Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 40/17

I, Barry Paul King, Coroner, having investigated the death of ***William Scott Bartlett*** *with an inquest held at the* ***Perth Coroner's Court*** *on* ***25 October 2017****, find that the identity of the deceased person was* ***William Scott Bartlett*** *and that death occurred on* ***25 September 2015*** *at* ***Royal Perth Hospital*** *from* ***hypoxic brain injury and myocardial ischaemia following cardiac arrest during restraint in a man with likely drug effect*** *in the following circumstances:*

Counsel Appearing:

Ms F M Allen assisting the Coroner

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INTRODUCTION

1. William Scott Bartlett (the deceased) died on 25 September 2015 at Royal Perth Hospital (RPH) after he was the subject of a citizen's arrest and was then taken into police custody.

2. The deceased's death was a 'reportable death' under section 3 of the *Coroners Act 1996* (the Act) because it 'appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury'.

3. Under section 19 of the Act, I had the jurisdiction to investigate the deceased's death because it appeared to me that the death was or may have been a reportable death.

4. As the deceased was under 'the control, care or custody of a member of the Police Force', he was a 'person held in care' under section 3 of the Act.

5. Section 22(1)(a) of the Act provides that a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care.

6. An inquest into the death of the deceased was, therefore, mandatory.

7. I held an inquest into the deceased's death on 25 October 2017 at the Perth Coroner's Court.

8. The focus of the inquest was on whether the force used by those arresting the deceased was reasonable and whether that force caused or contributed to the death.

9. The documentary evidence adduced at the inquest comprised:

    a. a brief of evidence,[1] including a report prepared on 8 April 2016 by Detective First Class Constable B N

[1] Exhibit 1

Tabet of the Coronial Investigation Squad of the Western Australia Police (WAPOL);[2]

b. an email dated 23 October 2017 from the deceased's mother to Ms Allen.

10. Oral evidence was provided by:

a. Detective Constable S Hutchinson, one of the arresting police officers;[3]

b. Mr M Capell, the manager of the Hyde Park Hotel at the time of the arrest;[4]

c. Mr K G Shurman, one of three men conducting the citizen's arrest of the deceased;[5] and

d. Dr D M Moss, the consultant forensic pathologist who conducted the post mortem examination of the deceased.[6]

11. I have found that the cause of death was hypoxic brain injury and myocardial ischaemia following cardiac arrest during restraint in a man with likely drug effect.

12. Under section 25 of the Act, where the death is of a person held in care, a coroner must comment on the quality of the supervision, treatment or care of the person while in that care.

13. I have found that force used during the arrest was reasonable and that it did not cause or contribute to the death.

THE DECEASED

14. The deceased was born in Aberdeen in Scotland on 10 August 1979, making him 36 years old at the time of his death.[7] He had been in Australia for 34 years.

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[2] Exhibit 1, Tab 2
[3] ts 4-16 per Hutchinson, S
[4] ts 16-25 per Capell, M
[5] ts 26-33 per Shurman, K G
[6] ts 33-39 per Moss, D M

15. As a boy, the deceased excelled at sports. He went to John Curtin High School on a soccer scholarship and travelled to Japan as a member of the school's soccer team. He was the junior champion at the Gosnells Golf Course for two years running.[8]

16. In Year 10 the deceased began to get into trouble. He started smoking cannabis and was eventually expelled from school. He was then able to find work as a scaffolder, but he became heavily involved in drugs. From then until November 2014 he spent over 15 years in prison.[9]

17. In addition to drug abuse, the deceased had a past medical history which included depression, hepatitis C, antisocial personality disorder and attention deficit hyperactivity disorder.[10]

18. Despite the deceased's self-destructive life-style, he was a loving son and brother, a doting uncle to his niece and nephew and a friend to many. He had great community spirit and would often help those less fortunate than himself.[11]

24 SEPTEMBER 2015

19. At around 6.30 pm on 24 September 2015 the deceased was walking south along Eden Street in West Perth. He was under the influence of methylamphetamine at the time[12] and was acting erratically, walking with no sense of direction or purpose and talking to himself. He was carrying a black draw-string bag, and in his hand was a squeegee used for cleaning windows.[13]

20. As the deceased was moving along Eden Street he went up to the porch of a newly constructed house. He then went

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[7] Exhibit 1, Tab 1
[8] Exhibit 2
[9] Exhibit 1, Tab 2
[10] Exhibit 1, Tab 18
[11] Exhibit 2
[12] Exhibit 1, Tab 16
[13] Exhibit 1, Tab 7

into a nearby construction site, and then back into the middle of the street.[14]

21. As the deceased walked past a small car parked beside the roadway, he swung the squeegee down onto the windscreen of the car and smashed a small hole in it. That action caused a loud thud sound.[15]

22. Shortly before the deceased had done those things, Mr Shurman walked out of the back door of a gym on Fitzgerald Street that backed onto Eden Street because he heard a couple of similar loud thuds. He and his wife had been training at the gym with a friend, J Rueda, and the owner of the gym. Also at the gym was another friend of theirs, P Horne.[16]

23. Mr Shurman saw the deceased acting erratically and witnessed him smashing the windscreen of the car. Mr Shurman was concerned about the deceased's actions because his wife walked around the local streets, as did his friends and their children. His first thought was to confront the deceased and to call the police.[17]

24. Mr Shurman's car was also parked on Eden Street. When he saw the deceased moving towards it, he called out and started running towards the deceased, who then ran south on Eden Street towards Bulwer Street. Mr Shurman yelled at him to stop and ran after him.[18]

25. Mr Rueda, who was still inside the gym but saw the deceased strike the windscreen and saw Mr Shurman chase after him, also ran after him. Mr Horne joined in the chase and ran past Mr Rueda.[19]

26. The deceased crossed Bulwer Street and into the rear car park of the Hyde Park Hotel, which becomes the car park for a liquor outlet. As he ran past a forklift and beer kegs,[20]

[14] Exhibit 1, Tab 7
[15] Exhibit 1, Tab 7
[16] Exhibit 1, Tab 7
[17] ts 27 per Shurman, K G
[18] Exhibit 1, Tab 7
[19] Exhibit 1, Tab 5
[20] Exhibit 1, Tab 5

he tripped, possibly on some covered timber,[21] and fell onto his left side on the bitumen.[22] Mr Shurman tried to restrain him on the ground by grabbing his arms.[23]

27. Mr Horne arrived at the car park next. He helped Mr Shurman to roll the deceased onto his stomach and then forced him down by placing a knee on his left shoulder and holding his head down.[24]

28. Mr Rueda then arrived and grabbed the deceased's legs. Mr Shurman's wife also arrived at the scene.[25]

29. Mr Shurman told the deceased that he saw him hitting the car and heard him hit other cars. He told him that he was going to hold him until police officers arrived.[26]

30. Mr Shurman, his wife and his friends asked bystanders to call the police. When they did so, the deceased began thrashing around with disproportionate strength to his size.[27] He was much smaller than any one of the three large strong men who were restraining him, but by pushing himself up, he was able to lift them.[28] He did that several times. Each time he did so, he screamed and thrashed and made irrational threats. He would then calm down before making another attempt to throw the men off.[29] At some stage, a syringe fell from the deceased's clothing onto the bitumen under him.[30]

31. Just before police officers arrived, the deceased's behaviour changed from thrashing and screaming to simply lying still and panting or groaning and grunting.[31]

32. After about 10 minutes after the call for police, Constable (now Detective Constable) Hutchinson and Constable Holland arrived in their police vehicle. They saw that the

[21] Exhibit 1, Tabs 7 and 13
[22] Exhibit 1, Tab 7
[23] Exhibit 1, Tab 7
[24] Exhibit 1, Tab 5
[25] Exhibit 1, Tab 8
[26] Exhibit 1, Tab 7
[27] Exhibit 1, Tab 5
[28] Exhibit 1, Tab 7
[29] Exhibit 1, Tab 7
[30] Exhibit 1, Tab 9
[31] ts 21 per Capell, M; ts 31 per Shurman, K G

deceased was lying on the bitumen and being restrained by the three men.[32] He was moving his head around and was grinding his face into the bitumen.[33]. He appeared to Constable Hutchinson to be under the influence of drugs at the time.[34]

33. As the police officers approached, one of the three men holding the deceased told them that the deceased had been breaking into cars and jumping fences, and that he was super strong and had needles in his possession.[35]

34. Constable Hutchinson took out his handcuffs and squatted beside the deceased. Mr Shurman moved away in order to allow Constable Hutchinson to place the handcuffs on the deceased's wrists.[36]

35. Constable Hutchinson moved the deceased's right arm to the small of his back and placed one handcuff on the right wrist. He then asked the deceased to pass his left arm from under his body to his back. The deceased did not speak, but he moved his arm back and Constable Hutchinson grabbed it and moved it to where he could put the other handcuff onto the left wrist.[37]

36. Constable Holland applied a leg-lock to the deceased and searched him with a quick pat down. He found a capped syringe in the deceased's shorts pocket.[38]

37. Constable Hutchinson saw blood from injuries on the deceased's face, so he asked him if he wanted an ambulance. The deceased did not respond. Constable Hutchinson then began to tell him that he was under arrest for criminal damage, but stopped before he finished when he realised that the deceased was not responding.

38. Constable Holland thought about positional asphyxia and told Mr Horne and Mr Rueda to let the deceased go.[39]

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[32] Exhibit 1, Tab 12
[33] ts 21 per Capell, M
[34] ts 13 per Hutchinson, S
[35] Exhibit 1, Tab 10
[36] Exhibit 1, Tab 12
[37] Exhibit 1, Tab 12; ts 8 per Hutchinson, S
[38] Exhibit 1, Tab 10
[39] Exhibit 1, Tab 10

39. About this time, two other police officers, Sergeant Hastings and Constable Trimmer, arrived in a police vehicle.[40]

40. Constable Holland recognised the deceased as a person with whom he and Constable Hutchinson had dealt on the previous evening. They had stopped and searched him in Subiaco after he had been creating a disturbance. He had told them that he had used drugs about an hour previously and that he had a contagious disease.[41]

41. As Constable Holland was bringing the fact that he recognised the deceased to Constable Hutchinson's attention, Constable Hutchinson and Sergeant Hastings noticed that the deceased's eyes were not focusing.[42] Constable Hutchinson called for an ambulance while Constable Holland checked on the deceased's condition, and then Constable Trimmer and Sergeant Hastings checked on the deceased again and found that he was not breathing.[43]

42. Constable Hutchinson called again for an ambulance and told the call-taker that the patient was not breathing.[44]

43. Constable Holland and Constable Trimmer removed the handcuffs from the deceased's wrists and rolled the deceased onto his back. Constable Holland commenced administering chest compressions.[45]

44. Ambulance paramedics arrived a short time later and took over the resuscitation attempts. The deceased was asystole when they arrived but there was a change to pulseless electrical activity. They transferred the deceased to the emergency department at RPH while administering CPR with a Lucas machine on the way.[46]

[40] Exhibit 1, Tab 11
[41] Exhibit 1, Tab 10
[42] Exhibit 1, Tab 12
[43] Exhibit 1, Tab 11
[44] Exhibit 1, Tab 12
[45] Exhibit 1, Tab 13
[46] Exhibit 1, Tab 14

ROYAL PERTH HOSPITAL

45. Upon arrival at the emergency department at RPH, the deceased's pupils were fixed and dilated but a return of spontaneous circulation was achieved. By that time, the duration of resuscitation time was more than 50 minutes. A CT scan confirmed the presence of extensive severe cerebral oedema consistent with a severe hypoxic brain injury.[47]

46. That night the deceased was admitted to the intensive care unit and given large doses of inotropes to maintain his circulation. Echocardiography showed globally impaired left ventricular function of his heart.[48]

47. The deceased's condition continued to deteriorate with progressive multi-organ failure and bleeding from the gastrointestinal system.[49]

48. Following discussion between medical staff and the deceased's mother, at 7.00 am on the morning of 25 September 2015, inotrope infusions were ceased and the deceased was extubated. He died a short time later.[50]

CAUSE OF DEATH AND HOW DEATH OCCURRED

49. On 1 October 2015 forensic pathologist Dr D M Moss conducted a post mortem examination of the deceased's body and found a soft and swollen brain and evidence of a recent 'heart attack' (subendocardial infarct). There was focally severe hardening of the blood vessels over the surface of the heart (coronary artery atherosclerosis).[51]

50. Microscopic examination confirmed the presence of an acute myocardial infarct and severe atherosclerotic narrowing of a coronary artery.[52]

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[47] Exhibit 1, Tab 18
[48] Exhibit 1, Tab 18
[49] Exhibit 1, Tab 18
[50] Exhibit 1, Tab 18
[51] Exhibit 1, Tab 15.A
[52] Exhibit 1, Tab 15.B

51. Toxicological analysis showed a blood methylamphetamine level of 1.1 mg/L and an amphetamine level of 0.08 mg/L. A low level of the antipsychotic medication quetiapine was detected. Alcohol and other drugs were not detected.[53]

52. Neuropathological examination of the brain showed cerebral swelling in keeping with the neuro-radiology findings of hypoxic ischaemic brain injury. There were no microscopic features of a recent traumatic brain injury. Dr Moss formed the opinion, which I adopt as my finding, that the cause of death was hypoxic brain injury and myocardial ischaemia following cardiac arrest during restraint, in a man with likely drug effect.[54]

53. In oral evidence Dr Moss said that the deceased's agitated exertion while under restraint fit in with the whole picture. He explained that the myocardial infarct was almost certainly driven by the cardiac arrest, which was due to an arrhythmia because the coronary artery disease led to insufficient blood supply in the circumstances of physiological stresses. He agreed that the arrhythmia was brought on by the combination of the straining, the agitation and the methylamphetamine in the context of severe atherosclerosis.

54. On the basis of the information available, I am satisfied that the deceased had severe atherosclerotic coronary artery disease which, during strenuous exertion while affected by methylamphetamine, led to cardiac arrhythmia, myocardial ischaemia and hypoxic brain injury, which caused his death.

55. I find that death occurred by way of misadventure.

COMMENT ON THE SUPERVISION TREATMENT AND CARE

56. I am satisfied that the force used by the three men and then by the police officers in restraining the deceased was appropriate in the circumstances. They were clearly

[53] Exhibit 1, Tab 16
[54] Exhibit 1, Tab 15.B

justified in holding the deceased and the force they applied was reasonable in all the circumstances.

57. In any event, it is clear that the restraint they applied did not cause or contribute to the death.

CONCLUSION

58. The deceased's tragic death occurred in relatively uncommon circumstances but with a background which is becoming too prevalent in our community: methylamphetamine addiction, drug-induced psychosis and violence. His early coronary atherosclerosis was also likely related to methylamphetamine use.

59. The inquest did not traverse potential solutions to the growing problems associated with methylamphetamine use. However, it is clear that much needs to be done on several fronts if those problems and the associated tragedies are to be reduced.

60. No mother should have to attend a similar inquest into the death of her son.

B P King
Coroner
7 March 2018