STATE
CORONER
VICTORIA

CORONERS REGULATIONS 1996

Form 1

State Coroners Office
57-83 Kavanagh Street
Southbank 3006
Telephone: (03) 9684 4380
(All Hours)
Toll Free: 1300 309 519
(Only Country Victoria)
Fax: (03) 9682 1206

20th February, 2008
Case No: 2579/05

RECORD OF INVESTIGATION INTO DEATH

I, **PARESA ANTONIADIS SPANOS**, Coroner,

having investigated the death of GEORGIA LOPICCOLO with Inquest held at Coronial Services Centre, Southbank on the 6th September to 8th September and 31st October to 2nd November, 2006
find that the identity of the deceased was GEORGIA LOPICCOLO and that death occurred on 21st July, 2005 in the police cells at Knox Police Station, 414 Burwood Highway, Wantirna South, Victoria, 3152 from -

1(a) NECK COMPRESSION (LIGATURE STRANGULATION)

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES

1. Ms Georgia Lopiccolo (nee Apostolidis, also known as Georgia Lo Piccolo) was a forty-seven year old woman born on 13 July 1958 in Greece, the eldest of five children. Her upbringing was largely in Belgium where her family migrated in 1962. When their parents separated in 1974 Ms Lopiccolo and her siblings remained with their mother. At sixteen Ms Lopiccolo gave birth to her son Patrick Andreoli. In or around 1984 Ms Lopiccolo's mother died and she and her son and siblings were sponsored to Australia by a brother who had migrated here in 1981. A rift developed between the siblings over distribution of their deceased mother's estate, and contact between Ms Lopiccolo and her family was spasmodic thereafter.

2. Medical records confirm a history of depressive illness and illicit substance abuse. Consistent with this, Ms Lopiccolo's criminal history in Victoria commences in 2001 with convictions for drug-related matters including trafficking, possession and use of amphetamines, heroin, pseudoephedrine, ecstasy and cannabis.[1]

3. In September 2004 Ms Lopiccolo was sentenced in the Drug Court to two years' imprisonment and released on a drug treatment order. By combination of alleged breaches of the drug treatment order, alleged further offences committed whilst in custody, alleged involvement in a burglary at her estranged brother's home on 22 February 2002,[2] and

alleged failures to answer bail, by 21 July 2005 Ms Lo Piccolo was subject to five Warrants of Apprehension.

EXECUTION OF WARRANTS OF APPREHENSION

4. On **21 July 2005**, Detective Senior Constable Paul O'Brien from the Knox Crime Investigation Unit **received information** that Ms Lopiccolo was staying at 23 Warrabel Road, Ferntree Gully and that there were a number of outstanding warrants for her arrest. After checking this information against Victoria Police computer records, and obtaining a copy of her LEAP personal history, DSC O'Brien and Detective Senior Constable Ian Brown attended at the Ferntree Gully address with back-up from Detective Senior Constable Kevin Morgan and Detective Senior Constable Bruce Rowe, also from Knox C.I.U. travelling in another police vehicle. On the way DSC Brown read aloud from Ms Lopiccolo's LEAP personal history by way of briefing.[3]

5. At about 2.26pm Ms Lopiccolo answered the door, and apart from indicating her **surprise** that police had found her and wanting to know who told them her whereabouts, she was **co-operative and compliant.** Ms Lopiccolo was taken back to Knox Police Station in the custody of DSC Brown, who had formally executed the warrants, and DSC O'Brien.[4]

RETURN TO KNOX C.I.U. - CHECKS AND SEARCHES

6. They **returned to Knox C.I.U. offices at about 2.40pm**, and Ms Lopiccolo was placed in the S.O.C.A.U. (Sexual Offences and Child Abuse Unit) interview room briefly with Detective Paul Cosgrove, as both C.I.U. interview rooms were occupied. At this time Ms Lopiccolo was **upset and crying on and off**.[5] DSC Brown asked DSC Morgan to conduct an **arrival check** was conducted by Senior Constable Kevin **Morgan at about 2.42pm**. He noted that she had 'nil injuries, nil impairment, safety and evidence search, all correct'.[6]

7. Having read her LEAP personal history, DSC Brown was aware personal history Ms Lopiccolo had a **history of secreting drugs on her person.** He asked **Acting Sergeant Deidre Ford** and **Senior Constable Donna Gale** of the S.O.C.A.U. to conduct a **safety and evidence** search, which he was about to 'clear' with Detective Senior Sergeant Garry McMillan, as the senior officer on duty. DSC Brown introduced the two female officers to Ms Lopiccolo and told her that she was about to be searched. DSC Brown and DSC Cosgrove left the interview room.[7] During this search which took place at **2.45pm** Ms Lopiccolo was required to remove all her clothing, and was **visibly upset intermittently and crying**. A set of keys and a metal hairclip were taken from her as having weapon potential. She refused to put her pantyhose back on saying "No, throw them out, they've got holes." SC Gale left the room to get her some tissues and A/gSgt Ford placed the pantyhose on the table with the keys and hair clip.[8]

8. As they were leaving the interview room, A/gSgt Ford advised Detective Sergeant Vasilios Chrisant that their search was concluded and that "She has a pair of pantyhose with holes in them. She wanted me to throw them out and I haven't. She won't put them back on so I've left them on the table with her keys and hair clip."[9] As DSC Brown was standing

behind DSgt Chrisant, both heard the comments about the pantyhose.[10] DSgt Chrisant then conducted an **initial supervisor check** at about **2.45pm.** As he entered the interview room he saw that Ms Lopiccolo was standing, wiping tears from her face and adjusting her clothing, and that there was a rolled up pair of skintone pantyhose on the interview table. After a brief discussion during which she became upset and shed some tears, DSgt Chrisant noted **"Nil injuries, Nil complaints, nil incapacity or impairment."** When he left the pantyhose were still in plain view on the table, with the keys and hairclip. He did not see fit to draw these items to the attention of DSC O'Brien or DSC Cosgrove who were about to interview Ms Lopiccolo.[11]

9. Ms Lopiccolo remained in the interview room, at times on her own while DSC O'Brien and Detective Senior Constable Cosgrove prepared to interview her. Neither mentioned seeing the pantyhose at any time either before during or after the interview. The formal taped **interview** was conducted by them **commenced at 3.45pmn and concluded at 4.08pm**. On occasions **during the interview Ms Lopiccolo was distressed**, but not beyond what the interviewing officers considered **normal**, and not so as to raise concerns for her welfare.[12]

10. At 5.20pm Ms Sue Crawford, Bail Justice, conducted an out-of-sessions bail hearing, and **shortly after 5.30pm remanded Ms Lopiccolo** to appear at Melbourne Magistrates Court at 10.00am the following day. Ms Lo Piccolo was given access to a telephone and called her son Mr Patrick Andreoli. She **appeared distressed** during this telephone call, but as it was conducted in French none of the police officers who heard it could understand what she was saying.[13]

11. In his statement to police made after his mother's death, Mr Andreoli said that he knew when she called him on 20 July 2005 that his mother was in custody, that she was **very upset and difficult to understand**, and that she warned him 'not to trust one of her brothers as all he was interested in was financial advancement.' He confirmed that this conversation was conducted in French.[14]

LODGEMENT IN THE POLICE CELLS

12. Apart from Section Sergeant Bruce Kent who was the senior officer on the afternoon shift, and would be expected to assist with watch-house duties if required, the two members rostered for watch-house duties were Leading Senior Constable Georg Berk and Senior Constable Dean Clinton.[15]

13. As there were no female police members at Knox by that time, LSC Berk asked if Ms Lopiccolo had been searched previously and was told by DSC Rowe that she had been searched by S.O.C.A.U. members prior to interview. LSC Berk then conducted a visual search of Ms Lopiccolo's clothing checking for "cords, belts and shoelace type things" to ensure she did not have any items with which to self-harm. Ms Lo Piccolo was **co-operative** with this search, lifting her top to show she had no belt and volunteering her jewellery.[16]

14. Initially Ms Lopiccolo was lodged in the holding cell.[17] At 6.00pm, as there was no one else in custody that evening, Sgt Kent and LSC Berk moved her to male cell number 1 which was larger, and gave her access to a larger exercise area and a television. Ms Lopiccolo was provided with cushions and blankets but declined the offer of tea, coffee or food, and just had some water. At this time she was told that she was likely to be there for about four hours before transportion to Melbourne. Sgt Bruce Kent had made the decision to **delay her transportation until 10.00pm** when a second divisional van crew was rostered to commence patrol duties, so that one divisional van crew would still be available to respond to calls within the Knox District.[18] LSC Berk turned on the television and they left her lying down under a blanket, and attended to other duties.

15. Apart from actual physical observation, police were able to **monitor Ms Lopiccolo via CCTV camera** high in the corner of her cell. The monitor displaying the vision captured by that camera was in the main office area, immediately above the one-way mirror which looked out onto the public foyer. While attending to other duties LSC Berk occasionally glanced at the monitor and saw that Ms Lopiccolo was still lying under the blanket. Sgt Kent was away from the watch-house area attending to other duties and SC Clinton was taking a statement from a member of the public regarding a 'hit and run' collision. At 6.25pm LSC Berk attended to a counter enquiry involving a road rage incident reported by a woman who was visibly upset and very agitated. At 6.37pm while he was conducting some computer checks, Sgt Kent returned to the watch-house and said he would check on Ms Lopiccolo.[19]

DISCOVERY OF MS LOPICCOLO'S BODY

16. At about **6.37pm Sgt Kent went into the cell to check on Ms Lopiccolo's welfar**e. He found her laying prone under a blanket, apparently asleep. When he tried to rouse her she didn't respond. Becoming increasingly concerned for her welfare, he approached her and saw her face was blue and her tongue protruding. Within moments of entering the cell Sgt Kent alerted LSC Berk and SC Clinton who were performing Watch House Keeper duties. All three struggled to remove the pantyhose which had been used a ligature from around Ms Lopiccolo's neck and/or feet. The ligature was removed and an **ambulance called at 6.42pm**. The ambulance crew arrived at 6.43pm but found no signs of life.[20]

INVESTIGATION

17. A number of people attended the Knox Police Station in the afermath. They included Dr Greg Wilks, a Forensic Medical Officer who pronounced death, Deputy State Coroner Iain West, Dr Linda Iles, the on-call Pathologist who later performed the autopsy and Detective Acting Sergeant Adam Forehan who investigated Ms Lopiccolo's death and compiled a comprehensive Inquest brief.

18. This **finding is based on all the material the product of the coronial investigatio**n of Ms Lopiccolo's death, namely the statements and exhibits comprising the Inquest brief, the evidence of those witnesses who testified at Inquest, the exhibits tendered at Inquest, and the submissions of Counsel - Mr Jack Vandersteen, Counsel Assisting, Mr John Olle, Counsel representing Sgt Kent, LSC Berk and SC Clinton, and Ms Fiona Ellis, Counsel representing the Chief Commissioner of Police. As that material and the Inquest transcript

will remain on the coronial file, I do not intend to summarize it in this finding, but have referred to it in such detail as is warranted on the basis of forensic significance and narrative clarity.

THE CORONERS ACT 1985

19. As Ms Lopiccolo was a person who was **under the control or care of a member of the police force** when she died her death is reportable to the State Coroner and an **Inquest is mandated** as part of the coronial investigation of her death.[21] This reflects a recognition that people in such circumstances are in a vulnerable position, and that the independant and transparent scrutiny afforded by the coronial process is appropriate.

20. The obligations on a Coroner investigating a reportable death are to establish, if possible, the **identity** of the deceased, **how the death occurred**, the **cause of death** and the **date and place of death**.[22] In order to distinguish 'how death occurred' from the 'cause of death', the practice is to refer to the former as the context within which the death occurred, or the *background and surrounding circumstances*, and the latter as the *medical* cause of death. In relation to Ms Lopiccolo's death there was no issue with her identity, nor with the date and place of her death.

CAUSE OF DEATH

21. There was also no controversy about the medical cause of Ms Lopiccolo's death. Dr Linda Iles, the Forensic Pathologist who attended Knox Police cells shortly after Ms Lopiccolo's death had been discovered, conducted an autopsy and provided a detailed report of her findings.[23] Dr Iles found no evidence of natural disease significantly contributing to death, and some anatomical evidence consistent with previous intravenous drug use.[24] Toxicological analysis of postmortem samples which confirmed recent use of cannabis and amphetamines was incorporated into Dr Iles' autopsy report.

22. Dr Iles formulated the cause of Ms Lopiccolo's death as *"Neck compression (ligature strangulation)"* and made the following comment, also relevant to 'how the death occurred'

> *"... There is a ligature mark completely encircling the neck that is consistent with being caused by the stocking ligature received with the deceased.*
>
> *The autopsy findings are consistent with a mechanism whereby the ligature is looped completely about the neck and the opposite end is hooked over the heels of the deceased's shoes. Traction is then applied by extension of the legs, thus tightening the ligature about the neck. Death in neck compression is caused by compression of the arteries and veins supplying and draining the head and neck, compression of the large airway or compression of the carotid sinus, or, as is often the case, a combination of the above mechanisms ..."*[25]

HOW THE DEATH OCCURRED - BACKGROUND AND SURROUNDING CIRCUMSTANCES

23. The main focus of the Inquest was on how Ms Lopiccolo's death occurred. A **number of inter-related themes emerged**, well-encapsulated by Counsels' submissions, but complex to unravel in terms of their significance to Ms Lopiccolo's death, and their

potential to yield benefits in the prevention of future deaths in similar circumstances. Those themes which seem to me to warrant comment in some detail are, in no particular order -

24. **Demeanour as an indicator of suicidality**

It was abundantly clear at Inquest that Ms Lopiccolo's **demeanour**, or rather the way she appeared to the various police members who came into contact with her on 21 July 2005, was **crucial to their assessment of her suicidality** or the risk that she would harm herself. Without exception, they testified that although at times distressed, upset or crying, they found her demeanour congruent with the situation she found herself in, that is being arrested, being subjected to a full body search, being denied bail and facing the prospect of incarceration.[26]

25. I am also satisfied that all members were aware, at least at the theoretical level, of their obligations to people in custody, and of the relevant parts of the Victoria Police Manual,[27] and that had Ms Lopiccolo's demeanour alerted them to a risk of suicide or self-harming behaviour, they would have looked to the LEAP personal history, including any warnings about a risk of suicide, as a resource, another source of information to be factored in to any decision-making regarding the person.[28]

26. Regrettably, as widespread as this approach seems to have been at Knox Police Station on 21 July 2005, it is a **flawed approach in two respects.** In the **first** place **demeanour is not a good indicator of suicidality** or self-harming intent. Without being more specific, there are any number of coronial findings which evidence the 'predictable unpredictability' of suicide, and the inability or failure of Psychiatrists, Psychologists, Psychiatric Nurses, close family members and friends of people who have taken their own lives, to anticipate the act of suicide. Police members cannot be expected to fare any better than clinicians, but they will inevitably come into contact with people with mental health issues, or people without mental health issues but in stressful situations. Some part of their ongoing professional development could be usefully targeted to meeting these challenges.

27. **Secondly**, such an approach substantially **undermines the value,** perhaps the whole rationale of **flagging warnings** on the LEAP system. By definition, the effectiveness of a warning should not wholly depend on the person in custody overtly displaying the same concerns which led to the warning being flagged in the first place. A warning on a computer based system such as LEAP accessible to members across the State should be heeded, and always given due weight depending on the circumstances. Even allowed to colour the witnessed demeanour.

28. **The LEAP warning**

Ms Lopiccolo's personal history on the Victoria Police LEAP system contained a "Suicide/Self Injury" and a "Medical Condition" warning under the heading "Interest Flags".[29] For more information, or the details of the perceived need for the warning, a member would need to click on the warning, and access another screen. Had they done so they would have gleaned that as at 14 August 2004 Senior Constable Whitehead[30] of Frankston Uniform Branch had completed the relevant "Person Warning Report" with the approval of Sergeant Wright. The gist of the report was as follows -

"LOPICCOLO remanded in custody Frankston Cells re Drug offences. Observed in cell croughing [sic] in corner sobbing. Stated she suffered from depression and was suicidal. Refused to elaborate further. Stated that she was taking tamzapam [sic] daily for her condition. Also stated that she used speed daily. Custodial nurse advised."[31]

29. In total Ms Lopiccolo was in police custody for about four hours on 21 July 2005. Nevertheless, none of the police who were involved with her arrest, interview, processing or lodgement on that day, and who provided statements for the Inquest brief and/or testified at Inquest, recalled seeing the suicide warning on that day, when it could have been most useful. Those who recalled having access to a hard copy of her LEAP personal history did not recall seeing the suicide warning and/or did not consider it relevant to the task at hand. Similarly those who accessed it on the computer, did not look at or for the warning, and were only focussed on the particular task at hand.[32]

30. In the case of those on watch-house duties, during the short time between moving Ms Lopiccolo to what was intended to be a more comfortable cell at 6.00pm and Sgt Kent's discovery of her body at about 6.37pm, there were a number of other demands on their time, and they were already one member down as the third rostered member for that shift had rung in sick.[33] I am satisfied that LSC Berk would have accessed the LEAP personal history as soon as he was able, in accordance with his general practice, although this may not have changed his management of Ms Lopiccolo, as he was candid enough to concede.[34]

31. Apart from the threshold problem of demeanour dictating whether members would even look for any warnings on the LEAP personal history, there were **two other forces** evident at Inquest could **potentially undermine the value of the LEAP system as an alert mechanism** for custody or welfare issues. One was the suggestion that there were too many warnings causing members to be cynical about their worth, a type of de-sensitisation or **information overload**, common enough in the computer age.[35]

32. The other, the mantra of the investigator's 'intuition or gut' which is more useful than any warning which finds its way onto the LEAP system and could contain old, baseless or unverifiable information. DSgt Chrisant was the leading proponent here.[36] Having read the transcript of his evidence carefully I have to say that I have concerns about his rationale. Conscious of the reasonable scope of this coronial investigation, I would simply comment that it is one thing to assert the value of investigative experience in relation to matters of investigation proper, and quite another to assert the value of an investigator's assessment of suicidality in a previously unknown person. After all how many police members can boast first hand experience of people about to suicide? Any readily available information whether on the LEAP system or otherwise should be welcomed in the interests of the person's welfare and the proper discharge of the custodian's obligations. I would endorse Sgt Kent's attitude in this regard -

"I believe that too many people can have their hands in the pot, and that one person needs to take control and be fully briefed on everything. I also believe that flags should be looked at, and that flags should be taken in, and the information should be taken on board. You don't necessarily use it but a good investigator should look at that material ... a good investigator takes every bit of information that he can on board. He then makes up his own

mind as to what he wants to use then and what he may use later. If he makes a decision not to use some of that information, I believe that other members further along the line are entitled to that information to make up their own mind, not have somebody make up their mind for them..."[37]

33. Acting Superintendent Douglas Witschi gave evidence at Inquest and provided a powerpoint presentation about the project he was currently seconded to "The Thin Blue Line" project which included enhancement to the information available to police members via computer. Those enhancements addressed one of the main concerns arising out of the circumstances surrounding Ms Lopiccolo's death, the failure to 'see' the suicide warning. As I understood his evidence in this regard the situation has improved to the extent that a member is 'forced' to view a warning, at least fixed with constructive knowledge, but may still not heed the substance of the warning.[38]

34. **"Checks" "searches" and the flow of information**

As summarised above Ms Lopiccolo was subjected to a number of checks and searches. The **pantyhose which she ultimately used as a ligature** were **removed** during the full body search conducted by the S.O.C.A.U. members. They mentioned the pantyhose to DSgt Chrisant, not as a potential ligature but in case of any allegation of a sexual assault. He noted the pantyhose on the table with Ms Lopiccolo's keys and hairclip. The information chain was broken when **DSgt Chrisant failed to pass on any information about the pantyhose** to the interviewing members DSC O'Brien and DSC Cosgrove. Nor do they recall seeing the pantyhose, let alone appreciating their ligature potential. In fairness to DSgt Chrisant, the pantyhose and other items were in plain view, and he may have felt their presence was obvious enough, but better practise would have been to ensure the information was passed on to the next police members involved with Ms Lopiccolo.

35. Communication is fatally flawed thereafter. The existence of the pantyhose as a loose item and not simply as an item of clothing being worn, is not drawn to the attention of LSC Berk. The situation is compounded when he is told that Ms Lopiccolo has already been searched by S.O.C.A.U. members, is assured by this fact and decides that a 'visual' search will suffice to fulfil his obligations to search on lodgement.[39]

36. Another flaw in the flow of information is related to the suicide warning on the LEAP personal history. LSC Berk expected to be advised of any suicide warnings or other warnings on the LEAP system, and inferred from what he was told by DSC O'Brien on lodgement that there were no matters of concern arising from the LEAP data, where the reality was the converse.[40]

37. **Was Ms Lopiccolo's death/suicide preventable?**

Based on the experience within this jurisdiction, it is trite that people at large in the community are free to take their own lives at any time and by any number of means. Equally obvious is the obligation police assume for people who are taken into their custody. In investigating Ms Lopiccolo's death on 21 July 2005, I am required to consider the particular circumstances in which she found herself. Circumstances which afforded her not

only the motivation to take her own life, but also the wherewithal. That she might have suicided at some other future time and place is beside the point.

38. It is now known that Ms Lopiccolo had a depressive illness and a number of personal stressors, including problematic usage of illicit substances which brought her into contact with the police and the court system over the last few years of her life. With the benefit of hindsight, it is clear enough that Ms Lopiccolo found the prospect of a period in custody, perhaps a lengthy period, given the nature and number of outstanding charges, intolerable.

39. I find it likely that at some stage after DSgt Chrisant left the interview room, and before DSC O'Brien and DSC Cosgrove saw them (or realised their significance or ligature potential), Ms Lopiccolo took the pantyhose from the table in the interview room and secreted them on her person, possibly by tucking them into her clothing. The pantyhose were secreted well enough that they were not detected by LSC Berk when he searched her 'visually' upon lodgement. Whether or not Ms Lopiccolo had already formed a plan to take her own life when she secreted the pantyhose or at some later time, I cannot ascertain.

40. She must have done so no later than shortly after 6.00pm when she was moved to male cell 1 and told she would be there for about four hours. Video footage from the CCTV camera[41] in her cell shows her last discernible movement under the blanket occurring about seven minutes later, although the discovery of her body is not made for another half hour or so. The same video footage also supports a finding that mindful of the presence of the CCTV camera and the possibility that her movements would be observed, Ms Lopiccolo used the pretence of sleeping to apply the ligature under cover of a blanket and away from the prying eye of the CCTV camera.

41. Also indicative of what Ms Ellis described in her submissions as "the strength of her intent"[43] is the method by which Ms Lopiccolo took her own life. The manner in which she secured the ligature and applied pressure by the use of her feet suggests not only some expert knowledge and forethought, but also resolve and determination to take her life.

42. Regardless of the strength of that resolve, the **ready availability of the pantyhose as a ligature** which was both easily secreted and strong enough to be effective was the **fundamental aspect of the circumstances which facillitated Ms Lopiccolo's suicide** whilst in police custody on 21 July 2005. Had the pantyhose been properly accounted for in the 'handover' from the members of the Criminal Investigations Unit to the uniformed members on watch-house duties, I find it unlikely that Ms Lopiccolo could have taken her own life as easily as she did. If she had to take off her long boots and trousers to remove the pantyhose first, she risked the likelihood of attracting the attention of the watch-house keeper via the CCTV camera, as she was clearly aware.

43. CONCLUSION

Communication, or the flow of information, is a challenge for any organisation. The two most salient features of the circumstances surrounding Ms Lopiccolo's death are the failure to track or account for the pantyhose, and the concommitant failure to access the suicide warning on LEAP. These are both features of dysfunctional communication, and need to be addressed in the interests of improving the safety of those held in police custody.

42. The natural tendency in the police context is to channel all information concerning a person in custody through, and to, the Informant. There is always a risk that the significance of some information may be lost, its relevance not appreciated. For all these realities the aim should be to concentrate as much information as possible in the one repository, in the one mind, so that any assessment of risk is made on as informed a basis as possible.

43. Athough the benefit of hindsight was not available, the cumulative significance of Ms Lopiccolo's intermittent distress, the substance of the suicide warning on her LEAP personal history, the portentious comments made by her during the interview, her knowledge of the likelihood that she was destined for incarceration, and the knowledge that the pantyhose taken from her were unaccounted for, should have been weighed together in the balance. Had these circumstances been so weighed there was at least the potential for different mangement of her in custody, and a different outcome.

44 RECOMMENDATIONS

- That the Chief Commissioner of Police considers establishing a procedure whereby those brought to a police station for questioning and/or in custody are processed through the watch-house upon arrival, and all arrival checks, searches and the like documented there before proceeding to interview.
- In the **alternative**, that the Chief Commissioner considers establishing a procedure whereby any property removed during any search, whether for evidentiary use, or in the interests of the safety of the person or of police members, is receipted on a document which remains with the person through to release from custody or lodgement in the cells.
- That the Chief Commissioner considers further training for members to assist them to recognise suicidal or self-injurious intent, and to identify the ligature or weapons potential of seemingly inocuous items.
- That the Chief Commissioner reinforces the need for better communication, particularly as between the Criminal Investigation Unit and Uniform Branch around the lodgement of prisoners so as to improve the welfare of people in custody.

45. DISTRIBUTION OF FINDING

Apart from the family, the parties and any witness who requests a copy, this finding is to be formally provided to:

Attorney-General
Minister for Police and Emergency Services
Chief Commissioner of Police
O.I.C. Criminal Investigation Unit, Knox
O.I.C. Uniform Branch, Knox
Chair, Victoria Police, Mental Health Expert Advisory Panel

Paresa Antoniadis Spanos
Coroner
20 February 2008

END NOTES

1 Exhibit "C".
2 The allegation that Ms Lo Piccolo and others had broken into her brother's home and "hog-tied" his de facto is at least a curious coincidence in light of the method by which Ms Lo Piccolo used the pantyhose as a ligature on herself.
3 Exhibits "A" and "G" the statements of O'Brien and Brown respectively, and transcript of their evidence at pages 6 and 76 respectively.
4 Exhibits "A" and "G" the statements of O'Brien and Brown respectively.
5 Exhibit "H" the statement of Cosgrove, and transcript page 92.
6 Statement of Morgan, in Exhibit "V" balance of Inquest brief, and Exhibit "C" for relevant computer entry.
7 Exhibits "G" and "H" the statements of Brown and Cosgrove, among others.
8 Exhibits "I" and "J" the statements of Ford and Gale.
9 Ibid.
10 Ibid and Exhibits "G" and "K" the statements of Brown and Chrisant respectively, and the evidence of Ford at transcript page 101 and Gale page 111.
11 Exhibit "K" and Exhibit "C" for the relevant computer entry in Ms Lopiccolo's 'personal history'.
12 Exhibits "A" and "H" the statements of O'Brien and Cosgrove respectively, and transcript of their evidence at pages 8-10, 24-25 (with benefit of hindsight) and 92 respectively.
13 Exhibits "A", "E" the statements of O'Brien and Rowe respectively, Exhibit "M" page 2 (inferentially) the statement of Berk, and transcript pages 14, 49-50 for the evidence of O'Brien and Rowe respectively.
14 Statement of Andreoli, part of Exhibit "V" balance of Inquest Brief.
15 At Knox at this time there were generally three members rostered to work in the watch-house, however one of those rostered on had rung in sick and only LSC Berk and SC Clinton who were rostered on as 'assistant watch-house keepers' reproted for work that shift. (See Exhibit "M" the statement of Berk.) It was common ground that Section Sgt Kent would help out as required. See transcript of Sgt Kent's evidence at page 172 et seq, and LSC Berk's at page 138.
16 Exhibits "M" and "O" statement and notes made by Berk.
17 See Exhibit "N" which shows the general layout of the ground floor of Knox Police Station including the watch-house. The cell designated 'holding cell' is where Ms Lopiccolo was first lodged, and 'male cell 1' is where she was lodged at about 6.00pm.
18 Exhibit "R"
19 Exhibits"M" "R" and "S" statements of Berk, Kent and Clinton respectively. Transcript page 155 regarding LSC Berk's other duties while Ms Lopiccolo was in the watch-house. Transciprt page 173 et seq for Sgt Kent's other duties. Transcipt page 192 for SC Clinton's otehr duties.
20 Exhibits "M" "R" and "S" the statements of Berk, Kent and Clinton respectively, and their evidence at transcript pages
21 See section 3 for the definition of "reportable death" and "person held in care", sections 15 and 17 of the Coroners Act 1985.
22 See section 19(1) of the Act. The date and place of death are effectively the only additional particulars required for registration of the death under the *Births, Death and Marriages Registration Act 1996.*
23 Dr Iles was not required to testify at Inquest. Her 27 page report (incorporating toxoicoloical analysis of postmortem samples) is dated 24 September 2005 and forms part of Exhibit "V" the balance of the Inquest brief.
24 Dr Iles noted within the left elbow crease (left antecubital fossa) "dermal fibrosis associated with occasional foci of refractile foreign material and scattered areas of iron deposition consistent with previous injury at this site and previous attempts at intravascular access." at page 23 of 27.
25 Page 25 of 27.
26 Transcript page 37 (O"Brien), page 59 (Brown), pages 57-58 (Rowe), page 97 (Ford), and pages 116-7, 120, 124 (Chrisant), page 170 (Rottinger), and page 146 (Berk).
27 As evidenced by the submissions of all Counsel, this was ultimately common ground.
28 Again, by the conclsuion of the evidence this was clear.
29 Exhibit "C".
30 See the statement of Sgt Andrew Whitehead at page 186 of the Inquest brief, and the Person Warning Report of 14 August 2004 at page 279 - Exhibit "V" balance of the brief. I note as a matter of interest that when he made his statement in August 2005 Sgt Whitehead was performing duties on the Thin Blue Line Project.
31 The efforts then made by Sgt Whitehead to alert the custody nurse and the consequent impact on how Ms Lopiccolo's welfare issues were addressed while she was in custody on that occasion stand in contrast to events on the day that she died, although in fairness she did not tell police that she was feeling 'suicidal' on 21 July 2005. See for example the statement of Dr Foti Blaher at page 183, Damien Morgan page 178.
32 Transcript page 6 (O'Brien), pages 46-49 (Rowe), pages 66-89 (Brown), page 92 (Cosgrove), page 96 (Ford), page 109 (Gale), page 114 et seq (Chrisant).

33 See note 15 above.
34 Transcript pages 144-146.
36 Transcript 116,118, 124 et seq
37 Transcript of his evidence at page 187.
38 Exhibits "T" and "U" and transcript pages 202 et seq. See also transcript of Sgt Kent's evidence at page 188.
39 Transcript page 141 et seq.
40 Transcript page 141 et seq.
41 The video footage was part of Exhibit "V" the balance of the brief.
42 Transcript of Ms Ellis' submissions page 248 et seq.