IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 0279

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**IAIN WEST, ACTING STATE CORONER**
Deceased:	**GORDON HARVEY**
Date of birth:	1 July 1953
Date of death:	Between 17 January 2016 and 19 January 2016
Cause of death:	Blunt force trauma to the head
Place of death:	425 Brunswick Street, Fitzroy, Victoria

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HIS HONOUR:

BACKGROUND

1. Gordon Harvey (**Mr Harvey**) was a 62-year-old man who lived in Fitzroy at the time of his death. Mr Harvey was the youngest son of three children born to May and Peter Harvey.

2. Mr Harvey studied at Norwood Secondary College and continued his studies at university, completing a Bachelor of Arts, Graduate Diploma in Computer Studies and a Master of Education. Mr Harvey was primarily employed as a teacher and assistant principal at several high schools in Victoria.[1]

3. In 1983 Mr Harvey and his friend Craig Baker (**Mr Baker**) opened a clothing and accessories store called 'Fetish'. This store largely sold art, clothing and jewellery. In early 1984 Mr Harvey returned to his teaching career. Mr Harvey met his wife, Daiva Verbyla (**Ms Verbyla**) in 1984 and they married in 1986. Mr Harvey and Ms Verbyla had two children, Peter and Adam Harvey.[2]

4. Mr Harvey retired from teaching in July 2012 and returned to working at the 'Fetish' clothing store at this time. Mr Harvey spent most of his time working at the 'Fetish' clothing store as his business partner and friend, Mr Baker, became terminally ill with liver cancer. Mr Baker ultimately passed away in April 2014 and Mr Harvey began to reside full time at the store until the fatal incident.

5. Mr Harvey and Suleyman Kepenci, also known as Simon Kepenci (**Mr Kepenci**), met on an internet dating website in late 2014 and they commenced a casual intimate personal relationship from this time until a family violence incident between the two in May 2015.[3]

6. On 11 May 2015 Mr Harvey and Mr Kepenci had dinner at Mr Kepenci's home. Mr Harvey fell asleep and awoke early the next morning to discover that his wallet, car keys and car were missing. He confronted Mr Kepenci and accused him of stealing them, and a physical altercation took place.[4] On the available evidence it is not clear who instigated the physical

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[1] *Coronial Brief,* Statement of Daiva Verbyla dated 26 January 2016, 91
[2] *Coronial Brief,* Statement of Daiva Verbyla dated 19 January 2016, 87
[3] *Coronial Brief,* Appendix Q, Transcript of interview - Suleyman Kepenci on 21 January 2016, 637
[4] *Coronial Brief,* Statement of Daiva Verbyla dated 19 January 2016, 91-95

altercation but material in the coronial brief suggests that Mr Kepenci physically assaulted Mr Harvey on this occasion.[5]

7. On 12 May 2015, after Mr Harvey left Mr Kepenci's property in the late morning, Mr Kepenci refused to let him back in to retrieve his property. Mr Harvey contacted his wife, Daiva Verbyla, for assistance, as well as the Police. Ms Verbyla and their son, Adam Harvey, arrived at Mr Kepenci's residence shortly afterwards.[6]

8. Mr Harvey told Ms Verbyla that Mr Kepenci had assaulted him, and she noticed that he had "*red grazing and bruising across the front of his face.*"[7] Mr Harvey told Ms Verbyla that he believed Mr Kepenci had put something in his drink at dinner the night before which made him sleep. Evidence in the coronial brief is not clear as to whether Mr Harvey was in fact drugged. However, the attending police officers who interviewed Mr Harvey noted that he appeared to be intoxicated or possibly drug affected.[8]

9. Mr Harvey stated that he had been assaulted when he initially contacted the police but when they arrived at the incident he stated that he just wanted to have his property returned.[9] As Mr Harvey had only identified Mr Kepenci as a friend, without disclosing their sexual relationship, the matter was not treated as a family violence incident by the police. Mr Kepenci did not answer the door to either Mr Harvey or the Police.[10]

10. In the days following the incident, Mr Kepenci sent several abusive and threatening text messages to Mr Harvey, telling him he was lucky he was able to walk out of his "*place alive unharmed*" and making numerous verbal threats.[11] In these messages Mr Kepenci repeatedly threatened to assault or kill Mr Harvey and made derogatory and abusive comments to him.[12]

11. The sexual relationship between Mr Harvey and Mr Kepenci stopped for several months following the incident in May 2015. However, the relationship resumed in mid to late 2015. Evidence from the coronial brief shows text messages exchanged between the two parties

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[5] *Coronial Brief,* Statement of Daiva Verbyla dated 19 January 2016, 94-95, 99
[6] *Coronial Brief,* Statement of Daiva Verbyla dated 19 January 2016, 88; Statement of Adam Harvey dated 19 January 2016, 102.
[7] *Coronial Brief,* Statement of Daiva Verbyla dated 19 January 2016, 95.
[8] Email from Senior Constable Kylie Bevan to Detective Sergeant Stephen Sheahan dated 30 December 2017.
[9] Email from Senior Constable Kylie Bevan to Detective Sergeant Stephen Sheahan dated 30 December 2017.
[10] Victoria Police LEAP records of 12 May 2015 reported incident
[11] *Coronial Brief,* Appendix E, 442.
[12] *Coronial Brief,* Appendix E, 442.

evidencing plans to see each other for sexual encounters on several occasions between October 2015 and January 2016.

THE PURPOSE OF A CORONIAL INVESTIGATION

12. Mr Harvey's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and resulted directly from injury and was unexpected, violent, and not from natural causes.[13]

13. The jurisdiction of the Coroners Court of Victoria (**CCOV**) is inquisitorial.[14] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[15]

14. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[16] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

15. The expression '*cause of death*' refers to the medical cause of death, incorporating where possible, the mechanism of death.

16. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all of the circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate to be considered relevant to the death.

17. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the '*prevention*' role.

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[13] Section 4 *Coroners Act 2008*.

[14] Section 89(4) *Coroners Act 2008*.

[15] See Preamble and s 67, *Coroners Act 2008*.

[16] *Keown v Khan* (1999) 1 VR 69.

18. Coroners are also empowered:

(a) to report to the Attorney-General on a death;

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

19. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[17] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

20. In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

MATTERS IN RELATION TO WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

21. On 21 January 2016, Mr Harvey's body was identified through dental record comparisons performed by Dr Jeremy Graham, a specialist forensic odonatologist practising at the Victorian Institute of Forensic Medicine.

22. Identity is not in dispute and requires no further investigation.

Medical cause of death, pursuant to section 67(1)(b) of the Act

23. On 19 January 2016, Dr Malcolm Dodd, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination of Mr Harvey's body and provided

[17] (1938) 60 CLR 336.

a written report, dated 24 March 2016. In that report, Dr Dodd concluded that a reasonable cause of death was '*blunt force trauma to the head*'.

24. Dr Dodd commented that external examination of the body disclosed a multiplicity of blunt force trauma to the head region and no evidence of defense type injuries.

25. Toxicological analysis of post mortem specimens taken from Mr Harvey identified the presence of mirtazapine[18] (0.3 mg/L), quetiapine[19] (0.9 mg/L), zolpidem[20] (0.02 mg/L), methylamphetamine (0.1 mg/L), morphine (0.03 mg/L) and cannabis (48 ng/mL).

26. I accept the cause of death proposed by Dr Dodd.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

27. On 17 January 2016, Mr Kepenci and Mr Harvey made plans to meet at Mr Harvey's shop, 'Fetish' in Fitzroy. According to CCTV footage at a neighbouring property to Mr Harvey's shop, Mr Kepenci was seen arriving at 9.04pm with Mr Harvey greeting him at the entrance.[21]

28. At some time between Mr Kepenci's arrival and the early hours of the morning on 19 January 2016, Mr Kepenci fatally assaulted Mr Harvey by striking him in the head repeatedly with a hammer. Mr Kepenci was seen exiting Mr Harvey's shop on 18 January 2016 at approximately 10.03am.

29. Mr Kepenci later returned to Mr Harvey's shop around 1.12am on 19 January 2016, stole several items from the shop, before setting fire to the premises and exiting the premises at 3.41am.[22] Emergency services were contacted at 3.45am and arrived at approximately 3.54am.

30. After the fire was extinguished, Victoria Police officers and Metropolitan Fire Brigade investigators conducted an investigation of the premises to find the cause of the fire. They discovered that the fire appeared to have been lit in the south-west corner of the rear room of the premises and this was where Mr Harvey's body was discovered.

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[18] Mirtazapine is used in the treatment of depression, therapeutic concentration levels in blood are between 0,02-0.10 mg/L

[19] Quetiapine is an antipsychotic drug used in the treatment of schizophrenia, therapeutic concentration levels in blood are between 0.1-0.4 mg/L

[20] Zolpidem is a hypnotic agent, therapeutic concentration levels in blood are up to 0.3 mg/L

[21] *Coronial Brief,* CCTV footage from 427 Brunswick St, Fitzroy

[22] *Coronial Brief,* CCTV footage from 427 Brunswick St, Fitzroy

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

Family violence

31. For the purposes of the *Family Violence Protection Act 2008*, the intimate personal relationship between Mr Harvey and Mr Kepenci was one that fell within the definition of 'family member'. Moreover, the actions of Mr Kepenci causing Mr Harvey's death constituted 'family violence' as there was a history of verbal and emotional abuse which culminated in physical violence resulting in Mr Harvey's death.

32. As a result, I requested that the Coroners Prevention Unit (**CPU**)[23] examine the circumstances surrounding Mr Harvey's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[24]

33. The *Family Violence Risk Assessment and Risk Management Framework* known as the *Common Risk Assessment Framework* (**CRAF**)[25] details several evidence-based risk factors which have been found to impact on the likelihood and severity of family violence. These risk factors are divided into three categories: those which relate to the victim of family violence, those which relate to the perpetrator, and those which relate to the relationship. The CRAF also identifies several additional factors which can impact on the options and outcomes available to family violence victims.[26]

34. It should be noted, however, that the CRAF was primarily developed to assess for risk within heterosexual intimate partner relationships.[27] As a result, it may not adequately identify the risk posed to those who experience family violence outside of heterosexual intimate partner relationships.[28] This has been acknowledged by the Royal Commission into Family Violence (**the Royal Commission**) which specifically recommended that a revised CRAF be developed

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[23] The Coroners Prevention Unit is a specialist service for coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

[24] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focussed recommendations aimed at reducing the incidence of family violence in the Victorian community.

[25] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition

[26] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition, 30.

[27] Jude McCulloch et al, 'Review of the Family Violence Risk Assessment and Risk Management Framework (CRAF)' (2016) *Monash University*, 11

[28] Jude McCulloch et al, 'Review of the Family Violence Risk Assessment and Risk Management Framework (CRAF)' (2016) *Monash University*, 11

which reflects "*the needs of the diverse range of family violence victims and perpetrators*", including those within lesbian, gay, bisexual, transgender and intersex (**LGBTI**) communities.[29]

35. Mr Harvey had two victim specific risk factors which indicate that he had a heightened level of vulnerability to family violence. He appeared to be a regular user of illicit substances, particularly marijuana,[30] and may have suffered from mental health conditions.

36. Toxicology tests indicated the presence of several drugs in Mr Harvey's system at the time of his death, including Mirtazapine, Quetiapine and Zolpidem, as well as Methylamphetamine, Cannabis and Morphine.[31] On the available evidence, there is no indication whether the first three therapeutic drugs were prescribed, however the toxicology report indicated that the levels in Mr Harvey's system were within usual therapeutic levels of use. As Mirtazapine is '*indicated for the treatment of depression*'[32] and Quetiapine is '*an antipsychotic drug used in the treatment of schizophrenia*'[33] it is possible that Mr Harvey suffered from mental health conditions. There is no further information in the coronial brief indicating that Mr Harvey had a mental health history, whether these medications were prescribed to him, and for what purpose. It is therefore unclear whether Mr Harvey suffered from depression or schizophrenia or was taking these medications for other medical or recreational purposes.

37. Mr Kepenci had a number of perpetrator specific risk factors which indicate that Mr Harvey was at a heightened risk of future and more severe family violence.[34] In particular, Mr Kepenci was a regular user of illicit substances and, at the time of the offence, was taking Methylamphetamine regularly.[35] Mr Kepenci also suffered from mental health issues,[36] had previously attempted to commit suicide, and exhibited suicidal ideation around the time of the fatal incident.[37] Mr Kepenci also had a history of violent behaviour[38] and of abusing and

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[29] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 1, 138.
[30] *Coronial Brief,* Statement of Kylie Hartstang dated 3 February 2016, 116; Statement of Grant McCracken dated 20 January 2016, 136; Statement of Steven La dated 19 January 2016, 161
[31] *Coronial Brief,* VIFM Toxicology Report dated 15 March 2016, 5
[32] *Coronial Brief,* VIFM Toxicology Report dated 15 March 2016
[33] *Coronial Brief,* VIFM Toxicology Report dated 15 March 2016
[34] Department of Health and Human Services, above n 25, 27.
[35] *R v Kepenci* [2016] VSC 817, 6; Coronial Brief, Statement of S Kepenci, 124.
[36] *R v Kepenci* [2016] VSC 817, 6; Coronial Brief, Statement of S Kepenci, 130.
[37] *R v Kepenci* [2016] VSC 817, 5-7; Coronial Brief, Statement of S Kepenci, 125, 130; Statement provided by Caraniche, dated 26 June 2017; Corrections Victoria records in relation to Suleyman Kepenci.
[38] Coronial Brief, Statement of S Kepenci, 125-127.

killing animals,[39] and had made several threats to kill Mr Harvey eight months prior to the fatal incident.[40] Mr Kepenci was also unemployed at the time he committed the fatal assault.

38. Of the above risk factors which applied to Mr Kepenci, the threats to kill Mr Harvey, the prior harm to animals, the suicide attempts and ideation, the drug abuse, and his unemployment are also risk factors that can indicate an increased risk of a victim being killed.[41]

39. Both Mr Harvey and Mr Kepenci engaged in relationships with both male and female partners, and their relationship with each other was a same-gender relationship. Whilst the CRAF does not identify risk factors specific to LGBTI relationships, it does outline additional factors which can make people in LGBTI relationships more vulnerable to family violence.[42]

40. Such factors were also identified by the Royal Commission, which noted that "*people from LGBTI communities are less likely to report violence, to seek support or to identify experiences of family violence and abuse, partly because of a fear of 'outing', as well as actual or perceived discrimination and harassment.*"[43] The Royal Commission also noted that "*LGBTI people face particular difficulties in reporting family violence to police and in accessing support services.*"[44]

41. It is unclear in this case whether Mr Harvey considered himself to be a victim of family violence. The fact that he contacted the police immediately after the initial incident of violence in May 2015 suggests that he did not suffer from a reluctance to seek assistance from the Police. This conflicts, however, with the fact that when police did attend, he did not provide details regarding the assault or the nature of his relationship with Mr Kepenci to them.

42. The Royal Commission noted that "*experiences of intimate partner violence within LGBTI communities can also be different to the experiences of heterosexual people.*"[45] Such violence might include threats to 'out' a person and the use of homophobia as a tool of control.[46] In this case, Mr Kepenci admitted to having significant anxiety around engaging in same-gender

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[39] Coronial Brief, Statement of S Kepenci, 125-127; Appendix R, 782.
[40] Coronial Brief, Appendix E, 442.
[41] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition, 27.
[42] Department of Health and Human Services, *Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3* (2012), 2nd Edition, 39.
[43] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 5, 145.
[44] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 5, 148.
[45] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 5, 144.
[46] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 5, 145.

sexual relationships and said he found Mr Harvey's openness about it stressful, as he did not want people to know that he engaged in such relationships.[47]

43. The understanding of family violence as a relationship of coercion, domination and control arises from a traditional notion of family violence which is largely based on understandings of violence between heterosexual intimate partners. I note that research into the forms of family violence that occur outside of the intimate heterosexual relationship is underdeveloped and thus an understanding of the unique causes, dynamics and consequences of these experiences of family violence is less known.[48]

44. The Centre for Forensic Behavioural Science and Forensicare suggest that individual psychosocial factors, such as mental health and substance misuse, can assist in accounting for the presence of family violence in non-heterosexual intimate partner violence where the impact of gender stereotypes is absent.[49] As noted above, such factors were present in this case. However, there are no current risk assessment tools designed specifically for LGBTI intimate partner violence, and more research needs to be conducted in this area.

45. I confirm that the CRAF has recently been replaced by the *Family Violence Multi-Agency Risk Assessment and Management Framework* (**MARAM**).[50] The aim of the MARAM framework is to increase the safety and wellbeing of Victorians by ensuring all relevant services are contributing effectively to the identification, assessment and management of family violence risk. To achieve this, the MARAM has been established in law under the *Family Violence Protection Act 2008* (Vic). This requires organisations that are prescribed through regulations, as well as organisations providing funded services relevant to family violence risk assessment and management, to align their policies, procedures and practice guidance to the new MARAM framework. The new MARAM framework will provide workers with an understanding of how LGBTI people experience family violence, how that should inform relevant safety planning, and how to provide safe and inclusive services.

46. The Royal Commission made several recommendations emphasing the vulnerability of same sex couples and inadequacy of services and supports available to them. The Royal Commission's recommendations 166-168 relate to research, funding and evaluation of services available to the LGBTI community and of responses to same sex family violence in

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[47] *Coronial Brief*, Appendix Q, 647-657
[48] State of Victoria, *Royal Commission into Family Violence: Report and Recommendations*, Volume V, Chapter 30, 1
[49] State of Victoria, Royal Commission into Family Violence, *Final Report* (2016) vol 3, 257.
[50] Family Safety Victoria, *Family Violence Multi-Agency Risk Assessment and Management Framework* (2018).

Victoria. Recommendation 169 relates to the Victorian Government's commitment to remove any capacity for accommodating same sex family violence or for service providers to discriminate against LGBTI Victorians.

47. I support the Royal Commission's recommendations regarding LGBTI family violence and support services for vulnerable LGBTI Victorians.

Corrections Victoria

48. Material provided to the Court by Corrections Victoria states that Mr Kepenci was subject to a Community Corrections Order[51] (**CCO**) from 6 March 2015 to 5 March 2016, which was managed by Carlton Community Correctional Services (**Carlton CCS**). Mr Kepenci had also been subject to several previous CCO's of which only one had been successfully complied with.

49. The most recent CCO had been ordered following an incident where Mr Kepenci had driven dangerously, causing him to hit a fire hydrant and, shortly afterwards, a parked car. Mr Kepenci attempted to drive away from this collision before his car stopped working approximately 100 metres away. When approached by bystanders Mr Kepenci became aggressive and yelled that "*he wanted to die and wanted to kill himself*."[52] He struck the front windscreen of his vehicle several times, causing it to crack. When police attended they noticed that Mr Kepenci had a knife, which he was stabbing into the centre of the steering wheel. Mr Kepenci failed to drop the knife when requested to do so by the police and was ultimately subdued using non-lethal force by the Police. As a result of this incident Mr Kepenci was charged with numerous driving and weapon offences.

50. Under the conditions of the CCO, Mr Kepenci was required to undergo supervision, assessment and treatment (including testing) for drug and alcohol abuse or dependency, mental health, offending behaviour programs and a Road Trauma Awareness program.[53] Mr Kepenci did not comply with these conditions. He failed to complete his treatment with a drug and alcohol treatment provider, stated he would not complete the Road Trauma Awareness program and did not complete an offending behaviour program.

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[51] A Community Corrections Order (CCO) is an intermediate sentencing option between a fine and imprisonment. It provides a community-based sentence for a wide range of offending while addressing the circumstances of the offender (section 36 of the *Sentencing Act 1991*)

[52] Corrections Victoria records for Suleyman Kepenci.

[53] Statement provided by Corrections Victoria, dated 11 Jan 2018

51. Case notes provided by Corrections Victoria indicate that the management of Mr Kepenci by Carlton CCS was not in accordance with their policies and procedures. An internal audit of Mr Kepenci's file on 23 December 2015 noted several significant deficiencies in how the file had been managed. Identified failings included a:

(a) Failure to follow up a report received from Caraniche on 22 May 2015, regarding the suicidal ideation of Mr Kepenci, at Mr Kepenci's next attendance on 29 May 2015;

(b) Failure to discuss Mr Kepenci reengaging with drug and alcohol treatment following the cessation of such treatment in July 2015 and Mr Kepenci's admission of ongoing drug use;

(c) Failure to take action in relation to disclosures by Mr Kepenci on 16 July 2015 that he was driving an unregistered vehicle without a license or discuss the illegality of these actions with Mr Kepenci;

(d) Failure to contact Victoria Police to conduct a welfare check following Mr Kepenci presenting to Carlton CCS with suicidal ideation on 25 November 2015;

(e) Failure to complete a Manager's Review form to 'highlight concerns with Mr Kepenci from the onset of his order and to determine appropriate non-compliance actions, which would be considered by the Operations Manager.'[54]

52. Despite the internal review requiring immediate action to be undertaken to address Mr Kepenci's contravention of the CCO, no action was undertaken and contravention proceedings were not commenced until well after the fatal incident in January 2016.

53. Based on the materials provided, Corrections Victoria appear to have processes and procedures for the management of their clients, and a file audit and review process to ensure compliance with those processes. However, although the file review measures were applied by Carlton CCS in this case, this ultimately did not lead to the failings being addressed.

54. Corrections Victoria have since provided a further statement to the Court indicating that case management and oversight of Mr Kepenci was likely due to high caseloads of staff not only at Carlton CCS but other CCS locations. Since the death of Mr Harvey, Community

[54] Statement provided by Corrections Victoria, dated 11 January 2018

Correctional Services have undergone a state-wide service reform, through an *Expansion and Reform Program* introduced in January 2017.[55]

55. I note that Corrections Victoria have acknowledged delays in finalising contravention proceedings and the key contributors to this have been resources pressures combined with offenders requiring adjournments to access legal advice.[56] The likelihood that Mr Kepenci would have been remand in custody pending completion of CCO contravention proceedings is unclear in the circumstances of this case.

56. I confirm however that Corrections Victoria in conjunction with a metropolitan Magistrates' Court are currently exploring the fast tracking of contravention matters to reduce the delays and risk of offenders committing further offences while awaiting the determination of the court.[57]

57. On 19 December 2016, in the Supreme Court of Victoria, Mr Kepenci was convicted of murder. He was sentenced to 15 years' imprisonment with a non-parole period of 10 years.[58]

58. I am satisfied, having considered all the available evidence, that no further investigation is required.

FINDINGS AND CONCLUSION

59. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) *Coroners Act 2008*:

    (a) the identity of the deceased was Gordon Harvey, born 5 September 1968;

    (b) the death occurred between 17 January 2016 and 19 January 2016 at 425 Brunswick Street, Fitzroy, Victoria, from blunt force trauma to the head; and

    (c) the death occurred in the circumstances described above.

60. I convey my sincerest sympathy to Mr Harvey's family.

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[55] Statement provided by Corrections Victoria dated 18 January 2019,1
[56] Statement provided by Corrections Victoria dated 18 January 2019, 5
[57] Statement provided by Corrections Victoria dated 18 January 2019, 5
[58] *The Queen v Simon Kepenci* [2016] VSC 817, 10.

61. Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

    (a) Daiva Verbyla, Senior next of kin.

    (b) Detective Senior Constable Simon Quinnell, Victoria Police, Coroner's Investigator.

Signature:

IAIN WEST

ACTING STATE CORONER

Date: 13 February 2019