IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 3839

Linked Cases: [1] COR 2018 2583
COR 2018 4780
COR 2018 5104

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**MS MH[2]**
Date of birth:	**19 December 1989**
Date of death:	**22 July 2019**
Cause of death:	**Hanging[3]**
Place of death:	**Craigieburn, Victoria 3064[4]**

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[1] Coronial investigations may be linked where deaths are connected by precipitating events or by data which indicates key similarities, i.e. cluster analysis. The nominated linked coronial investigations represent a "suicide cluster", which has been defined as a group of suicides that occur closer together in time and/or space than would normally be expected.

[2] The names of the deceased person and their family members have been redacted and replaced with pseudonyms of randomly generated two letter sequences to protect their identity.

[3] The mechanism of death in cases of hanging is thought to be due to one or a combination of the following: compression of the airway in the neck, compression of the major vessels in the neck, stimulation of the carotid sinus leading to profound bradycardia and cardiac arrest (vagal inhibition).

TABLE OF CONTENTS

FINDING INTO DEATH WITHOUT INQUEST **1**

REPORTABILITY **3**

PURPOSE OF THE CORONIAL INVESTIGATION **3**

INVESTIGATIONS **4**

FORENSIC PATHOLOGY INVESTIGATION 4

POLICE INVESTIGATION 5

Mobile Telephone Records 6

Ms MH's video recordings on 22 July 2018 7

COMMUNITY ENGAGEMENT 7

Whittlesea Community Concerns 8

Analysis of suspected suicides 8

Round-table meeting and submissions 9

Vulnerabilities of South Asian women in the City of Whittlesea 10

The Crossroads to Community Wellbeing Group 11

COMMENTS **11**

RECOMMENDATIONS **14**

FINDINGS **15**

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[4] The full address has been redacted to protect the identity of the deceased.

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

1. Ms MH was 29 years of age at the time of her death. Ms MH grew up in Punjab, India, and emigrated to Australia in 2018. She resided in Craigieburn with her partner Mr IF and two housemates. Ms MH had a young daughter who resided in India with her ex-husband Mr JI. She had a history of suicidality but had not been treated for mental health issues in India nor Australia.

2. On 22 July 2019 at approximately 4.15pm, Mr IF returned home from work. He could not locate Ms MH inside their home, and he went around the side of the residence, where he found her hanged from a wooden beam of the patio. At 4.28pm, Mr IF contacted emergency services; he cut the rope and moved Ms MH to the ground where he administered cardiopulmonary resuscitation (CPR) under instruction from the emergency call taker. At 4.32pm, Ambulance Victoria paramedics arrived and continued resuscitative measures, however, Ms MH was unable to be revived and was pronounced deceased.

REPORTABILITY

3. Ms MH's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act'), because it occurred in Victoria, and was considered unexpected, unnatural and as it resulted directly from injury.

PURPOSE OF THE CORONIAL INVESTIGATION

4. The Coroners Court of Victoria is an inquisitorial jurisdiction.[5] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[6] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate

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[5] *Coroners Act 2008* (Vic) s 89(4).

[6] Ibid 67(1).

and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[7]

5. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[8] Coroners are also empowered to report to the Attorney-General on a death; 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 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.[9] These are effectively the vehicles by which the prevention role may be advanced.[10]

6. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation.

INVESTIGATIONS

Forensic pathology investigation

7. Dr Heinrich Bouwer, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Ms MH, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Post mortem toxicological analysis did not identify any common drugs or poisons. Dr Bouwer ascribed the medical cause of death to hanging.

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[7] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[8] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

[9] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[10] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

Police investigation

8. Upon attending the Craigieburn premises after Ms MH's death, Victoria Police took measurements of the external area of the house, collected scissors and a knife found near Ms MH's body. There was no evidence of third-party involvement in the mechanism of Ms MH's death.

9. Senior Constable (SC) Natasha Bisogno was the nominated Coroner's Investigator.[11] At my direction, SC Bisogno investigated the circumstances surrounding Ms MH's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Ms MH's sister Ms LM, Ms MH's neighbour Ms HQ and a summary of evidence completed by SC Bisogno.

10. During the investigation, police learned that Ms MH had attempted to end her own life in India, approximately six months after her marriage to Mr JI in 2009. Ms MH ingested an unknown poison and was taken to hospital. Ms LM stated that her sister was not treated for mental ill health after that date, as it was '*not something that happens in India.*'[12] Ms LM stated that her younger sister's marriage was not a happy one and that her '*in-laws played a part in this.*'[13]

11. In 2012, Ms MH gave birth to a daughter. Mr JI took custody of the child after they separated, and Ms MH returned home to live with her mother. Ms LM stated that, while she was in India, her sister '*always said that she was not happy with her life, but she never made any threats of suicide.*'[14]

12. In October 2018, Ms MH emigrated to Australia upon being sponsored by Ms LM, who said that this was the happiest she had ever seen her sister. Ms LM stated that her sister was '*always a very happy person but sensitive*'.

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[11] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

[12] Coronial Brief, Statement of Ms LM dated 20 November 2019, p 11.

[13] Ibid.

[14] Ibid, p 12.

13. Approximately one week prior to Ms MH's death, she visited her sister in Lalor. On this occasion they did some at-home beauty treatments. Ms LM commented that they had a good time and there did not appear to be anything amiss with Ms MH.

14. On 20 July 2018, Ms MH and her partner Mr IF visited his parents. Ms LM stated that she has since been informed that Ms MH was '*very happy on this day*'.[15]

15. On 22 July 2018 at 12.38pm, Ms MH telephoned her sister in a state of distress. Ms LM stated that this '*wasn't unusual because she cried a lot as she was very sensitive.*'[16] Ms MH told her sister that she was upset as she had just received a phone call from their mother who was in India. Ms LM stated that she was not told the content of that conversation. She said that she told Ms MH to '*ignore it all and not let it bother her*'[17] and that she ultimately had to hang up on her sister. Ms LM said she had to end the conversation and she thought that Ms MH was '*getting upset about something she didn't need to.*'[18]

Further Investigation

16. SC Bisogno stated that Ms MH had worked in nursing in India but that she had not been able to secure employment in Australia; she remained at home most days while Mr IF worked. My investigator informed me that Ms MH relied on her sister for basic living expenses. SC Bisogno stated that Ms LM described her sister's relationship with Mr IF as very happy and that she was unaware of any issues between them. SC Bisogno stated that there were no LEAP-recorded[19] family violence incidents between Ms MH and Mr IF.

Mobile Telephone Records

17. On 30 September 219, the contents of Ms MH's mobile telephone were downloaded and analysed by my investigator, especially in relation to the date of her death.

18. On 22 July 2018 at approximately 6.50am, Mr IF left home for work.

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[15] Above n 11, p 12.

[16] Ibid.

[17] Ibid.

[18] Ibid.

[19] "Law Enforcement Assistance Program"; Victoria Police information database.

19. At about 10.30am, Ms MH answered a telephone call from Mr IF, and they spoke for approximately five minutes. SC Bisogno stated that the content of that conversation is unknown. At approximately 12.00pm, Mr IF telephoned Ms MH once more, but she did not take the call.

20. At approximately 12.28pm, Ms MH recorded two videos depicting her final message to her family and loved ones. Ms MH made the recordings in Punjabi.

21. Shortly thereafter, Ms MH made the telephone call to her sister Ms LM. Although she was unable to say with certainty, Ms LM disclosed her belief to SC Bisogno that Ms MH's difficult conversation with their mother on the date of her death was probably about her sister's pending divorce; SC Bisogno informed me that Ms MH was scheduled to divorce her ex-husband Mr JI on 23 July 2019.

Ms MH's video recordings on 22 July 2018

22. A NAATI[20] certified translator for the language pair English and Punjabi reviewed Ms MH's video recordings and provided translation and transcription in English. Ms MH's messages were not entirely intelligible. She stated explicitly '*I am responsible for this act, nobody else is responsible for this, neither Mr IF, nor his family and not my parent's family...*'[21] Ms MH does not identify the precipitating factors to the decision to end her own life in either recording.

Community Engagement

23. The City of Whittlesea is located approximately 20 kilometres north of Melbourne Central Business District. The City of Whittlesea is one of the largest municipalities in metropolitan Melbourne, covering an area of approximately 489 square kilometres. About 70 per cent of the City is classified as a rural area and 30 percent is urban. The City's council website states that it is one of the fastest growing municipalities in Australia:

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[20] National Accreditation Authority for Translators and Interpreters Ltd is the national standards and certifying authority for translators and interpreters in Australia. It is the only organisation to issue certification to practitioners who wish to work in this profession in Australia.

[21] Coronial Brief, Transcript of Video Recordings, dated 1 December 2019, Exhibit 5.

In the 2016/17 financial year, the City of Whittlesea was the fourth largest growing local government area in Victoria. We currently welcome around 8,000 new residents per year (about 156 a week)... Our current population is approximately 223,566. This is expected to grow to 382,896 by 2041.

We are one of the most multicultural municipalities in Victoria. In 2016, almost half of all local residents (over 86,000 residents) spoke a language other than English at home. In previous decades, a higher proportion of our overseas-born residents were of European heritage, particularly Italy, Macedonia and Greece. Between 2011-2016, emerging communities in the City of Whittlesea included residents born in India (+5,866 persons), China (+1,780), Iran (+1,300) and Sri Lanka (+1,211).[22]

Whittlesea Community Concerns

24. In early 2019, Victoria Police and the Crossroads to Community Wellbeing Group, through Whittlesea Community Connections, contacted the Coroners Court of Victoria (CCOV) to convey concern about a perceived increased frequency of suicides of South Asian women in the City of Whittlesea.

25. Following this notification, I directed the Coroners Prevention Unit (CPU)[23] to identify previous and monitor subsequent suspected suicides of South Asian women in the City of Whittlesea.

Analysis of suspected suicides

26. The CPU used the Victorian Suicide Register[24] to conduct a retrospective case series examination of suspected suicides amongst South Asian women in the City of Whittlesea. The CPU identified four suspected suicides of South Asian women in the City of Whittlesea in 2018, compared to one relevant death for the period 2009 to 2015.

27. This retrospective examination showed that during 2018, the City of Whittlesea experienced an elevated frequency of suspected suicide amongst South Asian women

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[22] Whittlesea Council, *Suburbs and Residents,* City of Whittlesea <https://www.whittlesea.vic.gov.au/about-us/our-city/suburbs-and-residents/> (date accessed 31 August 2020).

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

[24] The Victorian Suicide Register (VSR) is a database containing information on coroner-determined and suspected suicides reported to and investigated by Victorian Coroners between 1 January 2000 and the present.

and that this met the Centres for Disease Control and Prevention's definition of a suicide cluster.[25]

28. I also note that through the course of this retrospective examination, the CPU identified a further death of a South Asian woman that occurred in the City of Whittlesea during 2018, though in this closed matter, the death was determined to be due to natural causes. Despite this, the circumstances of this matter were reviewed in the context of this cluster and common themes have been found.

29. Additionally, in monitoring subsequent suspected suicides of South Asian women in the City of Whittlesea, the CPU identified a further two possibly relevant deaths that occurred in 2019. This brings the total number of suspected suicides of South Asian women in the City of Whittlesea for the period 2018 to 2019 to six.

Round-table meeting and submissions

30. Given this elevated frequency of suicides, I further directed the assistance of the CPU to seek input from relevant agencies and community leaders by convening a round-table meeting. The aim of the round-table meeting was to obtain informed input regarding the vulnerabilities of South Asian women in the Whittlesea area, with the aim of assisting me to make prevention focused and, if possible, consensus comments and/or recommendations.

31. I held a round-table meeting on 24 July 2019 at the CCOV. Representatives from Whittlesea Community Connections, Victoria Police, Eastern Melbourne Primary Health Network, Berry Street, Whittlesea Council Health Planning and Community Safety Planning teams, the Department of Health and Human Services and the Coroners Prevention Unit participated, as well as expert psychiatrist, community leader and South Asian Communities Ministerial Advisory Council member Dr Manjula O'Connor. All participants were invited to openly discuss vulnerabilities faced by South Asian women in the Whittlesea community and barriers to these women in accessing supports.

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[25] *A group of suicides or acts of deliberate self-harm that occur closer together in space and time than would normally be expected on the basis of statistical prediction and/or community expectation* (Centres for Disease Control, 1994).

32. To explore any opportunities for recommendations I invited attendees of the roundtable meeting to provide submissions in relation to their knowledge and observations of the vulnerabilities of South Asian women in the Whittlesea area, what services are currently available in the Whittlesea area and what more could be done to prevent such deaths. I would like to acknowledge and thank all the parties and organisations that provided submissions to me as part of this investigation.

Vulnerabilities of South Asian women in the City of Whittlesea

33. I received submissions from Whittlesea Community Connections, Victoria Police, Eastern Melbourne Primary Health Network, Berry Street, Whittlesea Council Health Planning, Community Safety Planning and Maternal and Child Health teams, and Dr Manjula O'Connor.

34. There was consensus amongst all submissions that many South Asian women living in Australia may be significantly affected by several stressors including: family violence, including extreme financial control and social isolation; dowry demands; language and cultural barriers in understanding women's rights and accessing services; concerns regarding immigration status; and the stigma of divorce in South Asian culture. It was widely accepted that violence and control can be compounded by South Asian patriarchal culture, including in situations where extended families are living together as this can create additional oppression of the woman. The submissions highlighted that due to these issues, South Asian women often lack agency and experience a sense of powerlessness, making them extremely vulnerable and unlikely to be able to access support services.

35. Whilst the submissions highlighted a range of supports and services currently available to vulnerable women in the Whittlesea area, there was consensus amongst the submissions of all persons and agencies that: the City of Whittlesea is disproportionately affected by lack of access to mental health and family violence services, compared with other municipalities; new and existing services need to be more culturally appropriate, which could be facilitated by further research and engagement with community members; and that vulnerable women often can't access existing services due to cultural barriers, experience of family violence including extreme controlling behaviours, and the geographical isolation of existing services compounded by the lack of public transport infrastructure in the Whittlesea area.

The Crossroads to Community Wellbeing Group

36. The Crossroads to Community Wellbeing Group was established in response to the emerging concern of a perceived increased frequency of suicides of South Asian women in the City of Whittlesea. The working group is comprised of those agencies and community leaders from whom the Court received submissions in this matter, and its purpose is "to prevent suicide of South Asian women, by reducing social isolation and increasing access to support and services" through engagement with the South Asian community to develop community-based solutions.[26]

37. Through the collaboration of stakeholders across the City of Whittlesea service system and the South Asian community, the Crossroads to Community Wellbeing Group has worked effectively in identifying gaps in services available to vulnerable South Asian women in the City of Whittlesea. In doing this, the Crossroads Group have identified a range of early intervention, prevention and postvention opportunities including: expansion of mental health, family violence, perinatal and other support services in the City of Whittlesea; the establishment of additional South Asian women's support groups, including increased use of religious leaders and survivors of abuse as mentors; increased education for South Asian women regarding women's rights, Australian law and accessing services; increased education regarding cultural sensitisation and appropriateness of service providers; and improved processes for information sharing and data collection across organisations.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. I note that Ms MH's death occurred in Craigieburn which falls within the Hume local government area, rather than the City of Whittlesea. I considered whether to add Ms MH's file to the Whittlesea Suicide Cluster files being considered by the CPU, or whether to consider this matter as a "follow-up case" where I may choose to reiterate some of the comments and recommendations contained in the cluster files. In light of the proximity of the two local governments areas, and particularly that Ms MH's residence

[26] Submission of Victoria Police dated 11 November 2019.

was very close to the border of the same, as well as the number of common themes and issues, I ultimately determined to include Ms MH's file in the suicide cluster analysis.

2. Round-table meeting attendees submitted that many South Asian women living in Australia may be affected by a number of particular stressors, including, *inter alia*: social isolation, family violence and financial dependence. I do not discount that these stressors can affect other women. Further, the available evidence cannot be held to state that these issues affect all South Asian women living in Australia. However, research undertaken at my direction has identified an elevated frequency of suspected suicide amongst South Asian women in the City of Whittlesea in 2018. It is evident that more must be done to identify appropriate public health and safety measures to prevent like-deaths.

3. I commend the actions of the Crossroads to Community Wellbeing Group in promptly responding to concerns in the community, and for working collaboratively to identify service gaps and subsequent prevention opportunities that would help to reduce isolation and increase access to services for South Asian women in the Whittlesea area. The Crossroads to Community Wellbeing Group is well placed to progress the necessary research and planning required to inform future work, including further inquiries into the broader issues faced by South Asian women in the City of Whittlesea that do not form part of the coronial jurisdiction.

4. I acknowledge that the elevated frequency of suspected suicides of South Asian women in the City of Whittlesea was first noticed by Sergeant Damian Lehmann of Mill Park Police Station. Sergeant Lehmann's notification of his observations to regional command triggered both community input through the establishment of the Crossroads to Community Wellbeing Group and the subsequent attention of this Court, to systemic issues affecting South Asian women in the Whittlesea region and the urgent need to help them. I commend the astute judgement and timely action of Sergeant Lehmann. Similarly, I acknowledge the efforts of Whittlesea Community Legal Service's Principal Solicitor Chris Howse who coordinated much of the community input into my investigation.

5. It is apparent to me that further investigation into the deaths of South Asian women in the Whittlesea area is warranted. Principally, the Victorian Department of Health and

Human Services ought to liaise with Whittlesea community groups and appropriate stakeholders to further the knowledge gleaned in my investigation concerning the three core questions considered in the 2019 CCOV and Whittlesea Community Stakeholders roundtable meeting and corresponding written submissions:

a. What are the concerns that exist regarding South Asian women in the Whittlesea area that make them vulnerable and possibly at risk of self-harm?

b. What supports or services are available to vulnerable South Asian women in the Whittlesea area?

c. What gaps exist regarding supports or services available to vulnerable South Asian women in the Whittlesea area?

6. During my investigation, I learned that the Murray Primary Health Network have engaged Wesley Mission to establish a Life Force Suicide Prevention Network in the Mildura area. Wesley Mission's Life Force Suicide Prevention Networks are described as:

> *...a coming together of people and organisations, a voluntary collaboration working together to influence outcomes of a specific problem. A suicide prevention network, addressing the specific needs of a local area, is one of the most effective ways of raising community awareness of the issue of suicide, while empowering its members to develop appropriate suicide prevention strategies at a grassroots level.*[27]
>
> *Member networks are provided with expert advice during establishment, initial funding, and 'hands on' support in planning and delivering suicide prevention projects in their local community.*[28]

7. This type of approach seems consistent with the solutions advocated in the submissions. However, further research into the most appropriate solutions are clearly warranted. Supporting vulnerable South Asian women in the City of Whittlesea may require initiatives from a number of government departments. At this juncture, it is clear that the

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[27] <https://www.wesleymission.org.au/find-a-service/mental-health-and-hospitals/suicide-prevention/wesley-lifeforce-networks/>, accessed 9 June 2020.

[28] Ibid.

Department of Health and Human Services ought to identify opportunities to improve South Asian women's access to and engagement with support services. A pertinent recommendation will follow.

8. There is no evidence to suggest family violence is a precipitating factor in the circumstances leading to Ms MH's death. However, family violence has been relevant to the circumstances of other linked cases. I consider it appropriate to maintain continuity in my comments and recommendations in the linked matters in light of my decision to consider them as a suicide cluster. Therefore, I have included these comments and a general recommendation in relation to family violence and the intentional deaths of South Asian women in the City of Whittlesea.

9. During my investigation, it was brought to my attention that Victoria Police Family Violence Investigation Units (FVIU) '*are now staffed by detectives and have primacy of investigation for incidents involving people from priority communities with increased likelihood of future family violence*'.[29] Consequently, the FVIUs are uniquely placed to investigate the deaths of women from culturally and linguistically diverse backgrounds in the Whittlesea area: to consider the relevance of any family violence issues and potential common themes in these deaths, including *inter alia* social isolation, which may, in turn, assist in suicide prevention. Pertinent recommendations will follow.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendations:

1. With the aim of promoting public health and safety and preventing like deaths, I recommend that the Secretary of the Department of Health and Human Services review current services that support the health and wellbeing of South Asian women in the City of Whittlesea, and consult with relevant service providers and other stakeholders, to identify opportunities to improve South Asian women's access to and engagement with such services.

2. With the aim of promoting public health and safety and preventing like deaths, I recommend that Victoria Police allocate Family Violence Investigation Units to

[29] Submission of Victoria Police dated 11 November 2019.

investigations into suspected intentional deaths of women in the City of Whittlesea who are from culturally and linguistically diverse communities, in circumstances where there is any indication that previous family violence incidents may have contributed to the death.

3. With the aim of promoting public health and safety and preventing like deaths, I recommend that Victoria Police allocate Family Violence Investigation Units to investigations into suspected intentional deaths of women in the City of Whittlesea who are from culturally and linguistically diverse communities, in circumstances where there is any indication that social isolation may have contributed to the death.

FINDINGS

1. I find that Ms MH, born 19 December 1989, died on 22 July 2019 at Craigieburn, Victoria 3064.[30]

2. I find that Ms MH had a history of suicidality but never received any mental health treatment in India or Australia.

3. Although the precise precipitating factors leading her to end her own life may never be known with any degree of certainty, I find that Ms MH suffered stressors proximate to her death, including: a lack of financial independence and an impending divorce.

4. I accept and adopt the cause of death ascribed by Dr Heinrich Bouwer and I find that the cause of Ms MH's death was hanging, in circumstances where I find she intended to end her own life.

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

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

Mr IF

Ms LM

The Hon. Ros Spence MP, in her capacity as Minister for Multicultural Affairs

The Hon. Jenny Mikakos MP, in her capacity as Minister for Health

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[30] The full address has been redacted to protect the identity of the deceased.

Kym Peake, Secretary, Department of Health and Human Services

Shane Patton APM, Chief Commissioner Victoria Police

Eastern Melbourne Primary Health Network

Whittlesea City Council

- Health Planning and Community Safety Planning
- Maternal and Child Health

Whittlesea Community Connections

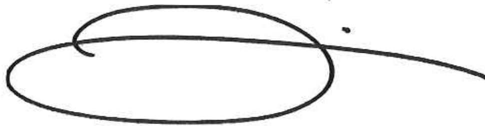
Berry Street Incorporated

Dr Manjula O'Connor

Principal Solicitor Whittlesea of Community Legal Service Chris Howse

Sergeant Damian Lehmann of Mill Park Police Station

Signature:



AUDREY JAMIESON
CORONER
Date: **7 September 2020**