IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 6492

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of Damien Marius VAN DER KORPUT

without holding an inquest:

find that the identity of the deceased was Damien Marius VAN DER KORPUT

born on 18 January 1964

and the death occurred on 24 December 2014

at the Northern Hospital, 185 Cooper Street Epping, 3076 Victoria

from:

1 (a) HYPOXIC ISCHAEMIC BRAIN INJURY

1 (b) HANGING

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Damien Van Der Korput was a 50-year-old man who resided in South Morang with his wife, Mrs Joanna Van Der Korput. They had two children, Ethan and Mitchell.
2. In 1995, Mr Van Der Korput was diagnosed as suffering from Attention Deficit Hyperactivity Disorder. He had also been diagnosed with depression and anxiety and was prescribed medications for these conditions. Family members also indicate that Mr Van Der Korput and his wife had ongoing relationship issues which greatly affected his personality and behaviour. He also drank heavily on occasions and would become verbally abusive towards Mrs Van Der Korput. During these times he would also threaten to self-harm but would apologize after sobering up.
3. Mr Van Der Korput had a number of consultations with Psychiatrist Dr Paul Wendiggensen and would see him every three to four months. On 19 April 2012, Mr Van Der Korput reported feeling depressed and indicated he had been drinking and arguing with his wife. He was considered to be suicidal and was admitted to the Psychiatry Centre at the Northern Hospital for a brief period. He also revealed having suffered sexual abuse in his younger years and felt a general sense of humiliation and shame about this. He last consulted with Dr Wendiggensen on 18 November 2014 when he again spoke of being drunk and having intimidated and aggravated his wife. He never indicated that he was suicidal but Dr

Wendiggensen noted '*he could at times react impulsively, and a suicidal act would be consistent with his deteriorating mental health.*'

4. On 19 December 2014, Mr Van Der Korput and his wife had lunch at their favourite sushi restaurant and went shopping in South Morang. At 3pm, Mrs Van Der Korput left to pick up their children from school. At some stage during the afternoon, Mr Van Der Korput and his wife were drinking and the family sang karaoke together.

5. At 10.30pm, the children were put to bed. Mr Van Der Korput was on the phone to his sister, Ms Victoria Blackmore. During the course of the call, he became upset about his relationship with his wife as well as other ongoing family issues. He finished the call at 12.30am on 20 December 2014. Approximately 20 minutes after this, Mr Van Der Korput started arguing with his wife. She was half asleep and could not understand what he was saying. He returned to the bedroom on two more occasions over the next few minutes and threatened to self-harm but Mrs Van Der Korput told him to go and sleep.

6. At around 1.10am, Mrs Van Der Korput heard a loud noise coming from the garage. She opened the internal garage door to find Mr Van Der Korput hanging from a rope which was looped around his neck and tied to an anchor point on the roof cavity of the garage through the opened manhole. He was not moving and his face was dark red, turning blue. She attempted to lift his legs to support him but could not do so and also tried to pull on the rope, in an attempt to loosen it. She then contacted 000 for assistance.

7. At 1.20am, police and paramedics arrived. Mr Van Der Korput was cut down using a knife and cardiopulmonary resuscitation was commenced. He was conveyed to the Northern Hospital Emergency Department in a critical condition. Initial investigations did not suggest a significant hypoxic ischaemic brain injury however he developed myoclonic jerks and then failed to show any neurological improvement. An MRI scan then showed a severe hypoxic ischaemic brain injury and it was evident that this chances of survival were minimal at best and it was exceedingly unlikely he would recover neurologically. As a result, a decision was made to withdraw his treatment on 24 December 2014 and he was declared deceased at 1.47pm.

8. A letter of concern was received from Ms Blackmore on 27 December 2014 relating to Mrs Van Der Korput's actions on the night of the incident. In particular, she queried why she did not cut the rope with a knife and why were the neighbours not called. Mrs Van Der Korput indicates in her statement that with hindsight, she is upset with herself for not obtaining a knife but she was so shocked and unprepared when she observed her husband hanging that she just knew she needed to get help. When an individual is in shock, they do not react the same way and therefore Mrs Van Der Korput's actions cannot be criticised in relation to not contacting neighbours or failing to get a knife.

9. A further letter of concern was received from Ms Blackmore on 17 December 2015 which queried whether the Emergency Services Telecommunications Authority (ESTA) followed their standard operating procedures when they received the emergency call on the night of the incident and whether they instructed Mrs Van Der Korput to cut Mr Van Der Korput down. The Court wrote to ESTA on 16 March 2016 with respect to these concerns and received a response on 21 April 2016.

10. Mr Mark Richards, the Quality Improvement Manager for ESTA stated that Mrs Van Der Korput's emergency call was received at 1.14am on 20 December 2014 and was taken by an ESTA Police call-taker. These are a dedicated group of call takers which handle emergency calls for Victoria Police which are in addition to the ESTA Ambulance Victoria call-takers.

11. Mr Richards explained that the '*wording and workflow for each event type contained within the Victoria Police structured call-taking manual are determined solely by Victoria Police... The ESTA Police call-taker handled the call exactly in accordance with the workflow, identifying the need for an ambulance and relevant details required for ambulance attendance. The Workflow does not provide any pre-arrival instructions to cut the victim down, but does provide instructions to transfer the caller to the Police Communications Liaison Officer which the call taker did at 1.16am and also arranged for ambulance attendance at 1.17am.*'

12. Once the call had been transferred to the Ambulance call taker, their workflow for this event type provides post-dispatch instructions to cut the person down, loosen the noose and identify whether the person is breathing. Mr Richards noted that '*Mr Van Der Korput's case is the first event within ESTA where the importance in the difference in the police and ambulance all taking workflows for someone who is found to be hanging has been identified.*' Given this, Mr Richards has asked that ESTA communicates with the Inspector in charge of the Police Communications Division with a view to ensure a consistency in approach between the Victoria Police structured call taking manual and ESTA's structured protocol known as the ProQA. With respect to Ms Blackmore's concerns, both the ESTA Police call-taker and the ESTA Ambulance call-taker acted in accordance with ESTA's procedures and call taking processes. Mrs Van Der Korput was advised by the ESTA Ambulance call-taker to cut her husband down, but at this stage police had already arrived at the premises and were able to do so.

13. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine performed an external examination of Mr Van Der Korput and provided a written report of his findings. Post mortem CT scan did not reveal any evidence of facial or skull fracture. The external examination was otherwise unremarkable. Toxicological analysis revealed the presence of 0.18g/100mL of ethanol (alcohol), morphine codeine, midazolam, doxylamine, amphetamine and traces of paracetamol and lignocaine.

14. I find that the cause of death of Damien Van Der Korput was hypoxic ischaemic brain injury in the context of hanging. I further find that he intended the tragic consequences of his actions.

RECOMMENDATION:

That the Victoria Police structured call taking manual and ESTA's structured ProQA protocol be reviewed, and where appropriate amended, in order to ensure their workflow procedures reflect a consistent approach in post-dispatch instructions.

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

Mrs Joanne Van Der Korput

Ms Victoria Blackmore

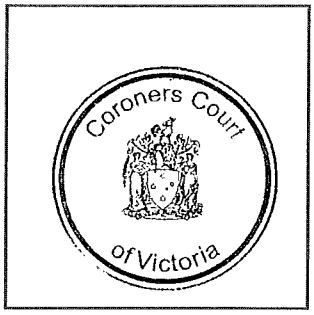
First Constable John Logan, Mill Park Police Station

Ms Lisa Sparke, Queensland Health-Heart Valve Bank

Mr Mark Richards, ESTA

Mr Fatmir Badali, Gadens Lawyers

Signature:



IAIN WEST
DEPUTY STATE CORONER
Date: **4 October 2016**