IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 6095

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**PHILLIP BYRNE, CORONER**
Deceased:	**MATTHEW THOMAS FITZPATRICK**
Date of birth:	**13 NOVEMBER 1984**
Date of death:	**BETWEEN 25 NOVEMBER 2017 AND 3 DECEMBER 2017**
Cause of death:	**I (a) COMPLICATIONS OF HYPERTHERMIA**
Place of death:	**MOUNT STIRLING, VICTORIA**

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

I, PHILLIP BYRNE, Coroner having investigated the death of MATTHEW THOMAS FITZPATRICK
without holding an inquest:
find that the identity of the deceased was MATTHEW THOMAS FITZPATRICK
born on 13 November 1984
and the death occurred between 25 November 2017 and 3 December 2017
at Mount Stirling, Victoria

from:

I (a) COMPLICATIONS OF HYPERTHERMIA

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

BACKGROUND

1. Matthew Thomas Fitzpatrick (**Mr Fitzpatrick**), 33 years of age at the time of his death, resided at 61 Garnook Grove, Badgers Creek.

2. Mr Fitzpatrick had a past medical history which included Bipolar Disorder in respect of which he did not always strictly follow his prescribed medication regime.

CIRCUMSTANCES OF THE DEATH

3. At about 6.30am on Saturday 25th November 2017, Mr Fitzpatrick left the family home at Badgers Creek to undertake an organised horse trail ride from Merrijig to Craig's Hut on Mount Stirling. Mr Fitzpatrick failed to attend at the scheduled location. The organisers of the ride contacted family members and advised of his non-attendance. The family made what I will term an 'informal report' to

Mansfield Police. On Sunday 26th November 2017, family members conducted their own search for Mr Fitzpatrick without success. On the evening of the 26th of November 2017, Mrs Leonie Fitzpatrick (Mr Fitzpatrick's mother), formally reported her son as a missing person to Lilydale Police. Over the following days a multi-agency search was undertaken in the area. During this period, family members and friends undertook their own search. On the morning of Tuesday 28th November 2017, Mr Fitzpatrick's car was observed from a helicopter, engaged by the family, located at a closed gate on Clear Hills Track near Craig's Hut. The multi-agency (and private) search continued over November 28, 29, 30 until the search was scaled back on Friday 1st December 2017 due to extreme weather conditions and a need to redeploy resources to 'flood activities' in the region. From 1st December 2017 through to 2nd December 2017, reduced police, SES and departmental personnel continued the search until mid-morning on Sunday 3rd December 2017, when a group of family friend searchers located Mr Fitzpatrick's naked body in thick bushland near Mount Stirling Circuit Track, some 90 metres south-east of the nearest search track. The police Air Wing recovered Mr Fitzpatrick's body and it was conveyed to the Victorian Institute of Forensic Medicine (VIFM).

4. The adequacy of the multi-agency search has been the subject of strident criticism by Mr Fitzpatrick's family, especially, but not exclusively, of the performance of Victoria Police. That, from the outset has been the principal focus of my investigation.

REPORT TO CORONER

5. Mr Fitzpatrick's death was reported to the coroner. Having considered the circumstances and having conferred with and taken advice from a forensic pathologist, I directed an autopsy and ancillary tests. Following my decision to direct an autopsy, the family lodged an application asking that I reconsider that direction and in lieu order an external only post-mortem examination. As I considered it important to seek to determine the precise cause of Mr Fitzpatrick's death, I refused the application and confirmed my earlier direction for an autopsy.

6. Subsequently, I received an Autopsy Report from Forensic Pathologist, Dr Gregory Young of the VIFM, in which he advised Mr Fitzpatrick's death was due to:

I (a) Complications of hypothermia

The accompanying Toxicology Report was unremarkable save that Acetone levels were elevated, indicative of a level of starvation/dehydration. I include in this finding a short excerpt from Dr Young's report which provides an explanation as to why Mr Fitzpatrick was located naked; Dr Young advised:

> *When found, the deceased was naked. This may be due to "paradoxical undressing", which is a feature seen in people with hypothermia where they remove their clothes, thus paradoxically exacerbating hypothermia. This is postulated to occur in the setting of disorientation and confusion prior to death.*

INITIAL COURSE OF INVESTIGATION

7. In March 2018 I had my coroner's solicitor, Mr Darren McGee, contact by phone Detective Senior Constable (DSC) Brylie Iskov of Benalla Criminal Investigation Unit, who we understood was the coroner's investigator, advising that I was aware an internal investigation was being undertaken following complaints made by family. I did not at that time require a formal brief to be prepared but asked that the statements and other material she had to that date be forwarded to the Court. I concede that for some time I did not appreciate the difference between a normal internal review per se and an operational review resulting in a report to the Operational Safety Committee. In any event, I indicated I would leave my investigation in abeyance anticipating being provided with a copy of any report flowing from what I then thought was a standalone internal review. Following my request, DSC Iskov lodged statements from people who observed and/or had dealings/contact with Mr Fitzpatrick on Friday 24th November 2017 and Saturday 25th November 2017, together with a statement by Mr Adam Austin, a friend of the Fitzpatrick family. In his statement, Mr Austin referred to his input in the search for Mr Fitzpatrick on 29th November 2017 and 1st December 2017. Mr Austin also detailed the circumstances where Mr Fitzpatrick's body was located. In her covering email, DSC Iskov advised she had "*been unable to obtain any statements from the family*".

8. Having examined the material to hand, and at that time not being aware of the family's criticism of the search, I had my registrar send a 21-day letter to the

Senior Next of Kin advising that I proposed to finalise my investigation by way of Findings without Inquest. The 21-day letter was forwarded on 2 March 2018. I penned a finding on 26 March 2018, three days after the 21-day period to respond had elapsed, a copy of which was forwarded to the family. Unfortunately, the Form 26, Request for Inquest, which detailed the family's complaints about the adequacy of the search, was only provided to me several days after the findings had been sent; that request was obviously moving through the system. In any event, becoming aware of the issues raised by the family, and being satisfied that information constituted "new facts and circumstances", I arranged for Mr McGee to prepare a formal application to set aside the finding I had made on 26th March 2018. Mr McGee did so, and I formally set that finding aside, so that my coronial investigation was re-opened.

9. Material highly critical of the Victoria Police response was lodged in early April 2018 at the Court by Mrs Leonie Fitzpatrick, together with a document detailing the family's issues penned by Mr Fitzpatrick's sister, Ms Jackie Anderson. Ms Anderson's material had been forwarded to Superintendent Matthew Ryan, who I understand was the Divisional Area Commander.

10. In Mrs Fitzpatrick's application for inquest, and in the material lodged by her and her daughter Jackie, it was suggested that there were numerous volunteer searchers who were *"appalled"* by the inadequacy of the search and the lack of cooperation by Parks Victoria in relation to opening gates within the search area. I had Mr McGee contact Mrs Fitzpatrick and ask that she identify those who supported her complaints so that I could get formal statements from them to assist in my investigation. No individuals were identified.

11. As the matter lay in abeyance and being somewhat concerned by the lack of progress of my investigation, I had on several occasions asked Mr McGee to make enquiries as to the state of the internal review. He was advised it was ongoing.

12. On 12 April 2019, through the Victorian Government Solicitors Office (VGSO), I received a copy of a report titled Operational Safety Committee Incident Report (the review) which was accompanied by a formal notice of Application for Suppression Order lodged on behalf of the Chief Commissioner of Police (CCP). I considered the basis of the application for suppression order and formed a tentative

view not to suppress the content of the review. I was concerned that if I made a blanket order to suppress, I would be working in a vacuum in seeking to reach conclusions as to the adequacy of the search, my major focus. Having formed that tentative view, I thought it necessary, as a matter of procedural fairness, to list the matter for a Mention/Directions open court hearing so counsel for the CCP and the family could make further submissions on the issue. The proposed hearing was scheduled for 3rd July 2019 and the family were advised of the hearing to give them an opportunity to be heard on the matter.

13. On 3rd July 2019, Mr Ronald Gipp, Counsel, appeared for the CCP. No family members were present.

14. The crux of Mr Gipp's submission was that if his application for suppression was successful, the report would be supressed from publication, but I could use the content in the penning of a formal finding. With that clarified I concluded I would not be operating in a vacuum.

15. Having reached that view, I considered it appropriate to address the Form 26 Request for Inquest lodged by Mrs Fitzpatrick back in March 2018. I considered that I could make the fundamental findings I am required to make under section 67(1) of the **Coroners Act 2008** and in light of the material I had, including the review, I could address the issue of the adequacy/efficacy of the search and other collateral matters.

16. On 2nd August 2019 I penned a formal Form 28 Decision by Coroner whether or not to hold an Inquest into Death, a copy of which was provided to Mrs Fitzpatrick. In that determination I advised that before writing a finding I would entertain any further submissions the family would care to make. Having regard to the criticisms lodged, I thought it appropriate to refer in that determination to the judgement of Justice Calloway in Keown v Khan (1999) 1 VR 69, where he reminded coroners that it is not part of their role/function to lay or apportion fault, blame or culpability. I believe the role of the coroner is widely misunderstood within the broader community. Having said that, I am entitled, indeed in this case required, to form a view as to the adequacy of the multi-agency search.

17. A Form 45 Application for Access to Coronial Documents dated 8th August 2019 was subsequently lodged by Mrs Fitzpatrick. The relevant material I had, together

with a transcript of the Mention/Directions Hearing was provided to Mrs Fitzpatrick. Although it was my intention to provide Mrs Fitzpatrick a copy of the Operational Safety Committee Incident Review report and appendices, this documentation was inadvertently not included with this material.

18. At the Mention/Directions Hearing of 3rd July 2019 I granted the application made by Mr Gipp on behalf of the CCP and under s17 of the *Open Courts Act* (2013) made a Suppression Order prohibiting publication of the Operational Safety Committee Incident Review report. It is important to understand the suppression order relates only to the publication of the report, and not provision to the family of a copy.

19. On 29th October 2019 a Form 45 application was received from Mr Ali Besiroglu of Robinson Gill lawyers representing Mrs Fitzpatrick, seeking a copy of the Operational Safety Committee Incident Report to enable him to provide legal advice to the family. On 29th October 2019 a copy of the report was provided to Mr Besiroglu, together with appendices attached to the report, which as previously indicated, we had inadvertently omitted to provide to Mrs Fitzpatrick when he sent her copies of the other relevant material on file.

20. On 26th November 2019 Mr Besiroglu emailed Mr McGee advising that the family proposed to seek a *"second opinion and advice from counsel"* and asked the time for a response be extended. I extended the period for response to 20 January 2020.

21. In an email dated 20 January 2020 Mr Besiroglu advised that after *"consultation with the Fitzpatrick family and counsel"* the family did not propose to provide further submissions. Mr McGee advised Mr Besiroglu that having been given that indication I proposed to finalise my investigation *"on the papers"* by way of Finding without Inquest. Mr Besiroglu responded indicating he would advise the family of what I proposed.

22. In reaching conclusions in relation to the contentious issues, particularly the adequacy of the search for Mr Fitzpatrick I rely on the available material; the material lodged by Mrs Fitzpatrick and her daughter highly critical of the performance of the official searchers, together with the material contained in the Operational Safety Committee Incident Review, and the attached appendices.

23. As stated, a copy of the report to the Operational Safety Committee (with appendices) has been made available to the family. In that circumstance, this being a Finding without Inquest, so not a finding in the public domain, I do not in this finding, propose to deal with the circumstances *"chapter and verse"*; the details are now known to the family. I propose to make broad comment only as to the adequacy of the search. In doing so I have to consider where the weight of the evidence lies.

DISCUSSION

24. Examining the matrix constituted by Appendix "A" of the review report, it is clear the family have possibly underestimated the extent of the resources brought to bear on the search for Mr Fitzpatrick. To demonstrate my point, I include in this finding a short excerpt from the report:

> *"More than 100 police members, 27 State Emergency Service (SES) staff, 21 Department of Environment Land, Water and Planning (DELWP) staff, 2 Mansfield Council staff, 6 Ambulance staff, 14 Bush S&R staff (volunteer experts), 6 Country Fire Authority (CFA) staff, 6 Shepparton Search & Rescue staff (private) were recruited at different times during the multi-agency response from Tuesday 28th November to Sunday 3rd December at 10.40m when the missing person was located deceased by family friends near Mt Stirling Circuit Track (within the search area)."*

I note Police Search and Rescue were involved and when weather permitted, even prior to the formal missing persons report being made, the Police Air Wing was also involved.

25. The fact is that while what I will call <u>private</u> searchers are entitled to take whatever risks they want, <u>official</u> searchers come under a totally different regime where the wellbeing and safety of those involved is, for better or worse, the principal guideline. In that regard I accept that the police commander undertook risk assessments, peer reviews of his decision making and perhaps more importantly, consulted with, and took expert agency advice, in relation to the deployment of resources. It is noted that floods in the search area demanded significant redeployment of resources.

26. I accept that the grief visited upon his family by Mr Fitzpatrick's untimely death has been profound and that the beliefs held by the family as to the adequacy of the search are genuinely and firmly held, but conclude those beliefs are to some extent founded on incomplete information.

27. Although I rely on the review report as to detailed circumstances and events surrounding the search, I do not have to accept the conclusions reached by the reviewers but am required to make my own objective assessment of the efficacy/adequacy of the whole exercise. It is important also to bear in mind that in undertaking that assessment I am required to consider whether it was reasonable and appropriate, not whether it was optimal.

28. I accept the information in the matrix constituted by Appendix "A" as to the overall numbers deployed at various stages of the search; save for the earlier complaints brought by Mrs Fitzpatrick and her daughter Jackie, that detailed information has not been challenged.

CONCLUSIONS

29. I am satisfied that the performance of those official entities involved in the search, Victoria Police, State Emergency Services, Parks Victoria and others, was undertaken in accordance with the relevant principles, guidelines and legislation.

30. In the final analysis, being satisfied interested parties have been afforded due process and being satisfied my investigation has been sufficient to satisfy public expectation, I conclude that objectively there is no reasonable basis to be critical of the conduct of the search for Mr Fitzpatrick. I add that I concur with the conclusions reached by the reviewers who undertook the Operational Safety Committee Incident Review that the response to the incident was in several ways challenging.

FINDING

31. I formally find Matthew Thomas Fitzpatrick died in bushland near the Mt Stirling Circuit Track between 26th November and 3rd December 2017 due to complications of hypothermia. I conclude that Mr Fitzpatrick likely became disorientated and confused due to the effects of hypothermia and lost his way and perished in tragic circumstances.

COMMENT

32. Pursuant to section 67 (3) of the *Coroners Act 2008* I make the following comments in relation to the death.

33. While not wishing to be overly critical of some of those involved, I note there were significant tensions between police, family and friends, and instances where volunteer searchers, not connected to the official search, did not follow directions, breached established roadblocks and were virtually impossible to manage. As my focus has been elsewhere, I do not propose to seek to pursue or resolve those particular issues.

34. Having regard to the conclusions I have reached as to the adequacy of the search; it is not imperative that I seek to determine precisely when Mr Fitzpatrick perished. However, I consulted Forensic Pathologist Dr Greg Young on the issue who advised he could not say with any level of confidence when the terminal event occurred; consequently, I can take that matter no further.

RECOMMENDATION

35. Pursuant to section 72 (2) of the *Coroners Act 2008* I make the following recommendation in connection with the death.

36. The issue of the obvious tension between the family and police members was recognised by the reviewers and a recommendation made that Victoria Police develop and implement a policy where trained Family Liaison Officers liaise with family members in some situations, including searches, for missing persons. Apparently, such an initiative was implemented in the United Kingdom several decades ago and the proposal is to a adopt a similar protocol here. I do not know whether the recommendation of the review committee has been adopted and implemented by Victoria Police. However, I support the proposal and if not yet implemented adopt the recommendations of the reviewers.

DISTRIBUTION OF FINDING

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

    Mr Ali Besiroglu, Robinson Gill Lawyers, on behalf of Mr John and Mrs Leonie Fitzpatrick, Senior Next of Kin;

Ms Laura D'Amico, Victorian Government Solicitor's Office, on behalf of the Chief Commissioner of Police; and

Senior Constable Brylie Iskov, Coroner's Investigator, Victoria Police

Signature:

PHILLIP BYRNE
CORONER
Date: 21 April 2020