IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 5903

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**Coroner Darren J. Bracken**
Deceased:	**Rachel Naomi Mihail**
Date of birth:	20 July 1981
Date of death:	22 November 2017
Cause of death:	Nicotine toxicity
Place of death:	195 King Street, Bendigo, Victoria

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HIS HONOUR:

BACKGROUND

1. On 22 November 2017, Ms Mihail was 36 years old when she ingested a fatal quantity of nicotine at her home. Police and paramedics attended Ms Mihail's home sometime after she had ingested the nicotine but were unable to stop its effect. Ms Mihail lived alone in Bendigo; she was estranged from her family, including her parents James Mihail and Lynette Mihail and her twin sister Sarah Mihail.

2. Ms Mihail had a medical history of anxiety, post-traumatic stress disorder (**PTSD**) agoraphobia, borderline personality disorder and depression with active suicidal ideation.[1] She alleged that she had been raped when she was about 14 years old but no criminal prosecution ensued.[2] Ms Mihail was prescribed antidepressant Citalopram for depression and prazosin for treatment of sleep disturbance and nightmares associated with her PTSD.[3] She had previously taken an overdose of medication when she was 16 years old.[4] She was admitted to hospital in 1995 and 2015 with chronic thoughts of self-harm.[5]

THE CORONIAL INVESTIGATION

Coroners Act 2008

3. Ms Mihail's death constituted a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (the **Act**) as her death occurred in Victoria, was unexpected and was not from natural causes.[6]

4. The Act requires a Coroner to investigate reportable deaths such as Ms Mihail's and, if possible, to find:

   (a) The identity of the deceased;

   (b) The cause of death; and

   (c) The circumstances in which death occurred.[7]

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1 Statement of Dr John Togno undated, p. 22; Statement of Sian Naeck dated 11 March 2018, p 31; Statement of Dr Teslin Mathew dated 20 February 2018, p. 27.
2 Statement of Lynette Mihail dated 15 January 2018, p. 12.
3 Statement of Dr John Togno undated, p. 22.
4 Statement of Lynette Mihail dated 15 January 2018, p. 12.
5 Statement of Dr Teslin Matthew dated 20 February 2018, p 27.
6 Coroners Act 2008 (Vic) s 4.
7 *Coroners Act 2008* (Vic) preamble and s 67.

5. For coronial purposes, "*circumstances in which death occurred*"[8] refers to the context and background to the death including the surrounding circumstances, rather than being a consideration of all circumstances which might form part of a narrative which culminated in the death. Required findings in relation to circumstances are limited to those circumstances which are sufficiently proximate to be considered relevant to the death.

6. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[9] It is not the Coroner's role to determine criminal or civil liability,[10] nor to determine disciplinary matters.

7. One of the broader purposes 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 making recommendations.

8. Coroners are also empowered to:

   (a) Report to the Attorney-General on a death;[11]

   (b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[12] and

   (c) 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.[13]

Standard of Proof

9. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[14] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[15] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of

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[8] *Coroners Act 2008* (Vic) s 67(1)(c).
[9] *Keown v Khan* [1999] 1 VR 69.
[10] *Coroners Act 2008* (Vic) s 69 (1).
[11] *Coroners Act 2008* (Vic) s 72(1).
[12] *Coroners Act 2008* (Vic) s 67(3).
[13] *Coroners Act 2008* (Vic) s 72(2).
[14] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[15] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

proof; there is no such thing as a "Briginshaw Standard" or "Briginshaw Test" and use of such terms may mislead.[16]

10. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the finding to be based on those facts.[17] Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[18] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[19]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

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

11. On 24 November 2017, Dr Lyndall Smythe, a Forensic Odontologist practising at the Victorian Institute of Forensic Medicine conducted a comparison between the deceased and antemortem dental records of Ms Mihail. Dr Smythe formed the opinion that the deceased was Rachel Naomi Mihail, born 20 July 1981, based on visual recognition, circumstantial evidence and dental record comparison.

12. I am satisfied that the deceased is Rachel Naomi Mihail, born 20 July 1981.

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

13. On 24 November 2017, Dr Pradeep Bandara, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Ms Mihail's body. Dr Bandara provided a written report, dated 23 January 2018, in which he opined that Ms Mihail died from *"nicotine toxicity"*.

14. Toxicological analysis of post mortem samples taken from Ms Mihail identified the presence of nicotine at a fatal concentration of approximately 44 mg/L. Diazepam, nordiazepam and quetiapine were also identified at levels consistent with therapeutic use.

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16 *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].

17 Anderson v Blashki [1993] 2 VR 89, following Briginshaw v Briginshaw (1938) 60 CLR 336, referring to Barten v Williams (1978) 20 ACTR 10; Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd [1979] VR 129; Mahon v Air New Zealand Ltd [1984] AC 808 and Annetts v McCann (1990) 170 CLR 596.

18 *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.

19 Briginshaw v Briginshaw (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd [1979] VR 129, at p. 147; Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

15. Dr Bandara commented that nicotine is an agonist on the nicotinic acetylcholine receptor of the central and autonomic nervous systems, as well as at the neuromuscular junction. At low doses, nicotine is a stimulant to these receptors. The initial stimulation phase may be followed by a depressive phase which may include symptoms of hypotension and bradycardia, central nervous system depression, coma, muscular weakness and/or paralysis, with difficulty breathing or respiratory failure. Higher doses or more sustained exposure can cause inhibitory effects leading to neuromuscular blockade.

16. I accept Dr Bandara's opinion.

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

17. On 16 October 2017, Ms Mihail attended a medical appointment with her General Practitioner Dr John Togno. She stated that she had stopped taking her antidepressant medication some two months prior because she believed it was causing heavy menstrual periods. Dr Togno noted that Ms Mihail appeared dishevelled, avoided eye contact, had a much flatter affect and was more aggressive in response to his questions than usual. She expressed active suicidal ideation but denied having made any plans. After a brief discussion, she terminated the consultation and left the clinic.[20]

18. On 20 October 2017, Ms Mihail attended the Psychiatric Triage section of the Bendigo Hospital Emergency Department. She expressed severe anxiety and reported that she had been unable to leave her home for several months except at night. She described her sleep as poor and being preoccupied with suicidal thoughts but, according to hospital records, had no plan or intent.[21] She said that she had recently abruptly stopped taking her antidepressant medication without tapering the dose. She reported that she did not use illicit substances or alcohol and had replaced cigarettes with e-cigarettes over twelve months prior. She was diagnosed with agoraphobia and severe panic disorder and was admitted as a voluntary patient to the Adult Acute Unit of Bendigo Health.[22]

19. On 21 October 2017, Ms Mihail was reviewed by the on-call consultant psychiatrist, Dr Teslin Mathew, at Bendigo Health.[23] He noted Ms Mihail was anxious and fidgety, dismissive, irritable and had fleeting self-harm thoughts with no plans. Ms Mihail was reluctant to disclose details of her past trauma, personal or family history. Dr Mathew noted

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[20] Statement of Dr John Togno, undated, p 22.
[21] Statement of Dr Elaine Kermode dated 30 January 2018, p. 24.
[22] Statement of Dr Elaine Kermode dated 30 January 2018, p. 24.
[23] Statement of Dr Teslin Mathew dated 20 February 2018, p. 27.

that Ms Mihail was preoccupied with obtaining 21mg of prazosin[24] and her escalating anxiety dealing with co-patients. He diagnosed Ms Mihail with social anxiety disorder with post-traumatic stress disorder and noted a differential diagnosis of factitious disorder[25] and borderline personality disorder. Dr Mathew prescribed quetiapine, desvenlafaxine and prazosin.[26]

20. On 22 October 2017, Ms Mihail elected to leave the hospital saying that she *'felt uncomfortable in hospital'*.[27] She was referred to the Short-Term Treatment Team for ongoing support.[28] Ms Mihail's treatment plan included regular contact via home visits from clinicians several times a week and referral to a psychologist for specific treatment for agoraphobia and severe panic disorder.

21. On 26 October 2017, Ms Mihail underwent a medical review with the Short-Term Treatment Team, at which time her antidepressant medication, desvenlafaxine was increased to 100mg. During subsequent regular home visits clinicians monitored Ms Mihail's mental status, together with her risk for suicidal plans and intent. It was noted that Ms Mihail responded slowly to the intervention and kept a journal of the gradual improvement in her activities. Given the support she was then receiving Ms Mihail expressed hope for the future. She agreed to see a psychologist specialising in agoraphobia and her General Practitioner with a view to them constructing a Mental Health Care Plan. She also agreed to attend a psychologist on 30 November 2017, with transport to be provided by Bendigo Health clinicians.[29]

22. On 13 November 2017, Ms Mihail attended a medical appointment with her General Practitioner, Dr John Togno, to complete the mental health care plan. On examination, Dr Togno found evidence of significant depression and anxiety using the Hospital Anxiety and Depression Scale. Ms Mihail reported that she remained socially isolated. Dr Togno noted only minimal evidence of suicidal ideation at the time of the consultation.[30]

23. On 15 November 2017, Ms Mihail's case was closed with the Short-Term Treatment Team in view of her improvement and positive plans for the future.[31]

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[24] Prazosin is a medication used to treat posttraumatic stress disorder.
[25] Factitious disorder is a mental disorder in which a person acts as if he or she has a physical or mental illness when, in fact, he or she has consciously created the symptoms.
[26] Statement of Dr Teslin Matthew dated 20 February 2018, p. 28
[27] Statement of Dr Elaine Kermode dated 30 January 2018, p. 25.
[28] Statement of Dr Elaine Kermode dated 30 January 2018, p. 25.
[29] Statement of Dr Elaine Kermode dated 30 January 2018, p. 25.
[30] Statement of Dr John Togno, undated, p 22.
[31] Statement of Dr Elaine Kermode dated 30 January 2018, p. 25.

24. At approximately 1.10am on 22 November 2017, Ms Mihail telephoned the Bendigo Health Psychiatric Services triage telephone number and spoke with mental health clinician Rachel Finch for approximately nine minutes.[32] According to Ms Finch, Ms Mihail told her that she wished to cancel her upcoming psychology appointment. She stated that she was very thankful for the care provided by clinicians from the Short-Term Treatment Team but reflected negatively on her time as an inpatient and the reduction in her dose of prazosin. Ms Mihail indicated that she could not "*fathom*" returning to the Emergency Department for treatment. Ms Mihail disclosed that she had researched suicide and planned to overdose on liquid nicotine and then hung-up the telephone.[33]

25. At approximately 1.20am, Ms Finch contacted emergency services to request a police *'welfare check'* on Ms Mihail at her home address. Ms Finch told the call operator that Ms Mihail had been diagnosed with anxiety, PTSD and agoraphobia and that she was taking an overdose of nicotine. Ms Finch told the call operator that Ms Mihail had not taken the overdose at the time of her call.[34] Ms Finch reported that she believed that a police welfare check was sufficient in the circumstances because, on the basis of what Ms Mihail had told her on the telephone, she did not believe that Ms Mihail had, at that time, taken the nicotine.[35]

26. Ms Finch states that she attempted to call Ms Mihail back numerous times after her call to emergency services but was unable to make contact as Ms Mihail's phone line was continuously engaged.[36] Ms Finch explained that it was not unusual for Ms Mihail's phone to be engaged as she did not like receiving calls.[37]

27. At approximately 1.23am, Senior Constable (SC) Mark Smeaton and Constable Mark Squire (as he then was) were tasked with conducting the police welfare check.[38] They were parked at the intersection of McIvor Road and Powells Avenue in Strathdale, approximately 5.4 kilometres which at that time of the night was a very slow ten minute drive to Ms Mihail's home.[39] Constable Squire's telephone records indicate that at this time, he was on the telephone. In his most recent statement he explains that he was then speaking to a complainant in relation to an earlier job.[40] There is inconsistency between the statements provided by SC Smeaton and Constable Squire as to which police officer was on the phone to

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32 Phone records of triage no 1300 363 788 dated 22 November 2017.
33 Statement of Rachel Finch dated 7 February 2018, p 29-30.
34 Event Chronology P1711166139; Audio recording of call made to emergency services by Rachel Finch; Statement of Rachel Finch dated 19 July 2018.
35 Statement of Rachel Finch dated 19 July 2018.
36 Statement of Rachel Finch dated 7 February 2018, p 30.
37 Statement of Rachel Finch dated 19 July 2018.
38 Electronic Patrol Duty Return Form WBI 311 dated 22 November 2017; Victoria Police audio recording of radio communication to Bendigo Police Unit 311 dated 22 November 2017; Statement of Sergeant Ian Randall dated 22 August 2018.
39 Statement of Senior Constable Mark Smeaton dated 19 July 2018; Statement of Senior Constable Mark Squire dated 13 July 2018.
40 Phone records of Senior Constable Mark Squire on 22 November 2017.

the complainant at the time the welfare check was dispatched.[41] However, given the phone records of Constable Squire, I am satisfied that either SC Smeaton or Constable Squire was on Constable Squire's telephone at about 1.23am.

28. At approximately 1.28am, SC Smeaton telephoned Ms Finch to clarify the information provided to emergency services and ascertain the urgency of the welfare check and spoke to Ms Finch for approximately four minutes.[42] Ms Finch told SC Smeaton that she didn't know if Ms Mihail had actually taken the nicotine but that Ms Mihail had told her of a plan to take it with the intent of ending her own life.[43] Shortly afterwards, SC Smeaton and Constable Squire began to drive to Ms Mihail's home.[44] According to Constable Squire, the traffic was light and the roads were wet. They kept to the posted speed limits and obeyed all traffic lights and signs.[45]

29. At approximately 1.34am, Ms Mihail contacted emergency services to request an ambulance. She was able to provide her address, but shortly after the telephone call commenced she ceased speaking. The telephone call was recorded and sounds indicated Ms Mihail had vomited and was experiencing difficulty breathing.[46] The call operator immediately dispatched an ambulance to Ms Mihail's address.[47]

30. At approximately 1.48am, SC Smeaton and Constable Squire arrived at Ms Mihail's street address. According to SC Smeaton, they initially experienced difficulty locating the premises due to the street being dark and the front of Ms Mihail's home having a long tin fence with no clear entry point.[48] SC Squire noted that the numbering for the street was sparse and they initially entered the front yard of the neighbour before they found Ms Mihail's home.[49]

31. SC Smeaton and Constable Squire knocked on the door but there was no answer. SC Smeaton found the front door unlocked, they entered the house and found Ms Mihail lying on the floor in the hallway next to the landline phone. SC Smeaton immediately requested an

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41 Statement of Senior Constable Mark Smeaton dated 19 July 2018; Statement of Senior Constable Mark Squire dated 19 July 2018; Statement of Senior Constable Mark Squire dated 13 July 2018; Statement of Senior Constable Mark Squire dated 27 December 2018;

42 Phone records of Senior Constable Mark Smeaton and triage no 1300 363 788 on 22 November 2017; Statement of Senior Constable Mark Smeaton dated 19 July 2018; Statement of Rachel Finch dated 19 July 2018.

43 Statement of Rachel Finch dated 19 July 2018; Statement of Senior Constable Mark Smeaton dated 17 June 2018.

44 Statement of Senior Constable Mark Smeaton dated 17 June 2018.

45 Statement of Senior Constable Mark Squire dated 13 July 2018.

46 ESTA Audio Recording dated 22 November 2017.

47 ESTA 000 Chronology Report Event ID 88105982 dated 22 November 2017.

48 Statement of Senior Constable Mark Smeaton dated 19 July 2018.

49 Statement of Senior Constable Mark Squire dated 13 July 2018.

ambulance via Police Communications. SC Squire found Ms Mihail was unresponsive and he was unable to locate a pulse.[50]

32. Ambulance paramedics arrived shortly afterwards at approximately 1.52am, in response to Ms Mihail's call to emergency services, and commenced cardiopulmonary resuscitation.[51] Ms Mihail was unable to be revived and she was pronounced deceased at 2.03am.[52]

33. Police conducted a search of the premises and located prescription medications, an open container of Staminade powder (an electrolyte sports drink) and an empty bottle of HiLIQ 200mg (unflavoured liquid nicotine) on the kitchen table.[53] There was also a small cardboard box on the table dated 17 October 2017 which stated 'Made in China'.[54] A packing slip dated 27 June 2017 was located for e-cigarette flavour concentrates, syringes and dispenser bottles for filling e-cigarette tanks addressed to Ms Mihail.[55] Police located a receipt for the liquid nicotine, but no copies of invoices or shipping documents.[56] Police also located Ms Mihail's journal in which she disclosed her intention and plan to end her life.[57]

Coronial Investigation

34. The evidence contained in the Coronial Brief evidenced about 25 minutes between when police were first allocated Ms Mihail's welfare check and when they arrived at Ms Mihail's home. The court made a number of requests for further statements from SC Smeaton and Constable Squire to explain why it took them 25 minutes to get to Ms Mihail's home in circumstances where they had been told that Ms Mihail had at least planned to end her own life and may have then had the means to do so to hand.

35. Specifically, by email dated 12 June 2018, the court requested a further statement from SC Smeaton setting out '*…as to why it took him 25 minutes to get to 195 King Street Bendigo on 22 November 2017*'. SC Smeaton's second statement (dated 17 June 2018) provided no explanation of the delay. By letter dated 11 July 2018, the court requested statements from each of SC Smeaton and C Squire '*…explaining, in detail what they did between 1.23am and 1.48am*'.

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[50] Statement of Senior Constable Mark Smeaton dated 27 February 2018, p 45; Statement of Senior Constable Mark Smeaton dated 17 June 2018; Statement of Senior Constable Mark Smeaton dated 19 July 2018; Statement of Senior Constable Mark Squire dated 13 July 2018.
[51] Statement of Senior Constable Mark Squire dated 13 July 2018; VACIS Electronic Patient Care Record dated 22 November 2017, p. 66
[52] Statement of Senior Constable Mark Squire dated 13 July 2018; VACIS Electronic Patient Care Record dated 22 November 2017, p. 65.
[53] Statement of Detective Senior Constable Debbie Graham dated 28 February 2018, p. 47; Statement of Detective Senior Constable Debbie Graham dated 19 July 2018.
[54] Photographs of scene dated 22 November 2017, p. 83-84
[55] Photographs of scene dated 22 November 2017, p 85.
[56] Statement of Detective Senior Constable Debbie Graham dated 19 July 2018.
[57] Statement of Detective Senior Constable Debbie Graham dated 28 February 2018, p. 48; Photographs of scene dated 22 November 2017, p 89-90.

36. By statement dated 19 July 2018, SC Smeaton said at the time the job was allocated he and Constable Squire were stopped at a service station and he was on the phone to a complainant regarding a previous job. He states he then contacted Ms Finch to confirm the information provided and seek any further detail. He states they then headed directly to King Street, Bendigo. He recalled they had trouble locating the premises and arrived at approximately 1.48pm.

37. By statement dated 13 July 2018, Constable Squire confirmed he and SC Smeaton were at the APCO Service Station in Strathdale when they received the job. SC Smeaton said that Constable Squire was buying food and when he returned to the vehicle he was informed by SC Smeaton that they had been allocated a welfare check. SC Smeaton then had a lengthy conversation with Ms Finch, after which they headed to King Street '*under no urgency and kept to the posted speed limits and obeyed all traffic lights and signs*'.[58] He said the street numbering was sparse and they initially went to 193 King Street. Realising that Ms Mihail's house was next door, they went to her property, where they had some difficulty opening the front gate. They entered the house through the unlocked front door and located Ms Mihail.

38. SC Smeaton's and C Squire's statements do not satisfactorily explain the 25-minute delay.

Adverse Findings Letter

39. By letter dated 18 June 2019, I wrote to the Chief Commissioner of Police (**CCP**) to advise that the Coronial Brief contained material that may support adverse findings in relation to the unreasonable delay in Victoria Police's response to the request to conduct a welfare check on Ms Mihail (**the Adverse Findings letter**). The letter enclosed sections of the draft coronial finding and invited the CCP to respond to the assertions contained therein. The Adverse Findings letter was also provided to SC Smeaton and C Squire inviting their own response.

40. The CCP provided a submissions dated 19 August 2019 in which he opined that 25 minutes was a reasonable allowance of time taken to:

    (a) Complete the telephone call with another complainant

    (b) Make the telephone call to Ms Finch

    (c) Travel to 195 King Street

    (d) Locate the entry to the premises

[58] Statement of Senior Constable Mark Squire dated 13 July 2018.

41. The CCP further submitted it was reasonable for SC Smeaton and C Squire to make inquiries with Ms Finch *'prior to attending the premises'* for further information about Ms Mihail and *'the nature of the issues'*. The CCP submitted it was reasonable, in circumstances when police anticipated engaging with someone suffering with serious mental health issues, to gather as much information as possible prior to engaging. The CCP submitted that any speculation that the call could have waited until after the police members arrived:

> *'Ignores that fact that it may be difficult or impractical for one of the members to have been engaged in a telephone conversation once at the address. For example, it may not be possible to make the telephone call in private without having to leave one member to deal with Ms Mihail on their own. Furthermore, this approach would make it more difficult for the members to make an initial plan about their approach to the situation which, ideally, should be made on the best available information prior to arrival at the scene.'*

42. Finally, the CCP noted there are no guidelines prescribing how police members conduct welfare checks:

> *'There is no prescriptive structure or procedure for a welfare check as the range of circumstances that may be encountered is very broad. Police members are expected to use their general policing skills, knowledge and experience together with their initiative to undertake inquiries and actions that are appropriate for the circumstances of the particular case.'*

43. SC Smeaton and C Squire did not respond to the Adverse Findings letter.

Victoria Police Manual

44. Police members are required to comply with the Victoria Police Manual (**VPM**) Policy Rules. The VPM Policy Rules provide members with minimum standards that they need to apply. The VPM Procedures and Guidelines (**Guidelines**) are provided to support the interpretation and application of the Rules and concomitant responsibilities but are not themselves mandatory requirements.[59] As noted by the CCP, there is no VPM Policy Rule or Guideline directed solely towards how police respond to a request for a 'welfare check'.

45. There is a Guideline dealing with priority categories for the Police Radio Communications (for the metropolitan area only). The categories designate a time frame for Police

[59] Victoria Police Manual – Procedures and Guidelines. Application.

communications to dispatch calls to a unit. They are not relevant to how members respond to jobs that are assigned to them. There is no direction regarding the priority to be given to 'welfare checks'. Police records indicate the task dispatched to SC Smeaton and Constable Squire was categorised a *'priority 2'*.[60] According to the guidelines, priority 2 prescribes a police response *'as soon as possible'*, and suggests persons may be injured but not life threatening. It is unclear whether this priority classification was appropriately applied to the call ESTA received in relation to Ms Mihail. In any event, the priority classification has no bearing on how members are to respond to welfare checks.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

46. Even taking into account the CCP's submissions it is unclear to me why SC Smeaton and Constable Squire did not begin to drive to Ms Mihail's home immediately they received the request for a 'welfare check'. Any phone calls could easily have been completed or made in transit. Further, given the information with which they had been provided including from Ms Finch their attendance at Ms Mihail's address should have attracted some priority and urgency. That information included something of Ms Mihail's psychiatric history and that Ms Mihail had, very shortly prior expressed a suicidal plan and apparently then had to hand the means to effect it. There is no evidence that SC Smeaton and Contable Squires could not have sought necessary information on the way to Ms Mihail's address.

47. The available facts do not allow me to say whether a timely police response would have saved Ms Mihail's life.

Finding into the death of Ms Janet Foster (COR 2016 2544)

48. I refer to my recent finding into the death of Ms Janet Foster without inquest (COR 2016 2544) in which I noted a similar lack of a timely response by police when tasked to conduct a welfare check. The CCP was provided an opportunity to respond to adverse comments about Victoria Police member's response to a request for welfare check and elected not to make any submissions in response.

49. In that finding I acknowledged the difficulties faced by Victoria Police in allocating limited resources across a large region and the limited capacity police have to respond to requests for welfare checks or take missing persons reports. However, given the dire potential consequences that may follow where police response is not timely, it is appropriate that police

[60] Electronic Patrol Duty Return Form, call sign WBI311, start time 21/11/2018 23:00, page 2

err on the side of caution in responding to requests for welfare checks or missing persons reports. Such requests and reports should be responded to, where possible, in a prompt and timely manner, proportional to the risks indicated by the facts with which police are provided. Significant issues informing the appropriate time of response include advanced age, frailty, physical and mental health, and the possibility of suicide and illicit drug use.

RECOMMENDATIONS

50. Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), and in the interest of public health and safety and preventing like deaths, **I recommend that**:

The Chief Commissioner of Police consider reviewing the extant processes, policies and procedures applicable to police responding to requests for conducting 'welfare checks' and attendance to tasks similar to the task allocated to SC Smeaton and Constable Squires in this case to include a requirement that the urgency of police response be proportional to the facts made known to police to whom such tasks are allocated and the threat to life evidenced by those facts.

FINDINGS AND CONCLUSION

51. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Rachel Naomi Mihail, born 20 July 1981;

    (b) the death occurred on 22 November 2017, at 195 King Street, Bendigo, Victoria, from nicotine toxicity; and

    (c) the death occurred in the circumstances set out in paragraphs 17-33 above.

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

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

    (a) Mr James & Lynette Mihail, senior next of kin;

    (b) Mr Jared Clow, on behalf of the Chief Commissioner of Police;

    (c) Senior Constable Mark Smeaton, Victoria Police;

(d) Senior Constable Mark Squire, Victoria Police;

(e) Associate Professor Philip Tune, Bendigo Health;

(f) Dr Neil Coventry, Chief Psychiatrist; and

(g) Detective Senior Constable Debra Graham, Victoria Police, Coroner's Investigator.

Signature:

DARREN J. BRACKEN

CORONER

Date: 6 February 2020.