms the evidence of Mr Ostojic and Mr Hayward that there was no other person there and I prefer their evidence, supported by the recording, to the recollection of Mr Halasz.

118. I find that the attempts made by Mr Hayward to perform CPR were genuine and that Mr Ostojic's role, if any, was disruptive to those attempts. I find that Officer Dammous and his MFB colleagues also performed CPR to the best of their ability and it is a credit to their efforts, and the efforts of the attending paramedics that

Al's heart beat and circulation were able to be restored at the scene and in the ambulance, though tragically the hypoxic brain injury could not be prevented. I find that that brain injury is no indication that the CPR performed was deficient.

119. I find that there was no reasonable basis for police officers Sekoa and Clinch to apprehend that Al would die or that any offence against him had been committed and that accordingly there was no basis for them to establish a crime scene or to otherwise secure and search the house. Even with the benefit of hindsight afforded to me by my role as a coroner, I am satisfied that Al was not the victim of any offence on 29 June 2014 and that further searches or investigations on 29 June 2014 would not have uncovered any evidence of such an offence. As Counsel Assisting submitted in her written submissions, whilst the circumstances of Al's death are very sad, they are not sinister.

120. I find that the investigation which followed Al's death was appropriate and that reasonable steps were taken to obtain relevant evidence to assist the coronial investigation of his death. Whilst I acknowledge that members of Al's family are dissatisfied with the way in which steps were taken or not taken to preserve Al's property after his death, those matters fall outside the scope of my investigation and I make no comment about them.

121. I express my deepest condolences to Al's family for the loss of their son and brother, recognising the distress they feel not only for Al's death but for the circumstances of that death which, I accept, are for them quite out of keeping with the man they knew.

Pursuant to section 73(1) of the *Coroners Act* 2008, I order that this Finding be published on the Internet in accordance with the rules.

I direct that a copy of my findings be provided to each of the following:

Mrs Kaniz Kayani

Ms Sophia Kayani

Ms Sarah Davis

Chief Commissioner of Police

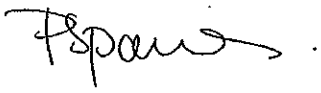
Western Health

Ambulance Victoria

Metropolitan Fire Brigade

Her Majesty's Coroner for Walthamstow

Signature:



PARESA ANTONIADIS SPANOS

CORONER

Date: 22 June 2018