Coroners Act, 1996
[Section 26(1)]

Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 22/17

I, Evelyn Felicia Vicker, Deputy State Coroner, having investigated the death of ***Anthony William KUSTER****, with an Inquest held at Perth Coroners Court, Court 51, Central Law Courts, 501 Hay Street, Perth, on 12 & 13 June 2017 find the identity of the deceased was* ***Anthony William KUSTER*** *and that death occurred on 20 April 2013 at 57 Lydiard Retreat, Canningvale, and was consistent with ligature compression of the neck and methylamphetamine effect in the following circumstances:-*

Counsel Appearing:

Ms K Ellson assisted the Deputy State Coroner

Table of Contents

INTRODUCTION 2
BACKGROUND 3
SATURDAY 20 APRIL 2013 6
Return of the deceased's partner to the home 11
Arrival of Ambulance and Police 14
POST MORTEM EXAMINATION 17
LATER POLICE INVESTIGATIONS FROM THE SCENE 20
DR JOYCE'S EVIDENCE 25
CONCLUSION AS TO THE DEATH OF THE DECEASED 31
MANNER AND CAUSE OF DEATH 41

INTRODUCTION

On 20 April 2013 Anthony William Kuster (the deceased) was located by his partner, collapsed in their home with a tourniquet around his neck.

Initially, his partner believed the deceased was pretending to have committed suicide and, after releasing the tourniquet and seeing colour return to the deceased's face, there was a significant elapse of time before his partner became concerned and commenced cardiopulmonary resuscitation (CPR) in an effort to revive the deceased. He called emergency services and continued CPR until the arrival of two ambulance crews who continued with emergency resuscitation of the deceased, before advising his partner the deceased had died and the police needed to be involved.

The deceased was 44 years of age.

Police investigation of the death confirmed there were issues surrounding the deceased's death which warranted further investigation in an attempt to clarify timelines and whether others may have been involved in the death. The timeline of the events of the afternoon remained unclear and the police requested an inquest in an attempt to clarify the evidence.

The matter was reviewed by a coroner and it was determined an inquest was desirable pursuant to section 22

(2) of the *Coroners Act 1996* (WA), in an attempt to clarify, if possible, the circumstances surrounding the death of the deceased and how it occurred.

BACKGROUND

The deceased was born on 9 September 1968 in Newcastle, New South Wales, before the family moved to Toowoomba, Queensland in 1972. He was one of two children with an older sister. He was described by his family as a frail child, very shy until he was confident in a person's company. He was above average academically, but did not enjoy school, although he was a talented long distance runner. He trained in hospitality and left Toowoomba and eventually ended up in Western Australia working for Qantas where he progressed to a service manager.

In 1995 the deceased met his partner and they commenced a relationship. His partner had previously been in a heterosexual marriage and had two daughters to whom the deceased became very attached. Both the families of the deceased and that of his partner became part of one extended family which for many years worked very well.[1]

The deceased and his partner built a home together in Canning Vale and were acknowledged as a partnership, although it is clear that over time there were differences in the expectation of what exactly that relationship involved.

[1] Ex 1, tab 9

The deceased's partner described their relationship as open, and their work and lifestyle commitments meant each had a certain amount of time out of each other's company.

It would seem both the deceased and his partner were emotionally committed to one another, but the deceased wanted to share other friendships and experiences with his partner, while his partner was uncomfortable in those situations and preferred to keep other associations on a one to one basis. They were involved in bigger groups on occasions and drugs became a facilitator for their differences on those occasions.[2]

The evidence would suggest drugs became a significant part of their lifestyle from at least 2010-2011, but the deceased became more dependent than his partner. His partner indicated this caused problems in their relationship and probably also the deceased's employment.

The deceased and his partner had separated in late 2012 into early 2013, with some acrimonious exchanges resulting in the pursuit of violence restraining orders due to the differences developing between them as to lifestyle and expectations of their relationship.[3]

By April 2013 the deceased and his partner had recently reconciled, but were still in the process of establishing a

[2] t 12.06.17, p28, 62
[3] t 12.06.17, p13, 15-16

work and play framework which would allow their relationship to grow in ways that would accommodate their different expectations. There were still elements of difficulty and distress for both men which needed to be clarified. From an outsiders' perspective the deceased appeared to depend on drugs to help him through this time, while his partner used an obsession with fitness and work to facilitate a transition.

It is common ground the deceased was an extremely loving and generous person who strived to make those around him happy.[4] He was meticulous in his arrangements and in attempts to ensure things ran well for those with whom he came into contact or was responsible for through work. I speculate his efforts to keep everybody happy caused him some anguish and encouraged his self-medication with drugs to a level which began to erode his usual personality.[5] This affected his work.

The deceased's partner seems to have responded to personal stressors by becoming even more involved in his fitness activities and his work, and become almost obsessive about matters over which he used to have control, but realised he could no longer if he wished to maintain his relationship with the deceased. For whatever reason counselling was not effective and the outcome was two very stressed individuals who were desperately trying to find a common platform for

[4] t 12.06.17, p11
[5] t 12.06.17, p20

their relationship to return to its original compatibility. I have no doubt both men were very distressed and emotionally frustrated by April 2013.[6]

On Friday 19 April 2013 the deceased told his partner he was being suspended from his work with Qantas, which he loved, until a discrepancy with cab vouchers had been investigated.[7]

SATURDAY 20 APRIL 2013

On the night of 19-20 April 2017 the deceased and his partner had fallen asleep on a mattress in the living area of their home. In the early hours of Saturday 20 April 2013 the deceased contacted a friend of his partner, via a social network site, and suggested the friend visit at their home address. The evidence indicated the deceased intended his partner be party to the invitation, but his partner was unaware of the contact and had commitments of his own for that Saturday, involving both work and later, tickets for a football game.

When his partner woke the deceased told his partner his friend would be visiting possibly with the expectation there would be mutual engagement between the three of them. Very shortly after the deceased advised his partner the

[6] t 12.06.17, p12
[7] Ex 1, tab 12

friend would be coming, the friend contacted his partner and stated he had arrived.[8]

The deceased's partner found the situation confronting due to his prior interactions with the friend while he and the deceased had been separated. The friend appears to have entered into the situation without realising there were issues of trust and control between the deceased and his partner which they needed to address.

The deceased engaged with activities around the house while his partner and friend reacquainted themselves and assessed the dynamics of the situation. It is not clear whether drugs were used. The evidence between the friend and the deceased's partner is at variance.

The deceased borrowed his partner's car to run an errand and his partner became concerned the deceased would not return in time for him to attend his work commitment. He ended up leaving late for his tutoring engagement which meant he would need to work later to make up the time.[9]

The deceased's partner assumed his friend and the deceased would engage in physical activities in his absence and it is clear he had mixed feelings about that situation. It is not entirely clear the deceased wanted the same type of relationship as his partner wanted, but did not know how to

[8] Ex 1, tab 12
[9] t 12.06.17, p61

express that. It is possible the deceased was trying to find a formula which would involve, rather than distance, his partner.

During his partner's travel to his tutoring commitment, late, there were exchanges of text messages of various descriptions between the deceased, his partner, and the friend. It is evident the deceased had expected his partner to be at home for events that morning and wanted his presence. The deceased's partner had clear work commitments which he could not reasonably dismiss.[10]

At some stage during the morning, times are very unclear, the deceased asked the friend to move his car so he could again run an errand. I suspect this was for the purposes of obtaining drugs because there had been a suggestion of drug taking between the deceased and the friend prior to the friend's arrival.[11] While the deceased was out the friend contacted other people on social media sites and on the deceased's return asked if it would be possible for another two people to join them. The deceased replied that it was and shortly thereafter two additional males arrived at the house.[12] It would appear the deceased had returned home with some drugs because there was evidence of drug use at the property and some of the evidence refers to the use of

[10] Ex 1, tab 19 & 20
[11] Ex 1, tab 14, t 13.06.17, p152
[12] t 13.06.17, p149

champagne glasses as implements prior to use of a glass pipe.[13]

It is unclear whether the drug taking involved all four men at the house during the course of the morning/afternoon or whether that occurred prior to the arrival of the additional men. It is very difficult from the evidence to establish certain timeframes for events at the house other than by timing messages on different servers and carriers, some of which are incompatible. There is also the added difficulty that some drug use can affect perception of time.[14]

The friend stated in evidence the situation was fairly awkward because the deceased, while playing host, seemed to be a little dissociated from events and continued with activities around the house or interspersed his time with the other men by going outside.[15] From the messages exchanged between the deceased and his partner it would seem the deceased did not wish to involve himself too closely with the other two men and wanted and expected his partner to return to the house and deal with the situation.[16]

The evidence of the friend and one of the other males who had attended the house that day indicated the deceased disappeared for a considerable amount of time. The other male stated in evidence he believed the deceased was

[13] t 12.06.17, p49, 50, t 13.06.17, p154, Ex 1, tab 19
[14] t 13.06.17, p154, 157
[15] t 13.06.17, p152
[16] Ex 1, tab 12, 19, 20, t 12.06.17, p63

outside because he could see him from time to time, apparently on the telephone.[17]

The deceased's partner had turned off his phone once he reached his tutoring engagement and did not turn it on again until he was leaving that session. Messages after that time indicate he was advising the deceased there were things he needed to do before he could return to the house. He encouraged the deceased to ask people to leave if he was not comfortable, because it was his home, and it was up to him to make decisions around the situation which the deceased's partner believed the deceased had created.[18] He did not understand the deceased had created it in an expectation it would be an event they could share.

It is not clear when exactly the two additional males left the house, but at the time the deceased was not visible and they left without saying goodbye. The friend remained at the house a short while after the other two had left and then looked for the deceased in an attempt to say goodbye. He was unsuccessful in locating the deceased and sent the deceased's partner a message to the effect he was leaving, the deceased had disappeared and he asked the partner to say goodbye to the deceased and thank him for the visit.[19]

[17] t 12.06.17, p110
[18] Ex 1, tab 12
[19] Ex 1, tab 14, 19, t 12.06.17, p65

As best as can be ascertained that message exchange between the deceased's partner and the friend occurred at 2.50 pm. At that time the deceased's partner had completed his chores at Carousel Shopping Centre and was on his way home. Download of the partner's telephone after the event make it clear there were a number of exchanges between the partner and other people, some of which related to the expected football game attendance that evening.[20]

The deceased's partner also spoke to the deceased as he was travelling home through heavy traffic from Carousel to the house. He was advised the others "*had gone*" and the deceased sounded distressed. The deceased was cold because he had been outside in clothing only suitable for inside the home. The deceased clearly understood his partner was travelling towards the house and would be returning soon.[21]

Return of the deceased's partner to the home

The timing of the following events is extremely unclear due to the state of the deceased's partner on discovering the deceased and trying to establish a comprehensive timeline of events from the forensic evidence available.

The deceased's partner believed he arrived home very shortly before 3pm and was disturbed at the state of the

[20] Ex 1, tab 19
[21] t 12.06.17, p63

living room which did not appear as meticulously cared for as was usual on the part of the deceased. He did not locate the deceased.

The deceased's partner saw the deceased's phone was unlocked and having been somewhat obsessed by what was occurring at the house in his absence took the time to review messages and interactions on social media on the part of the deceased while he was absent. He felt guilty doing this and hid to ensure he would hear the deceased before he saw him, so he could pretend he had not been checking up on the events of the day. He could not recall how long he had spent doing this and was focused on trying to work out events in his absence from the deceased's telephone. He believed that while checking the telephone he suddenly realised it was getting late and he still needed to get changed, find the deceased and go to the football. He initially could not find the deceased, but noted items in disarray, unusual for the deceased. He began to be concerned the focus of events had been drugs rather than sexual activity.

In the process of looking for the deceased his partner had passed the door of the study a number of times, but not really registered it was closed which was unusual. When he could not find the deceased outside the home he looked inside the house again and this time registered the study door was closed. He went into the study.

It is unclear on the evidence as to whether the deceased was on the study chair or had fallen from the chair and was on the ground.

The deceased's partner noted a medical tourniquet around the deceased's neck and that his face was blue. He immediately unfastened the tourniquet which he believed flipped onto the desk as tension was relieved, and observed colour to return to the deceased's face. It is not clear whether he thought the deceased made a sound at that stage.

On seeing the colour return to the deceased's face, his partner believed the deceased had been pretending to have committed suicide, as he had done in the past.[22] The partner was in an angry, frustrated frame of mind as a result of his concern over what had been happening and on seeing the deceased's camera on the desk, decided to take some photographs of the deceased in an effort to jolt him out of his pretence.[23]

The deceased's partner took three photographs before he realised the deceased was not breathing. He then commenced CPR on the deceased. He was first aid trained and had recently completed a refresher course. He performed a cycle before ringing '000' and calling for the assistance of St John Ambulance Service (SJA). The

[22] t 12.06.2017, p22
[23] Ex 1, tab 12/3

operator counted cycles for him pending the arrival of the ambulance.[24]

The '000' SJA operator's call is timed at 4.30 pm on Saturday 20 April 2013.[25] In that call the deceased's partner is clearly very distressed and asking for help with the knowledge the deceased had *"taken some drugs and he's put this thing around his neck"*.[26] He goes on to explain the deceased is on the ground and is fairly disjointed in what he says to the call operator. The call operator asked him to check the status of the deceased, and then commenced counting compressions for the deceased's partner while waiting for the ambulance to arrive.

Arrival of Ambulance and Police

The first ambulance to the house is recorded as arriving at 4.37 pm on 20 April 2013.[27]

The ambulance crew and a clinical support paramedic arrived at approximately the same time and discovered the deceased's partner performing CPR on the deceased.

The deceased's partner stated he had located the deceased on the chair and moved him to the floor to perform CPR once he realised the deceased was not breathing. It was clear to the clinical support paramedic the deceased was in

[24] Ex 1, tab 12
[25] Ex 1, tab 23
[26] Ex 1, tab 8
[27] Ex 1, tab 23

cardiac arrest[28] and they continued to work on the deceased for 21 minutes before realising further resuscitation would be pointless and confirming the deceased's death.

The paramedics noticed a tympanic temperature of 31°C which they considered to be extremely low for a body in which there was no evidence of rigor mortis in the jaw joints.[29]

The SJA call centre was asked to arrange the attendance of police at the scene. The paramedics, bar 1 ambulance crew, left, and that crew remained with the deceased's partner until the police arrived.[30]

The first police to arrive at the scene were two Senior Constables attached to the South East Metropolitan Response Team South. They arrived at the house at 5.40 pm and were briefed by the SJA clinical support paramedic before he left.

The police officers were aware there had been previous domestic violence incidents recorded for that address. The police officers noted fresh scratches on the kitchen bench, the state of the living area, the pornographic DVD's, and then spoke to the deceased's partner.

[28] Ex 1, tab 6
[29] t 12.06.17, p43
[30] Ex 1, tab 7

One of the police officers recognised the deceased's partner through their mutual fitness and gym associations. He noted the deceased's partner to be very upset, verging on incoherent, and thought his behaviour entirely appropriate to the circumstances and not unexpected from his prior knowledge of the deceased's partner. This police officer took the deceased's partner's telephone and placed it with other items he thought may be of interest. He believed there was a possibility the scene was suspicious. He declared the premises to be a protected forensic area and advised police communications of that fact, requesting the attendance of local detectives.[31]

The local detectives attended at approximately 6.30 pm and were briefed by the police at the scene. They examined the items of interest. The items were seized for further investigation, but the detectives deemed the death not to be suspicious and the police officer who knew the deceased's partner served on him the coronial brochure as the most appropriate person in the circumstances because of his prior knowledge of the deceased's partner. While one of the detectives had been concerned at the deceased's partner's manner and demeanour, he was reassured that was his normal way of speaking. It was apparent, even at that stage, the deceased's partner had a very uncertain grasp of times, although his recall of figures was good. This may be

[31] Ex 1, tab 6

to do with his vocation which is predominantly in the area of mathematics.

It was clear from the scene and the deceased's partner there had been drug activity in the premises during the course of the day. However, the deceased's partner did not believe there had been as much sexual activity as he had feared due to the state of paraphernalia revolving around sexual activities, and the presence of paraphernalia related to drug taking.

POST MORTEM EXAMINATION[32]

The post mortem examination of the deceased was undertaken on 24 April 2013 by Dr Daniel Moss, Forensic Pathologist of the PathWest Laboratory of Medicine.

At post mortem examination Dr Moss noted heavy fluid-laden lungs (pulmonary oedema and congestion) with a possible recent injection site to the left arm. He also noted a mark to the neck that possibly represented a faint ligature mark and there were florid petechiae to the face.

In evidence Dr Moss commented the photographs he was shown as part of the inquest, taken by the deceased's partner at the time he released the tourniquet around the

[32] Ex 1, tab 24

deceased's neck, showed the ligature mark more clearly than had been observable at post mortem examination.[33]

The combination of findings were consistent with a cause of death of ligature compression of the neck.

Dr Moss clarified there are a number of mechanisms by which death is achieved during ligature compression of neck structures. The fact of the petechiae and their distribution satisfied him the physical compression of the neck structures in this case had obstructed the venous flow of blood away from the brain, but maintained the arterial blood to the brain. Due to the difference in pressure, the small blood vessels burst and caused the petechiae, which was a sign there had been physical compression of blood flow away from the brain.[34] This did not mean all the arterial flow had been maintained, but there was a greater flow of blood to the brain than away from the brain. The absence of petechiae would not necessarily have meant there was no ligature compression of the neck, merely that it was not the venous flow which had been interrupted alone.

Death from ligature compression of the neck can arise in a matter of minutes depending upon the compression. Unconsciousness occurs before death and prevents self-preservation.

[33] t 13.06.17, p136 & 146
[34] t 13.06.17, p136

Dr Moss did not see any other physical evidence at post mortem which would suggest another cause of death or any significant trauma of any kind sufficient to have caused death, or implicate another person.

Further investigations were undertaken, including toxicology. This revealed a methylamphetamine blood level of 1.6mg/L. Amphetamines are a metabolite of methylamphetamine and amphetamines were also present. This meant methylamphetamine had been in the system for enough time to metabolise amphetamine. Dr Moss stated the levels were difficult to interpret, although the level was within reported fatal ranges.

In Dr Moss's view the presence of methylamphetamine at that level would have contributed to the deceased's death by ligature compression of the neck. Aside from the effects of methylamphetamine physiologically, there was also the issue of behaviours encouraged by the use of amphetamine type drugs.

In Dr Moss's opinion the cause of the deceased's death was consistent with ligature compression of the neck and methylamphetamine effect.[35]

Dr Moss stated it was impossible from the information available surrounding the deceased's death to provide a

[35] t 13.06.17, p139-40

time of death, despite the clinical support paramedic's concern the deceased's tympanic temperature appeared to be very low for someone who did not appear to have been deceased for very long (1 hour).

Dr Moss considered the tympanic temperature may have been misleading in this case.[36]

Dr Moss believed that while the level of methylamphetamine was in the fatal range, it was still survivable depending on the circumstances of the death and the tolerance of the user of the drug. This would indicate the ligature compression contributed to the fact of death, but whether that was due to an intention to die or was due to encouraging behaviours that were risky, was impossible to conclude in the given circumstances.

Dr Moss was of the opinion the whole circumstance of the deceased's death led to the conclusion the amphetamines and ligature compression, in combination, had resulted in a cardiac arrhythmia as a very real mechanism of death, which could have been unintentional.[37]

LATER POLICE INVESTIGATIONS FROM THE SCENE

Following the post mortem examination which clarified the components of the mechanism of death, but not

[36] t 13.06.17, p138
[37] t 13.06.17, p140

conclusively why or how it occurred, police investigation of items removed from the scene for forensic examination revealed significant discrepancies in the deceased's partner's recall of events and times. These were established from forensic examination of the camera, computer downloads from the scene, the deceased's and his partner's telephones.[38]

While it was not possible to clarify times from the evidence of persons visiting the deceased's house during the morning and early afternoon of 20 April 2013, downloads from the relevant telephones and the evidence of the deceased's partner's friend of his own downloads make it clear the two other men who attended after the friend, and left before the friend left, were gone from the premises by 2.50 pm. It was at about that time the friend sent the deceased's partner a message saying he was leaving, could not find the deceased and to thank the deceased. The other two had left.[39]

The deceased's partner's telephone records show a text message at that time reflecting the friend's evidence and at about that time the deceased's partner believed he spoke with the deceased by telephone on his way home and the deceased repeated *"they're all gone, they're all gone"*. As far as we can judge the deceased was still alive at approximately 2.50 pm.

[38] Ex 1, tabs 19-22, tabs 12-13
[39] t 13.06.17, p157

The deceased's partner believed he had returned home just before 3.00 pm, intending to get changed and talk with the deceased before he went out to a football match. On the various occasions he had spoken with police he had seemed confused about the exact sequence of events once he arrived home. He believed he had spent a period of time checking the deceased's telephone prior to locating the deceased, loosening the tourniquet, taking photographs, and then instituting CPR.

The download of the deceased's camera supported the partner's evidence that he took photographs of the deceased once the tourniquet was removed.[40] Those photographs show the deceased lying on the floor of the study with marks around his neck. The timing of those photographs from the forensic examination was at approximately 3.04 pm. It was unclear initially as to whether the police had checked the times on the camera, but information supplied to the inquest confirmed police had checked the times on the camera and were satisfied the times shown on the photographs were correct plus or minus two minutes.

If we understand the deceased was alive after 2.50 pm when he spoke to his partner about the other men having left, but being photographed a few minutes after 3.00 pm, it would seem he was very recently in that unresponsive state at the time the photographs were taken.

[40] t 13.06.17, p146

During various interviews with the police and evidence in court it was clear the deceased's partner had no explanation for his recalled chronology that he had taken the photographs just before commencing CPR.[41]
The SJA records make it clear the first call to St John Ambulance was at 4.30 pm and the deceased's partner was clearly frantic and instituting CPR.

There is no evidence of a cover up in the deceased's partner's evidence, he advised police he had taken photographs, he provided them with the camera which may well otherwise not have been seized because initially the detectives believed it was a straight forward suicide.

All that can be said about the time from approximately 3.00 to 4.30 pm is that the deceased's partner must have been mistaken in his chronology of events. There is no evidence this was a deliberate misrepresentation to cover untoward events. It is not uncommon for traumatic events to be recalled out of chronological order.

The only explanation for the deceased's partner's recall and the timelines obtainable from other sources would indicate the deceased's partner returned home shortly before 3.00 pm and located the deceased very soon thereafter with the tourniquet around his neck. It is unclear whether the deceased was in the chair or on the ground in the study

[41] t 12.06.17, p8-35 & 45-81, Ex 1, tab 12

when his partner located him due to his partner's differing recall between discovering the deceased and instituting CPR.

It would appear the deceased's partner in his emotionally obsessed state about events in the house in his absence, misconstrued the deceased's state on releasing the tourniquet. He believed the deceased was joking, in line with events that had occurred in the past[42] and believed the deceased would recover naturally on removal of the ligature. He took the photographs. He did not understand the deceased was unresponsive and so did not institute CPR promptly.

Instead, he became obsessed about what had occurred in the household in his absence and examined the deceased's telephone.

It would seem a considerable amount of time elapsed while he became more and more frustrated at trying to work out whether drugs and/or sexual activity had been taking place in his absence and who was involved. The fact he recalled hiding while doing this, if correct, and I have no reason to believe it is not, would seem to support the fact he believed the deceased would recover and come and find him. The deceased's partner was clearly extremely angry and irrational at this point in time.

[42] Ex 1, tab 12 & t 12.06.17, p22

The deceased's partner then became aware of the time and his need to leave for the football game and so returned to the deceased and discovered he had not recovered.
At this point I would speculate the deceased's partner panicked. His efforts to revive the deceased were at least an hour and a half too late. Events then unfolded as supported by the SJA paramedics' evidence, and police arriving at the scene.

DR JOYCE'S EVIDENCE

Evidence was sought from Professor Joyce, a Clinical Pharmacologist and Toxicologist, as to the effects of methylamphetamines in order to try and determine whether it was possible to clarify the deceased's death as being suicidal or accidental.

Professor Joyce explained the level of methylamphetamine and amphetamine in the deceased's system would indicate the deceased was a heavy user. Amphetamine is a metabolite of methylamphetamine and the ratios of one to the other indicated the deceased was an effective metaboliser of amphetamine and such high levels would indicate a tolerance built up over a period of time. This does support the deceased's partner's concern the deceased was becoming addicted to methylamphetamines and at a state where he was dependent upon them to function.

Professor Joyce outlined that in a heavy user of amphetamine that level of amphetamine, although high, was probably survivable. It would more likely be fatal to a naive user. The evidence did not support the deceased was a naive user so the fact of the high level of methylamphetamine would indicate he was a heavy user, but certainly intoxicated at the time of his death. That level of intoxication is completely supportive of the deceased exhibiting serious risk taking behaviour. This includes violence to others and violence to one's self. Methylamphetamine users are at risk of committing suicide while intoxicated, but also at risk of injury or death from risk taking behaviours while intoxicated.

This makes the issue of the use of a tourniquet around the neck, generally used around the arm to assist an intravenous access, problematic. Risk taking behaviour not comprising suicide can take many forms. While there were other drugs present in the deceased's system including antidepressants, Professor Joyce was of the view the only drug which was of relevance to the death was the level of methylamphetamine.

Professor Joyce explained that methylamphetamines are a powerful stimulant with largely psychological effects which make people feel good and confident and encourages them to take risks and get involved in violence.[43]

[43] t 13.06.17, p123

The main issue for consideration is there is no antidote for methylamphetamine overdose and that people who are excessively intoxicated can only be assisted through life support processes, there is no ability to reverse the effects of the drug. The only thing which will assist a person who has experienced cardiac arrest as the result of methylamphetamine intoxication, or during the course of methylamphetamine intoxication, is reinstitution of cardiac rhythm and life support in the hope the effects of the drug can be worked through. Professor Joyce noted that cases of methylamphetamine intoxication were comparatively uncommon until about 1995, since which time their use seems to have been progressively increasing with supporting evidence of the effects on cardiac function.

Aside from the psychological effects, the physical effects are an acceleration of the heart rate which increases blood pressure and increases the risk the heart will have rhythm disturbances that are serious and "*potentially lethal*".[44] Professor Joyce pointed out high blood pressure in itself can be a source of serious damage due to the bursting of small arteries either in the brain or elsewhere resulting in death. The final physical effect which provides a pathway to death is that some people experience fitting or seizures as the result of methylamphetamine intoxication which can be difficult to control, and can be lethal.

[44] t 13.06.17, p124

The normal methods of using methylamphetamines which are of concern are intravenously or by smoking, which appear to have been the methods used by the deceased. In these cases the doses are higher than if taken orally and enter into the blood immediately, rather than through the gut. The effects on the brain are more immediate as a result of smoking or intravenous use.

In Professor Joyce's view the level of methylamphetamine in the deceased's blood indicated it was consistent with using many hundreds of milligrams of the drug every day, approximately a half to a gram of methylamphetamine daily which was very heavy drug use.[45] At that level one would expect the user to have a level of tolerance to the drug, but regardless of their tolerance there were cumulative effects as a consequence of long term exposure and those are serious psychiatric and social effects. That level of drug use tends to effect changes in the brain which make people paranoid, and then go on to make them subject to delusions and hallucinations. This can result in a vivid psychiatric presentation called the amphetamine induced delusional state which never resolves without the user being brought into psychiatric care and the drug stopped. A user's lifestyle dramatically deteriorates while they reach that point, with their behaviours and beliefs being centred upon drug seeking behaviour. They lose their social support,

[45] t 13.06.17, p126

their jobs, their income and almost inevitably their friendships.[46]

In the case of the deceased, despite the high levels of amphetamine, Professor Joyce was of the view it was not simply a methylamphetamine induced death, although that was a possibility. He thought it was more likely death occurred at that concentration, in conjunction with other risk taking behaviours. This would include the placing of a ligature around the neck which can also cause physical effects, which in combination with the effects of the drug, would compromise a person's survivability and make them more prone to death.[47]

Professor Joyce used "*deaths during restraint*" as an example where the drug in combination with the restraint, or strenuous physical activity, cause a syndrome where the coincidence of methylamphetamine exposure and restraint or excessive physical activity result in rhythm disturbances of the heart. These are caused by low oxygen in the blood or by the sympathetic nervous system being over activated by the physical activity, and so result in death.

The issue in this case was, did the high level of methylamphetamine exposure and the presence of a ligature which may have restricted oxygen availability or blood to the brain, work together to cause the deceased's death by

[46] t 13.06.17, p127
[47] t 13.06.17, p128

sudden cardiac arrest. Professor Joyce postulated there didn't seem to be anything against a proposition the pathway to death in the deceased was the coincidence of the airway obstruction and the methylamphetamine exposure, both affecting oxygen levels and causing a cardiac death.[48] By restraint Professor Joyce was not referring to the necessary involvement of another party, but rather the physiological effects of restraint could be seen as similar to the physiological effects of a ligature.[49]

Professor Joyce was asked whether methylamphetamine intoxication would affect a person's coordination in the event they had a tourniquet around their necks, were conscious, it was beginning to cause them a problem and attempted to release it. While Professor Joyce did not believe it would affect a person's coordination, he did think it was possible methylamphetamine intoxication would encourage a person to believe they could tolerate more extreme physiological stress than was actually the case. As Professor Joyce put it "*So it's credible to say that somebody who is methylamphetamine intoxicated may have been less attentive to the serious risk that was involved in leaving the ligature there*".[50] He also confirmed a sudden cardiac event as the result of methylamphetamine intoxication and the beginning of the effects of ligature compression may well prevent a person from loosening their ligature as it became

[48] t 13.06.17, p129
[49] t 13.06.17, p130
[50] t 13.06.17, p133

too tight due to the heart stopping, and so perfusion to the brain ceasing almost immediately, with consciousness being lost very shortly there afterwards.

This makes the issue as to whether the deceased's death was an intentional suicide or an accidental outcome a difficult determination.

CONCLUSION AS TO THE DEATH OF THE DECEASED

I am satisfied the deceased was a 44 year old man in a fragile homosexual relationship at the time of his death. That relationship had been in place for approximately 18 years, however, it is apparent the deceased and his partner had numerous issues to address with respect to the future stability of their relationship. I have no doubt both the deceased and his partner were under significant emotional pressure and strain in the beginning of 2013.

This does not seem to have been the normal situation for the deceased since he had become an adult. The evidence indicated he was an extremely loving, generous and fun loving person with those about whom he cared. He certainly had a reputation for being meticulous in his arrangements which would have become a feature in his employment. While he was meticulous in himself, it is probable he was rather more tolerant of those around him and expected his friendships and relationships to be reasonably forgiving.

The evidence related to the deceased's recent difficulties at work would also indicate the deceased was becoming dependent on drugs to a level which was harming his lifestyle.

The evidence would suggest the deceased's partner was somewhat more demanding and controlling in his expectation of their relationship. I suspect the deceased's partner had very high expectations in a relationship which caused some difficulty for the deceased, and the deceased's partner agreed that for a period they relied on drugs to assist with social interactions.

There appears to have been occasions upon which the deceased felt he couldn't give his partner the love he needed and were indicative of the growing rift in their expectations of a long term relationship.[51]

I have no doubt the deceased's lifestyle encouraged the use of drugs, especially those based on amphetamines. The fact the deceased needed antidepressants supports the probability the deceased was having some difficulty coping with certain aspects of his life.[52] As he became more dependent on the use of drugs for his recreational interactions, so his partner appears to have drawn away from the use of drugs due to a concern about the effects he was seeing in the deceased.

[51] t 12.06.17, p11/12
[52] Rx 1, tab 31

The deceased's partner described how in the months immediately prior to his death there were episodes of the deceased appearing to create situations which would reassure him his partner cared enough about him to put him before his other commitments. The deceased's partner saw some of those situations as the deceased being a prankster, however in hindsight, it would seem the deceased was concerned the efforts they were both making in their relationship may prove to be fruitless. He needed some reaffirmation about their level of caring for one another, as opposed to loving one another. I am particularly referring to the events when the deceased pretended to have overdosed on pills, but was still breathing heavily when his partner checked on his welfare.[53]

It is this difficulty in understanding the deceased's state of mind by 20 April 2013 which makes a decision as to his manner of death difficult.

It is clear to me the deceased arranged the events early on the morning of that Saturday, 30 April 2013, with the expectation he and his partner would enjoy the company of a person with whom the deceased knew his partner was comfortable. He did not know/remember his partner had a work commitment that morning which he would not interrupt.

[53] t 12.06.17, p22

The friend of his partner arrived before his partner had left for work and the deceased's partner said he felt awkward about the situation, although he was quite comfortable with the deceased and his friend separately. The partner seems to have accepted there would be physical interaction between the other two during his absence and, although he clearly found that concept difficult, he appears to have made an effort to accommodate the deceased in his rather more open concept of relationships.

It is clear from the evidence the deceased did not actually want to spend time with others, without his partner, and found he had created a situation which he did not want. Despite his assurance to the friend it was perfectly permissible for the friend to stay, events did not develop as the deceased had envisaged.

Two other males attended at the premises, but the whole situation from the friend's description appears to have been awkward. There is no doubt the deceased was contacting his partner during this time begging him to return to assist him with events. This could not happen due to his partner's work commitments.

On leaving his work commitment the deceased's partner undertook errands at Carousel before returning home. Despite understanding the deceased wished him to return home, I speculate the partner thought he was

accommodating the deceased by not controlling his time. It would seem this was a significant misunderstanding of the situation.

The deceased removed himself from exposure to those at the house until they left. He did not make himself known prior to their leaving and the deceased's partner returned home very shortly after having communicated with the deceased, expecting the deceased to be there.

I have no doubt the deceased's partner was feeling somewhat emotionally unsettled due to his misinterpretation of the situation and assumption about what had been taking place.

The totality of the evidence indicates the partner arrived home shortly before 3 o'clock as he believed.

However, the evidence would also suggest that, rather than being distracted by the deceased's phone as a means to discovering what had happened in his absence, the deceased's partner located the deceased at that stage.

The fact the photographs the deceased's partner took are timed very shortly after 3 o'clock indicate he found the deceased collapsed with the tourniquet around his neck on his arrival home.

The fact the deceased had so recently spoken to his partner indicated the deceased must have known his partner would be home very shortly and he, either impulsively used the ligature in a suicide attempt, or intending to be unconscious on his partner's arrival home, tightened the ligature to an extent where he considered he would be alive, but unconscious and recoverable when his partner located him.

There was only an elapse of minutes between the deceased's conversation with his partner and his partner locating him collapsed with the tourniquet around his neck. The fact that when his partner released the tourniquet the colour return to the deceased's face implies congestion had only recently occurred.

The deceased's partner then walked away, believing the deceased would recover, and became fixated on the deceased's telephone to try and explain the events of the day. This would seem to be the only possible explanation for the delay in his partner realising the deceased was not pretending to be unresponsive. By that time the deceased was unrecoverable despite the partner instituting CPR and calling SJA at 4.30 pm.

In my view the deceased's partner's evidence was far too confused and disjointed for it to have been a fabrication as to the flow of events. I suspect he is enormously remorseful and in denial over the fact he left the deceased for such a

considerable period of time before realising the only chance of reviving the deceased was competent CPR. By that stage it was inevitably too late, whether the death was the result of a restriction of blood flow from the brain, amphetamine induced fatal cardiac arrhythmia or a combination of both.

That does not, however, answer the question as to whether the deceased would have survived had CPR been instituted at the time the photographs were taken, as the deceased's partner believed he had done.

Due to the difficulties outlined by Dr Moss as to the precise mechanism of the deceased's death, "*the best explanation of death is that combination of the compression of the neck and the methylamphetamine*"[54] it is impossible to be confident about the deceased's intent. Dr Moss described there were several mechanisms by which death could have occurred with that combination of drugs and neck compression. Depending on the precise mechanism, the inevitability of death hinges.

If it was a sudden, fatal cardiac event in response to the methylamphetamine and a degree of airway obstruction, then it is unlikely death would have been averted. Similarly, if the degree of hypoxia as a result of airway obstruction and methylamphetamine effect caused a

[54] t 13.06.17, p141

cerebral death, then it is also unlikely the outcome could have been reversed.

However, if there was methylamphetamine effect with the beginnings of hypoxia, enough to cause unconsciousness, but not irrepairable brain damage, then the institution of immediate CPR could have been effective, but, there was still the risk of a sudden cardiac death in response to the physiological stressors to the deceased's system.

All of this makes the determination as to whether the deceased's survival was possible at 3.05 pm impossible to gage. As Dr Moss explained there are also other mechanisms by which death could have occurred with the combination of obstruction of the blood flow and methylamphetamine effect.

Add to that the impossibility of determining whether the deceased, in response to what he perceived as a crisis in his need for a reaffirmation of his relationship with his partner intended to end his life, or intended to be saved, or was so reckless as to his future wellbeing that he no longer cared, makes it impossible for me to determine whether this was an accidental death or an intentional death by way of suicide.

I am satisfied the deceased was in an unknown state at the time the photographs were taken and that CPR was not

instituted at that point in time. CPR was the only possibility for his survival.

There is no evidence to support this was an autoerotic asphyxiation, in fact there was no evidence to support the fact of any significant sexual activity leading up to his death.

The deceased's partner, having believed he had done enough to rectify the deceased's collapsed state by releasing the tourniquet, became frustrated at the whole course of their relationship, which did not appear to be going in the direction either of them had hoped. He became fixated on whatever had occurred throughout the day, whether it be a sex party or a drug party, and attempted to assess that issue by examining the deceased's telephone and access to various social media sites.[55]

The fact the partner became obsessed and distracted by that is evidenced by the fact he should have left for his football appointment prior to 4 o'clock for that to have transpired the way he had envisaged.[56]

At some point he realised it was late and he needed to discuss with the deceased the fact he was going to the football. It was at that stage he returned to the deceased, realised he was still unresponsive and, I am completely

[55] t 12.06.17, p68
[56] t 12.06.17, p81

satisfied from the evidence, he at that point did everything he could as well as he could to revive the deceased.

Unfortunately, no matter what the initial intention of the deceased, it was too late and his partner was unable to save his life.

It is pointless at this stage for anyone involved with the deceased to lay blame or experience personal remorse as to the outcome of these events although they inevitably will. The deceased was most assuredly in a very distressed space at the time of his death and saw his life as spiralling out of control for a number of reasons. I suspect these related to drugs, relationships, and his general difficulty in finding peace of mind.

The deceased's heavy use of methylamphetamines predisposed him to risk taking behaviour and a violent and unplanned death. He was, I would speculate, very reckless as to his own self-preservation while under the influence of methylamphetamines. In his rational and normal state of mind, possibly not seen for some time, it is clear the deceased loved life and people and would have been a continuing valuable contributor to the cohesion of his community.

MANNER AND CAUSE OF DEATH

I am satisfied the combination of drugs used by the deceased during the course of the morning and his use of a ligature to obstruct blood flow to his brain, for whatever reason, was the cause of the deceased's death. As I have explained I am of the view it is more likely it was accidental, in that he did not intend to die.

I have to acknowledge, however, the deceased had made comments about wanting to disappear in a 'puff of smoke' and this related to the state of not only his personal relationship by then, but also his work, which he loved. In view of those issues I am not able to determine the deceased's intention.

Consequently, I make an Open Finding as to the manner of the deceased's death.

E F Vicker
Deputy State Coroner
9 October 2017