CORONER'S COURT

Inquest:	Jason William REA
Hearing dates:	23-26 March 2015
Place of Inquest:	Gosford Courthouse, Gosford NSW 2250
Date of findings:	26 June 2015
Place of findings:	Coroner's Court, Glebe NSW 2037
Findings of:	Paul MacMahon Deputy State Coroner
Catchwords:	CORONIAL LAW – Cause of Death, Death in circumstances of restraint, Death arising out of, or in the course of, a police operation, effects of Methylamphetamine.
File number:	14/38053

Representation:	Mr W Hunt – Counsel Assisting Mr J Downing – NSW Ambulance Mr R Hood – NSW Police Force

Non-publication order made pursuant to Section 74(1) (b) Coroners Act 2009:

Nil

Findings made in accordance with Section 81(1) Coroners Act 2009:

Jason William Rea (born 15 February 1975) died on 5 February 2014 whilst en-route by ambulance from the M1 Freeway, near the Brooklyn Bridge, to Gosford Hospital, Gosford in the State of New South Wales. The cause of his death was the combined effect of Methylamphetamine Toxicity and prolonged restraint in a person suffering from single vessel coronary artery disease. The Methylamphetamine had been self-administered without the intention of ending life.

Recommendations made in accordance with Section 82 (1) Coroners Act 2009:

Nil

Paul MacMahon
Deputy State Coroner
26 June 2015

Reasons

Jason William Rea (who I will refer to in these reasons as ‘Jason’) was born on 15 February 1975. In February 2014 Jason resided in Woy Woy on the central coast of New South Wales. On 5 February 2014 Jason was the driver of a motor vehicle on the M1 freeway north of the Brooklyn Bridge that was involved in a collision. As a result Jason, and the occupants of the other vehicle involved, sustained serious injuries.

Notwithstanding the injuries he suffered Jason extricated himself from his vehicle and began moving towards the freeway. Persons nearby became concerned and restrained him until police arrived. Jason resisted the restraint. He was aggressive and confrontational. Jason was handcuffed and held face down with his hands behind his back. Shortly after paramedics arrived Jason went into cardiac arrest. Jason was subsequently declared deceased as he was being transported to Gosford Hospital.

Jason’s death was reported to the Office of the State Coroner on 6 February 2014.

Role and Function of the Coroner

The Coroners Act 2009 (the Act) governs the role and function of a Coroner.

The Objects of that Act are set out in Section 3 and include the jurisdiction:

> *(c) To enable coroners to investigate certain kinds of deaths in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths, and*
> *(e) To enable coroners to make recommendations in relation to matters in connection with an inquest*

The certain kinds of death that a coroner is able to investigate are *reportable deaths*.

Section 6 defines a *reportable death* as including one where a person died a *violent or unnatural death* or under *suspicious or unusual circumstances.*

Section 35 requires that all *reportable deaths* be reported to a coroner.

Section 18 gives a coroner jurisdiction to hold an inquest where the death or suspected death of an individual occurred within New South Wales or where the person who has died, or is suspected to have died, was ordinarily a resident of New South Wales.

Section 27(1) (b) provides that if it appears to a coroner that a person died, or might have died, in circumstances to which Section 23 applies then an inquest is mandatory.

Section 23 gives exclusive jurisdiction in respect of the investigation of certain deaths to Senior Coroners.

Section 22 (1) defines a Senior Coroner as being the State Coroner or a Deputy State Coroner.

The exclusive jurisdiction given to Senior Coroners includes the investigation of deaths that occur *as a result of or in the course of a police operation* (Section 23 (c)).

The primary function of the coroner when an inquest is held is to be found in Section 81(1). That section requires that, at the conclusion of the inquest, the coroner is to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

In addition to the matters to be determined in accordance with Section 81(1) in a case where a death occurs *as a result of or in the course of a police operation* it is important that the contribution of police action, if any, to the circumstances of the death be the subject of a full and public inquiry.

The Parliament requires that inquests in such circumstances be conducted so as to provide a positive incentive to police to ensure that their actions, in the course of the performance of their duties, are appropriate in all situations and to satisfy the community that those deaths that occur when police are involved are properly investigated. It is also in the interest of the police that such deaths be properly

investigated so as to ensure that the officers involved, and police in general, are not the subject of unsubstantiated or malicious allegations.

Section 82 (1) of the Act provides that a coroner conducting an inquest may make such recommendations, as he or she considers necessary, or desirable, in relation to any matter connected with the death with which the inquest is concerned. The making of recommendations are discretionary and relate usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way coronial proceedings can be forward looking, aiming to prevent future deaths.

Issues for Inquest

Jason's identity as well as the date and place of his death were not issues of controversy at the inquest.

Jason's mother, Jacqueline Norma Rea, identified his body at the Department of Forensic Medicine, Newcastle on 7 February 2014. I am satisfied that the evidence discloses that the person involved in the incident on the M1 Freeway on 5 February 2014 was Jason William Rae.

The evidence is that Jason, having crawled out of his vehicle was unable to stand because of a fractured left leg/ankle. He became aggressive towards bystanders and appeared to be delusional. He was restrained firstly be bystanders and then by police. He was handcuffed. A decision was made to sedate him however before this had occurred he became limp and went into cardiac arrest. CPR was commenced by ambulance officers' and continued until his arrival at to Gosford Hospital.

On arrival at Gosford Hospital he was found to have bilateral air entry but no cardiac output. His pupils were dilated and non-reactive. He was declared deceased soon after arrival in the Emergency Department. I am satisfied that it is more probable than not that Jason died en-route to Gosford Hospital.

As a consequence the issues for inquest concerned the cause and manner of Jason's death and the contribution, if any, of the actions of police officers, and others, to the death. To assist me in determining this matter I had available an

extensive, and well-constructed, brief of evidence prepared by the officer in charge of the investigation of Jason's death, Detective Inspector Grant Taylor, and heard oral evidence from Detective Inspector Taylor and fourteen other witnesses.

The Evidence

The evidence assembled shows that Jason had a troubled adolescence and got into trouble with the law from about the age of twelve. The matters that resulted in Jason coming before the Courts, both as an adolescent and as an adult, were those that are commonly associated with illicit drug use. By 2014 Jason had been using Amphetamines for many years and this adversely affected his mental health.

One of Jason's partners described Jason's state of mind when he was on amphetamines as follows:

> *Jason would get paranoid when he used 'gas' (amphetamines). The more 'gas' he used the more paranoid he would get. When Jason was paranoid he would always say that people were following him. He did not say who exactly. Jason would also get paranoid when I used my phone as he thought I was telling people where he was. He would always want to walk through the door first before me to make sure I was safe and he would always keep looking out windows all the time to see if people were following him. Jason would also say things that did not make sense. I remember he would say the word 'Nimitz' and 'deployment.' It sounded like army stuff that made no sense. Jason would also flap his arms about in jerky movements when he was paranoid.*

Evidence also showed that when Jason was using amphetamines, alcohol or other drugs he could become violent. In 2010 he was convicted at Coffs Harbour Local Court of Common Assault and Assault Occasioning Actual Bodily Harm (2) following an incident in which he assaulted his de-facto and his daughter after a lengthy session of alcohol consumption. In March 2013 at Gosford Local Court he was again convicted of in respect of further acts of violence.

In the period immediately prior to the events of 5 February 2014 Jason's life was out of control. In 2013 he had commenced a relationship with a Michelle Stoken. She described Jason's drug use during the course of their relationship as follows:

> *I first met Jason Rea about ten months ago at the Ettalong Hotel playing the card machines. I was using speed at the time and asked Jason where I could get on. Jason helped me score some speed.*

I was using speed about once a week and Jason probably three times a week. We were both shooting it up. Sometimes Jason would be on the gear for a full week. Four months after going out I broke up with Jason and went into a rehab place at Canton Beach, Toukley. We broke up because of Jason's drug use. I wanted to stop it but I knew that Jason couldn't.

When Jason was using he was in a mess, by that I mean that he would often start talking about spun out shit. Saying stuff like he was 'trying to work out who the enemy was' and paranoid that people would be talking about him. When he was sober he was a completely different person.

Jason's mother, who was a continual witness to the cycle of Jason's life summed up to investigators Jason's situation in the period prior to 5 February 2014 as being *'controlled by his addiction to narcotics'* and that he '*was spiralling downwards and out of control.'*

Jason's actions immediately prior to 5 February 2014 followed a similar pattern of illicit drug usage and associated criminal activity. I do not need to go into the events in detail other than to note the following:

- Jason was described by people who knew him as being affected by drugs,
- Jason, whose only lawful source of income was the Newstart pension, was suspected to have been involved in the theft of a safe containing $15,000 and a rare coin collection worth about $200,000 form a property at Umina Beach,
- Shortly after the theft at Umina Beach Jason paid $2,000 in cash for a silver Ford Falcon motor vehicle,
- When Jason attended the Roads and Maritime Office at Woy Woy to register the car his demeanour was described by a witness as being:

  I thought he was drunk by the way he was acting. The guy appeared to be on edge and was talking fast and he made me nervous because he just didn't seem normal.

- On 4 February 2014 Jason, and a friend, travelled to Sydney where he was in contact with a person who was suspected by police to be a drug dealer. Jason also attended the Westmead Hospital and whilst there asked his friend to purchase needles for him,

- Jason returned to the Central Coast later that evening and went to his mother's home. Jason's mother described his demeanour at the time as follows:

> *Jason appeared to be hyperactive again and was pacing back and forth. He had gotton up a number of times and was opening and closing doors. He was turning lights on and off and moving about the house continuously. It was getting late in the night and I wanted to get some sleep but couldn't sleep if Jason was going to be opening and closing doors all night. I believed that Jason had used drugs again due to his behaviour and mannerisms.*

- Jason subsequently left his mother's home and at about 22:30pm, with a female friend, Jason attended the home of an acquaintance who he gave $2000 in cash for him to look after. The acquaintance thought that Jason was drug affected at the time.

- Jason, and his female acquaintance, then attended the McDonald's outlets at Woy Woy (04:12am on 5 February 2014) and subsequently Wyoming. Sometime later Jason then went to his mother's home and had breakfast with her. He then left her home at about 09:00am on 5 February 2014.

- Jason then returned to his friend's home and retrieved the $2000 he had asked him to mind for him. He was once again with the female friend that he had been with the previous night. The investigation has shown that Jason and his female friend then travelled to the Westfield complex at Tuggerah.

- Whist at Westfield Jason made a phone call to the person, who he had called the day before, who was a suspected drug dealer. Having done so Jason then travelled to Sydney. At 2.00pm he again called the suspected drug dealer from a location near that person's residence in Wentworthville. It is believed by the investigators that Jason then obtained Methylamphetamine.

- Jason then drove to the Prospect Hotel in western Sydney where he and his female friend checked into a room for one night. Sometime later Jason left his female friend for a short time. She described him as being different when he came back. She said:

> *Jason left me in the bar. I'm not sure where he went, but he came back about twenty minutes later. When Jason came back he was different. It is difficult to describe, but he had this black evil look on his face and in*

his eyes. I was scared. I have seen this look before and it was the same look he had when he pulled me off his bike. I did not see Jason use any drugs, but he had used something.

- Jason then decided to leave the hotel. His friend said that she had become scared of him and hid. Jason searched for her until he was told by the manager to leave the hotel. He then left. The manager described Jason's demeanour as follows:

  From the very first moment I saw this male person get out of the car I formed the opinion that he was heavily affected by something. During my interactions with him I formed a stronger opinion that he was drug affected and appeared to be suffering from mental health issues.

- Jason drove out of the hotel car park by himself at 17:52.

- At 18:35 Jason was in South Toongabbie and made a phone call to another person who was known by police to be a drug dealer.

- At 18:49 Jason phoned his ex-girlfriend Michelle Stoken. Stoken records that during the conversation Jason told her *that police and detectives were looking for him and following him.* Stoken described Jason as being *paranoid.* She suggested that he return to the hotel and get some sleep. He replied that he could not do so as: *That was red hot there and police would get him for sure.* Stoken told investigators that: *He sounded like he hadn't had any sleep. I got the impression he may not have slept for about six days.* Stoken had some further contact phone with Jason after that but then lost contact.

- Jason then appears to have decided to return to the Central Coast. At 19:36 CCTV situated at the Mount White Heavy Vehicle Checking Station captured a vehicle that fit the description of Jason's vehicle travelling north towards to Central Coast on the correct side of the road. It would seem that Jason travelled towards the Central Coast and then, for some unknown reason, turned around and began to travel south in the direction of Sydney.

I have recited the above history to record Jason's erratic behaviour in the period leading up to the circumstances of his death in order to show that Jason was drug affected for an extended period and that the effects of his drug use were apparent to those with whom he came into contact and, over time, became more pronounced. It is also clear that by the time Jason commended his journey to return to the Central

Coast he appeared to have become both paranoid and delusional. The investigation established that Jason was not the subject of a police attention at the time although it is clear from what he said to Stoken that he believed he was.

The Motor Vehicle Collision:

On 5 February 2014 the Roads and Maritime Services (RMS) planned to undertake road works on the M1 Freeway. At 19:45 RMS employees had placed witches hats and signage just before the work which reduced the speed limit to 40km/h. The Witches hats started about a kilometre before the Jolls Bridge.

Jason drove across Jolls Bridge at about 20:18. He was observed by a witness, Fred Hendricks, to be driving erratically. Mr Fredericks told investigators that:

> *It looked like the vehicle turned off its headlights immediately before it reached the workmen – the workmen were scrambling out of the path of the car and jumping into the side barriers lining the road itself.*

One of those workmen, Troy Laws, described what happened:

> *As soon as I saw the silver falcon, I ran up against the guard rail closest to lane one, the car swerved directly at me missing me by no more than half a metre. The car then swerved back towards Gavin who was standing in the middle of lane one about five metres in front of me towards the bridge, the car missed Gavin by about the same amount as me.*

Jason then continued south towards the Hawkesbury River Bridge. He was observed by Gregory Illingworth, who was driving towards Sydney, when Jason accelerated past him down to Mooney Mooney towards the Hawkesbury Bridge. Mr Illingworth described what happened next in the following terms:

> *As the sedan approached the left hand exit lane near the bottom of the hill which gives access to the Old Pacific Highway, the sedan seemed undecided as to whether or not to take the exit lane or stay in the left lane of the freeway, and hence it was slowing. As the sedan approached the exit alternative the sedan steered straight towards the divider that separates the exit from the freeway. At the last minute the sedan suddenly swerved right, back onto the left lane of the freeway.*

Mr Illingworth then continued across the Hawkesbury Bridge with Jason's vehicle ahead of him. Jason then did a complete U-turn and began to drive his vehicle to the

north towards the vehicle driven by Mr Illingworth. Mr Illingworth described what happened in the following terms:

> *When perhaps a third of the way up that long hill, still in the right lane, the sedan braked hard and then, incredible, took the full width of the freeway to U-turn anti-clockwise and then come, accelerating flat out, with its headlights on high beam, straight towards the front of my car. That was the most heart-stopping moment of my fifty six year driving experience.*

Megan Simmons, at the same time, was also travelling south bound on the M1 nearing the Hawkesbury Bridge. She described her experience as follows:

> *I realised that there was a vehicle travelling on the wrong side of the motorway in my direction. I thought it was either a police car or the driver of the vehicle had made a mistake. I stayed in the middle lane and slowed to about 80km/h. The vehicle continued to travel in the right lane building up speed as it got closer it moved into my lane, the middle lane. When I saw this I thought that the driver was doing this deliberately to crash into my car. The vehicle got closer to my car I could see that the vehicle was a light coloured sedan. I realised that if I did not move the vehicle was going to crash into my car. I suddenly moved into the left lane. I did not have time to check if there were any vehicles travelling in the left lane – the vehicle passed me in the middle lane. I continued in the left lane. I slowed down to about 70km/h and watched the vehicle in my rear view mirror. I saw the vehicle deliberately try and hit the cars that had been behind me.*

Shortly after this Jason stopped his vehicle and witnesses said that they thought he may have been going to turn around and travel in the correct direction. This was however not the case. He, in fact, crossed to the north bound lanes and began to travel south on the wrong side of the freeway travelling down the hill towards the Hawkesbury Bridge during which time he narrowly missed a number of vehicles.

Shortly before this the O'Donnell family had completed a family dinner at the Mooney Mooney Workers Club. The family were from the Central Coast area of New South Wales and had other family members at the dinner who were from Sydney and Western Australia.

Christine O'Donnell had driven from her home on the Central Coast with her sons Benjamin and Andy, and Andy's wife Stephanie. Andy and Stephanie were from Western Australia. Christine was the designated driver and had not consumed any alcohol at the family dinner. They left the car park of the Club at about 20:20 with

Christine driving, Benjamin in the front passenger seat and Andy and Stephanie in the rear seats.

Ms O'Donnell drove onto the Old Pacific Highway and then onto the entry ramp of the M1 freeway northbound. She travelled along the merging lane increasing her speed to about 85km/h in order to merge onto the M1. She described what happened as she began to merge onto the freeway as follows:

> *I saw some headlights facing towards me in the distance in the same lane as me coming towards me. I couldn't believe the car was travelling in the wrong direction going faster than what I was travelling. The car beside me braked so I was to move over into the second lane to get out of the way of the oncoming lights. As I swerved across, the other car approaching me mirrored my actions and was coming straight for us.*

Mark Porter, a member of the Rural Fire Brigade, was travelling north on the M1 at the time. His description of the events that followed was clear and precise. He said:

> *I had just hit the deck of the bridge, I was in lane one of three, travelling at 110km/h. There were no cars travelling in front of me on the motorway. I saw a Holden Captiva driving on the looping section of the ramp towards the merging lane, it was travelling slowly. I would estimate it was travelling about 80-90 km/h. I moved into lane two so that the Holden Captiva could merge safely.*
>
> *I was two thirds the way across the bridge when I noticed a set of bright lights. The lights were on the left hand side of the north bound lanes, about 100 metres north of the bridge where the road starts to rise to travel up the hill. The lights were very bright. I initially thought that a road work crew had set up a spot light facing in the wrong direction. The lights were stationary for a couple of seconds then the lights started to move slowly. I realised that it was the headlights of a motor vehicle.*
>
> *The vehicle was travelling south in the north bound lanes. Because the vehicle was moving slowly I thought it was a roadwork vehicle. The vehicle accelerated harshly, I know because the angle of the headlights changed moving upwards as the front of the vehicle went up. I believe this is when the driver of the vehicle would have first seen me. At that time the Holden Captiva was in the merging lane, there was a slight left bend at that section of the road which may have prevented the driver of the Holden Captiva form seeing the vehicle.*
>
> *The vehicle was accelerating rapidly in the left lane leading towards me. I checked my rear view mirror and saw that there was a semi-truck travelling behind me. I started to tap my brakes to warn the semi-trailer driver that something was wrong and that I may have to stop in a hurry.*

> *I looked forward. The street lights had illuminated that section of the roadway. The Holden Captiva had just merged onto the motorway and was now travelling in lane one. I saw that the vehicle that was travelling south was a grey BA Ford Falcon sedan and that it was going to crash head on into the Holden Captiva. I braked heavily and stayed in lane two. The driver of the Holden Captiva turned right trying to avoid the collision. The Ford Falcon did not make any attempt to avoid the collision and it crashed head on into the Holden Captiva, on impact I saw white powder come out of both vehicles, which I believe was when the airbags were deployed. The back of the Holden Captiva was lifted off the road. It was pushed backwards towards the merging lane. The Ford Falcon rotated slightly sideways and stopped blocking lanes two and three. As the cars separated the engine bay of the Ford Falcon caught on fire.*

The above events were dramatically captured by a video recording, which formed part of the evidence, from a vehicle travelling behind Mr Porter's vehicle.

As a result of the collision members of the O'Donnell family received significant injuries, some of which were life threatening. Some members of the O'Donnell family were trapped within their vehicle and required rescue personnel to extract them in order to render adequate medical aid. Christine O'Donnell was taken by helicopter to Royal North Shore Hospital at St Leonards in a critical condition.

Mr Porter also observed what happened to Jason. He said:

> *I heard the male in the Ford Falcon he was screaming and yelling. I started to move towards the car. There were a number of bystanders near the Ford Falcon they were yelling at the male. The male was banging on the inside of the Ford Falcon. It sounded like he was hitting the centre console and dash board. I thought that he was trying to get out of the vehicle. The male was aggressive. I could not determine what he was trying to say but I remember that he was swearing. Other bystanders and I were yelling at the male telling him to stay in the car. I was concerned that he was going to get out of the vehicle. I formed the opinion that the male was drug affected due to his behaviour in the vehicle and the manner of driving. I was concerned that he was going to get out of the car and that we would not be able to control him because he was way too angry and aggressive.*

Mr Porter phoned his supervisor in the RFS and asked that police be called as at the time Jason was *going off his head*. Mr Porter then assisted the O'Donnell family members. Shortly after that Mr Porter looked over towards the Ford Falcon. He

noticed that Jason was out of his vehicle and was moving towards the carriageway of the freeway. He went on to say that:

> *A couple of male bystanders, I think that one was a road worker and the other was possibly a truck driver, they grabbed the male driver and held him face down on the ground. I don't know how they got him on the ground. I am not sure how they were holding the male down. They were positioned towards the male's back. The male was struggling with them moving and trying to get up from the ground.*

Ryan Fisher was a traffic controller who left the north bound road works further along the M1 and travelled to the crash scene. He approached the Ford Falcon and observed what was occurring. He described it as follows:

> *While I was standing there the driver was attempting to reach across to the glove box. The airbag was deployed and I could not see the glove box. When he did this I moved back as I was concerned about what he was trying to get from the glove box. I thought he was drug affected; he was restless scratching his arms and head. He would continually rub the top of his head. He was rambling and saying I've done nothing wrong. The Emergency Traffic Control vehicle (ETC) arrived at the scene and commenced setting up.*
>
> *A 4WD Ambulance vehicle arrived first with it and had its red and blue warning lights activated.*
>
> *I noticed that, when the Ambulance arrived, the driver's behaviour changed, he became more agitated and aggressive in his movements. He was trying to get out of the vehicle by pushing up on the central console, the driver's door and the steering wheel. He said 'Get me out!'*
>
> *I said to the male with the English accent, to go and get the Ambulance officer to turn off the flashing lights because it was making the driver 'hyped up', agitated and aggressive. The Ambulance officer turned the flashing lights off, when he did this the driver calmed down.*

When more emergency vehicles arrived; Jason, once again, reacted to them by becoming aggressive and agitated. He got himself free and left this vehicle. Mr Fisher saw this and described what then happened. He said:

> *The driver was able to get out of the vehicle; he put his right leg on the ground and then attempted to stand on his left leg. I noticed that his left leg was broken, the bone was at an off angle and his foot was moving freely. The driver fell to the ground and rolled onto his back. He said 'Fuck, my ankle.'*

Shortly after that police arrived. Jason then became more agitated and aggressive. Mr Fisher observed a police officer approach Jason who said *I'm on fire, I'm on fire*.

The police officer said to him *No you are not, calm down*. At which point Jason started swinging his arms and legs around and repeating himself about being on fire.

Intervention by Police:

All police officers involved in the incident gave evidence at the inquest. I do not propose to recite their evidence in these reasons as it was in accordance with the evidence of the lay witnesses who observed the events that occurred following the police intervention. I will, however, outline those events through the words of the lay witnesses.

Mr Fisher's evidence was as follows:

> *Myself and another person I don't know who this person was stood near the driver. The driver was lying on the left side of his body, his chest and back was off the ground. The first police officer was standing behind the driver and the officers legs were near the drivers back. I was standing with my legs on one side of the driver and another person was standing opposite me. We were trying to stop the driver from kicking his legs around and hurting himself. The driver swung his right arm across his body and hit the first police officer's legs. The police officer told him to stop.*
>
> *The driver swung his right arm again and hit the first police officer in the leg. The first police officer bent down into a squatting position. He had his body next to the driver and attempted to grab hold of the driver's right arm. The driver kept swinging his arm around and the police officer was unable to grab hold of the arm. The first police officer put one of his knees on the ground next to the drivers back, his other leg was parallel behind him and his chest was resting on the right shoulder of the driver. The driver was moving his body around and struggling with the first police officer. The first police officer repeated 'Calm down, calm down stop resisting.' The driver's legs were moving around. So I put my left knee on both of the driver's knees to stop him moving about. Another male put his knees on the lower part of the driver's legs. I told that person to be careful of the driver's ankle. A third male was near me, he was trying to help the first police officer. I could not see what this person was doing.*

The evidence is that eventually Jason was handcuffed behind his back and was lying on the ground on his stomach. The police used two handcuffs, one on each wrist, and then the handcuffs were joined together. Jason, however, continued to struggle and lash out at those around him.

Mr Fisher expressed his view of the actions of the police as follows:

> *When the police officers were dealing with the driver they were calm and controlled in their actions. They only used their body weight to restrain him; at no time did they strike or hit the driver. I thought the level of force the police used was reasonable as they were just trying to restrain him for his own safety. It was clear that he was trying to get up and move away.*

Ms Robyn Collins, and her husband, were travelling north on the M1 at the time of the collision. They stopped their motor vehicle. Ms Collins described what she saw as follows:

> *I saw people around him trying to hold him down, because he was thrashing around uncontrollably and appeared to be very aggressive. I immediately thought that he was on some kind of illicit drugs because he seemed so strong and powerful and making it difficult for the people around to hold him still and calm him down. I cannot recall who the people were trying to calm the driver down, but I know I saw high visibility vests on them. The driver continued to scream out he was burning, and continued to thrash around aggressively. The people trying to calm him down were having a very hard time, trying to control him.*

Ms Lana Middleton was also a person who stopped at the scene of the collision. She described what she saw as follows:

> *Based on my observations of the male's movements and general behaviour and speech, I drew the conclusion that he was having a psychotic break. He was quite manic.*
>
> *I next looked across to the male who, at that point in time, was lying face down on the roadway. I saw that there were now five police officers with the male. Four of these officers were positioned around the upper body of the male driver, with all officers either kneeling down or crouching over the male driver and using their upper bodies to hold the make driver in place on the road. I couldn't see where their hands were.*
>
> *I heard the police officers talking to the male driver but can't recall what was said to him. I can recall that they appeared to be trying to calm him down and their tone of voice was reassuring and not forceful or aggressive in any way.*

John Swan was an employee of Tropic Asphalt and was preparing to start work on the northbound lanes of the M1 north of the collision scene. He attended the scene. He gave an extensive statement as to what he saw. The following sums up his observations of the actions of Jason and the police:

I saw that there was a small blond female police officer helping to hold down the male driver and I saw him throw her off him.

When the Police Officers were holding the male driver down, I did not see any of them punch or kick the male driver. I did not see any Police Officer be excessive with the male driver and I thought they treated him with care. When the Police were trying to restrain the male driver they were only using body mass. He was throwing the Police Officers around and they were just holding him down.

The evidence of other lay witnesses who observed the events was generally consistent with that outlined above.

Intervention by Paramedics:

Lee Matthews was working with the road works north of the crash site. He attended the site and provided the police with his observations. He was there when police were restraining Jason and a paramedic was *standing nearby trying to look over the police at the male. It appeared he was trying to assess the male's condition.* Mr Matthews said:

I saw the male on the ground stop trying to wrestle with the police and he went limp. One of the police officers felt the male's neck, and then the police rolled him straight over onto his back. A female paramedic began Cardio Pulmonary Resuscitation (CPR).

James Blackwell was the Deputy Fire Captain with the Rural Fire Service. He responded to the crash site. He described his observations in detail. He sought to assist the police to restrain Jason. He observed the action of the police and paramedics who were involved. He said:

The male was still struggling with us when the Paramedics walked over to assess the scene. I recall at least one of the Paramedics who walked over to us being male. The Paramedics started speaking with one of the male police officers, explaining that they needed to access a vein on the male to insert a needle. I cannot remember the name they referred to the actual needle. I thought that they might need to sedate the male to calm him down he was too dangerous and aggressive to let go of. I did not know how else they were going to be able to assess his condition if he remained thrashing around and acting so aggressive.

I watched and heard the Paramedic decide to try and access the male's right forearm. Each time the male tensed and attempted to struggle out of our grip, the veins in his forearm pumped up. The same Paramedic yelled out to

someone nearby that he needed more light, because he couldn't find a vein. Ian Wells … got his torch out and shone it down on the male's body.

The male Paramedic waited poised with the needle above the male's arm. During one of the occasions the male attempted to break free from our hold on him, the Paramedic inserted the needle into that forearm. The Paramedic also taped up the needle to secure it to the male's arm. This entire time, the male continued to struggle and yell out, he never stopped, I just cannot explain how he had the energy to do so; it was so unnatural.

It seemed like only a few seconds (approx. 10) after the needle was placed into the males arm, that he stopped struggling and yelling out. I was relieved at the time, because I thought he had given up trying to escape. I eased my grip on his legs, but maintained contact with him, just in case he was getting ready to start again.

Jeremy Morris was the Deputy Captain of the Rural Fire Service who attended the crash site as part of the emergency response. He was observing the actions of the police and paramedics. He stated that:

I saw two Ambulance officers one was male and the other a female. The male was still face down in the same position on the road. There were 3 police officers now holding the male and Jim was still helping hold the feet of the male on the ground. The two Police officers that had been holding the right shoulder and torso had moved back to allow the Ambulance officers some room. The Ambulance officers had a kit bag it was about a foot and a half long and was red. The male ambulance officer was on his hands and knees beside the male on the ground. The Ambulance officer had hold of the man's right arm and it looked like he was putting a line in. It was not a syringe it looked like a line that they would use for fluids. The line was at the back of his right forearm. The female Ambulance officer was reading out dates to the male Ambulance officer. I do not remember what those dates were. One of my RFS crew Ian Wells was standing beside the female Ambulance officer with a torch shining it in the vials for the Ambulance officer.

Ambulance Officer Stuart Billins was the first Ambulance officer to arrive at the collision site. He was working as a solo ambulance officer at the time. He had been a Paramedic for more than nineteen years. He was a qualified intensive care Paramedic and Special Operations Responder. He arrived shortly after the collision.

Mr Billins approached the car in which Jason was. He said that:

> *I saw a male person sitting in the driver's seat. As I approached, I saw him throwing his arms in a frenzied fashion, screaming out and appeared to be behaving in what can only be described as 'Psychotic.' He was so aggressive.*
>
> *I asked them to restrain the male driver of the silver sedan. He was screaming and I believed he was too aggressive for me to treat at this point of time.*

Mr Billins then attended to the needs of the O'Donnell family who he believed had priority because of the injuries that they had suffered.

When Ambulance Duty Operations manager Greg Wiggins arrived on scene Mr Billins was asked to attend to Jason. Mr Billins outlined what happened after that as follows:

> *Officer Wiggins directed me to assist with the treatment of the male driver of the silver sedan. He requested that I use some Midazolam (sedative) for patient management. The male was still acting in an aggressive manner and was combative towards the police and Paramedics nearby. I could still hear the male screaming and yelling out at everyone as I approached.*
>
> *As I got closer I saw Paramedic officer Mark Lanning with the male driver. The male driver was lying face down on the roadway with handcuffs on his wrists. I did not take much notice of who was standing around because he was still moving around. I asked Officer Lanning for an update on the male's condition so that I could assess the appropriate ongoing treatment. Mark stated that he had cannulated the male patient. At this point I noticed the male patient stop yelling and thrashing about. Mark and I rolled the male patient over onto his back and Officer Carol Bryan came over to assist. I think that Carol checked for a pulse. The patient was in cardiac arrest.*

Paramedic Mark Lanning was one of the ambulance officers attempting to care for Jason. He was the ambulance officer who inserted the cannula into Jason's arm. His evidence was that:

> *From the time I arrived at the patient to the time I inserted the cannula it would have been about 4 to 5 minutes. As I was completing the tape for the cannula, a female voice said something like 'Is he breathing?' There was no indication the patient went limp so I said 'Everybody off.' The officers removed themselves slowly form the patient just in case he started thrashing again. The patient wasn't moving as the police officers stood up.*

Paramedic Carol Bryan was working with officer Lanning. She said that:

> *While Mark inserted the cannula, I prepared Midazolam. I was required to focus on the drug kit to do this, so I was concentrating on drawing the drug and briefly took my focus off the male. While I was measuring the drug dose, I heard Mark say, 'He's Code 2 (Cardiac Arrest), get the stretcher'. I dropped the drugs back into the kit and ran over to get the stretcher.*

At this point Officer Lanning described what he did then as follows:

> *I rolled the patient over onto his back with some assistance of others. It was only at this time I saw that the patient was in handcuffs with 2 sets locked together. I looked at his face and there didn't appear to be any signs of life. His eyes were open; there was no chest movement or response what so ever. I said, 'He's gone code 2, he's not breathing.*

Ambulance officers thereafter performed CPR and applied other attempts to resuscitate Jason as he was transported to Gosford Hospital. They arrived at the hospital at 21:46 where hospital doctors continued those efforts. Unfortunately the efforts were to no avail and Jason was declared deceased at 21:58 on 5 February 2014 by Dr Martin Pallas, a member of the emergency staff, at Gosford Hospital.

Cause of Jason's Death:

Following Jason's death his body was transported to the Department of Forensic Medicine at Newcastle where an autopsy was performed by Dr Brian Beer a senior staff specialist in Forensic Medicine. Dr Beer prepared a report setting out his findings during that examination and his conclusions as to the cause of Jason's death. Dr Beer also gave evidence at the inquest.

At autopsy the pathology summary identified by Dr Beer was as follows:

- *Upper one third sternum, right anterior 4-6 rib and left anterior 3-5 rib fractures,*
- *Focal mild central Mediastinal haemorrhage, and 50ML of Haemorrhage in each of the right and left pleural cavities,*
- *Lung congestion, acute pulmonary oedema and focal intra-alveolar haemorrhage,*
- *Focal superficial fresh haemorrhage in the subcutaneous soft tissues in the small of the back,*
- *75-80% narrowing by stable athermanous plaque in the left anterior descending coronary artery,*

- *The toxicology showed massively raised Methamphetamine (Methylamphetamine) levels (greater than 10MG/L, 7.4ML/L in two separate specimens), with low levels of Amphetamine (a metabolite of Methamphetamine) and Midazolam, there was no alcohol detected,*
- *Fractured lower left Tibia and Fibula (non-compound) with associated haemorrhage in adjacent soft tissues,*
- *Wide spread abrasions; face, arms and legs, with facial abrasions very marked,*
- *Diagonal and lap seatbelt abrasions and bruising,*
- *Wist abrasions consistent with handcuff marks, and*
- *Relevant negative findings: normal anterior and posterior neck dissection, no evidence of head injury, no external skin bruising on the back.*

Dr Beer commented that, from a forensic pathologist's point of view, the case was a complex and difficult one. He said that there were aspects of the case that were contentious and open to differing views and interpretations. There were a range of potential causes of death without definite evidence that any of the causes either alone or in combination caused the death. In addition he considered that the likely mechanism of death was a physiologic one without morphological findings.

In summary Dr Beer opined that there had been a complex interaction of drug toxicity, natural disease, restraint, and possibility respiratory compromise resulting in the death. As to the relative contribution of the various factors (drug toxicity, coronary artery disease, the restraint process and respiratory compromise) Dr Beer considered that these were open to debate and that there would be differing views amongst forensic pathologists.

Dr Beer considered, however, that the contribution to the death of respiratory compromise both from the chest injuries and the period of restraint in the prone position was of a low magnitude in comparison to the factors leading to the fatal arrhythmia.

Dr Beer recommended that the cause of Jason's death was due to the complex interaction of:

a) *Acute methamphetamine toxicity,*
b) *A single focus of significant coronary atherosclerosis in the left anterior Coronary artery,*
c) *A prolonged period of active agitated resistance to the restraint, and*

d) +/- A minor contribution from respiratory compromise.

It was Dr Beer's opinion that there was a significant component of direct Methamphetamine toxicity in the death however the cause of Jason's death was multifactorial and not solely due to the methamphetamine use.

The period of prolonged restraint that Jason experienced, in Dr Beer's opinion, would have been a further significant adrenergic stimulus to Jason's already highly stimulated sympathetic nervous system that was secondary to the effect of the methamphetamine Jason had consumed.

These factors were superimposed on the existing heart condition of significant focus narrowing (75-80%) narrowing by atheroma of the left anterior descending artery which would have been a significant factor in increasing the 'ischaemic' stress on the heart adding to the other factors predisposing towards a cardiac arrhythmia and death.

In his autopsy report, and also when giving evidence, Dr Beer discussed the syndrome known as *Excited Delirium*. The existence of this syndrome, as Dr Beer acknowledged, is a controversial issue and one that it is not necessary for me to delve into in undertaking my function as a coroner and making findings as to the manner and cause of Jason's death. I do not need to discuss that issue any further in these reasons other than to note that, were it to be accepted, the understanding of the syndrome may contribute to an understanding of the mechanism by which death can occur in circumstances such as occurred with Jason.

Dr Judith Perl, an expert pharmacologist, also prepared a report and gave evidence at the inquest. Dr Perl noted that at post mortem femoral blood samples taken from Jason indicated the presence of midazolam at 0.02 mg/L, amphetamine <(less than) 0.2 mg/L and Methylamphetamine > (greater than) 10 mg/L. A subclavian sample also indicated the presence of amphetamine 0.09 mg/L and Methylamphetamine 7.4 mg/L.

Dr Perl indicated that the preferred (most accurate) measure of drug toxicity at death was a sample taken from the femoral area and that she had based her opinion on that measure.

Dr Perl said that research had shown levels of Methylamphetamine above 0.2 mg/L were potentially fatal and that levels above 10 mg/L are considered likely to be fatal.

As, in Jason's case the Methylamphetamine level was found to be above 10 mg/L (it was above the level that the laboratory was able to measure which was 10 mg/L) that level was, without any other factors being taken into account, likely to be fatal even taking into account the fact that Jason was a regular user of the drug.

Dr Perl said that a blood Methylamphetamine concentration in excess of 10 mg/L was indicative of extremely high doses of Methylamphetamine being used. She said that in her experience such concentrations tend to occur in very heavy users of Methylamphetamine and usually after a 'run.' A 'run' is when the drug is used repeatedly (i.e. several doses) over a short period of time (sometimes for 2-3 days).

During a 'run,' Dr Perl explained that the user ingests numerous doses of the drug over several days during which the user remains awake, hyperactive, stimulated, in a euphoric state characterised by rapid speech, often jerky movements, dilated pupils which are relatively unreactive to light, high energy , depressed appetite, tremors, increased agitation paranoia, apprehensiveness, confusion and occasionally hallucinations.

In addition to the above Dr Perl explained that Methylamphetamine was a potent central nervous system stimulant which will result in an increase of blood pressure and heart rate, pupillary dilation, palpitations, pallor, increased sweating and hyperthermia. The toxic effects included headache, palpitations, pallor, hypertension, hyper-reflexia, restlessness, nervousness, talkativeness, aggressive or hostile behaviours, paranoia, hallucinations, mental processes sped up and attention jumps ineffectually and rapidly form one thing to another (a flood of thoughts) and a person may appear as if in a manic psychosis and there may be continued purposeless motion.

It was Dr Perl's evidence that as a result of the increased blood pressure and cardiac effects at high doses, death can occur as a result of a stroke or cardiac arrest. Methylamphetamine use, especially chronic use, was also known to cause cardiomyopathy.

In summary it was Dr Perl's opinion that the Midazolam found in Jason's blood at autopsy was likely to be the result of the drugs administered by the paramedics who were attempting to resuscitate Jason and that it was highly unlikely to have directly contributed to the cardiovascular collapse that led to Jason's death.

Dr Perl was also of the opinion that the extremely high Methylamphetamine concentration found in in Jason's blood at autopsy was highly likely to have produced toxic effects and likely fatal effects due to cardiovascular effects. She said that even the emergency treatment with Midazolam (to reverse the toxic effects of Methylamphetamine and to sedate Jason so that proper assessment and treatment could be administered), naloxone (to reverse possible overdose effects of suspected narcotic drugs and adrenaline for cardiac life support, may be insufficient to reverse the toxicity due to an extremely high blood level of Methylamphetamine.

Dr Perl therefore concluded that in Jason's case sudden death due to such a high Methylamphetamine concentration may have occurred at any time irrespective of the restraint that he experienced or the emergency drug treatment he received.

Consideration and Conclusions:

The circumstances of Jason's death highlight the devastating consequences that can arise from the abuse of the illicit drug Methylamphetamine which is commonly known as Ice or Speed.

There is no doubt that Jason was a chronic user of the drug and had been using it for a number of days prior to these events. The evidence from those who observed him was that he was said to be *'off his face'* and *'had not slept for a number of days'*. There were also indications that he was exhibiting paranoia and possibly experiencing hallucinations.

These effects almost certainly explain his actions of driving against the flow of traffic on the M1 Freeway which ultimately resulted in the collision with the motor vehicle driven by Christine O'Donnell.

The O'Donnell family are also victims of the use of this terrible drug. At the inquest I had available an impact statement form Christine O'Donnell that outlined the devastating consequences that this event had had on herself and her family. Ms O'Donnell recorded that for her the event had been life changing and that she had lost nearly two years of her life fighting for some quality of life to be restored. At the time of the inquest she had had thirteen operations and had not been able to weight bear on her right leg for three months.

Ms O'Donnell was, however, remarkably forgiving and saw the real culprit as being the Methylamphetamine rather than Jason. She expressed the hope that the coronial

process might result in recommendations that *would increase mandatory help for individuals with repeat appearances before the court in relation to Narcotics.*

It is also important to remember that as well as the O'Donnell family Jason's mother was also a victim of Methylamphetamine. The evidence is that she undoubtedly cared for her son and tried her best to encourage him away from the abuse of the substance. Unfortunately she was unsuccessful and has now lost her son to this tragedy.

I have indicated above that part of the role of the coroner in cases such as this is to examine the actions of the police to determine whether or not their actions contributed to the circumstance of the death being examined. In this case the question to be asked would be whether or not it was appropriate for Jason to be restrained by police and, if so, was he restrained appropriately?

As far as the need for restraint is concerned there is no doubt that it was necessary to restrain Jason. The toxic effect of the Methylamphetamine in his system was such that he needed to be restrained for his own protection. This was for a number of reasons not the least being the evidence, which I accept, that he was trying to escape in the direction of the M1 freeway carriageway which, had he got onto the carriageway, may have resulted in him being hit by a passing motor vehicle at speed.

Having taken over the restraint of Jason, all the evidence from the lay observers, which I accept, was that the police officers involved did so in a remarkably restrained and patient manner using only the force that was necessary. The officers involved are to be commended for their actions.

As to whether or not the actions of the police involved contributed to Jason's death the evidence of Dr Beer was that the manner of the restraint by the police was a minimal, if any, contributor to Jason's death occurring at the time it did. I accept that evidence.

It is also the case that there is no evidence to suggest that the ambulance officers involved acted other than appropriately in caring for Jason. Unfortunately their efforts were unable to assist him. Indeed it was Dr Perl's opinion that given the level of Methylamphetamine in Jason's system it was unlikely that they would have been

able to revive him in any event. They nonetheless tried to do so in a proper and professional manner. They too are to be commended for their efforts.

Description of cause of death:

As set out above there is a subtle difference in the views as to the cause of Jason's death between that of Dr Beer and Dr Perl. Put simply Dr Beer has, as a forensic pathologist, taken into account all the circumstances of the death and the various factors that would, to a greater or lesser degree have resulted in Jason's death at the time. Dr Perl does not disagree with Dr Beer but opines that the level of Methylamphetamine in Jason's system would have been fatal.

I accept Dr Perl's opinion that the level of Methylamphetamine in Jason's system would have likely been fatal to Jason and that his actions in the period preceding his death particularly his confused driving and resistance, can be explained by the effects of the Methylamphetamine however it is clear that he was at the time suffering from a cardiac condition that would, no doubt, have been a contributing factor to his death occurring at the time it did. I therefore consider that a variation of the cause of death recommended by Dr Beer would be appropriate in explaining what happened.

I therefore propose to record the cause of Jason's death as being:

> *The combined effect of Methylamphetamine Toxicity and prolonged restraint in a person suffering from single vessel coronary artery disease.*

Section 82 Recommendations:

Ms O' Donnell, as already mentioned, hoped that recommendations might come from the inquest that would mandate that persons such as Jason who were suffering the effects of the abuse of Methylamphetamine and other such illicit drugs might be mandated to undergo treatment programmes that might assist them to overcome their addiction. Unfortunately the evidence available in this inquest is not such as would allow me to make such a recommendation as the nature of such programs and other structural information was not presented during the inquest. I have, however, noted that in recent times a body has been appointed by Government to exam this issue on a national basis. Hopefully appropriate recommendations will come from that body.

I do not consider that any other issues raised by the examination of Jason's death make it necessary or desirable for me to make any recommendations in accordance with Section 82 of the Act.

I do note, however, that the evidence before me shows that circumstances of Jason's death has led to the Ambulance Service examining, and updating, the protocols used by ambulance officers in such situations. As I have found the actions of the ambulance officers involved was completely appropriate however it is good to see that the Ambulance Service has used this situation to review such protocols. They are to be commended for their action.

Paul MacMahon

Deputy State Coroner

26 June 2015