IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 1882

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**HILTON DAVIS**
Date of birth:	**19 March 1968**
Date of death:	**23 April 2018**
Cause of death:	**Mixed drug (Oxycodone and Methadone) and ethanol toxicity**
Place of death:	**16 Moyston Grove, Corio, Victoria**
Catchwords:	**Family violence, suicide, unexpected death**

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

1. Hilton Davis was a 50-year-old man of Torres Strait Islander descent, who lived with his wife and youngest son, at 16 Moyston Grove, Corio, Victoria. Mr Davis had three children with his wife and was a compliance analyst with a national bank before he had a significant motor vehicle accident in 2012 and was unable to continue work. Mr Davis had a history of issues with suicidality, mental health and alcoholism.

2. On 23 April 2018, at approximately 11:00am, Mr Davis' son woke up and found his father hunched over and leaning against an armchair unconscious. Mr Davis' son called emergency services whilst attempting to resuscitate him, paramedics arrived shortly after and declared Mr Davis deceased at 12.30pm.

3. Mr Davis' death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act'), because it occurred in Victoria and was considered unexpected and unnatural.

INVESTIGATIONS

Forensic pathology investigation

4. Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination of Mr Davis' body, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83.

5. Dr Lynch commented that the external examination of the body showed findings in keeping with the clinical history. The postmortem CT scan revealed fatty liver but no obvious pill residue within the stomach.

6. Toxicological analysis of Mr Davis' postmortem blood detected the presence of oxycodone (~0.7 mg/L), methadone (~0.03 mg/L) and amlodipine (~0.07 mg/L). Ethanol was also detected at 0.15 g/100 mL. The toxicologist commented that the drugs detected are consistent with excessive and potentially fatal use and that the combination of drugs and alcohol detected may cause respiratory depression and sedation which could have precipitated death in the absence of other contributing factors.

7. Dr Lynch ascribed the cause of death to mixed drug (oxycodone and methadone) and ethanol toxicity.

Police investigation

8. Upon attending the Corio premises after Mr Davis' death, Victoria Police members observed Mr Davis hunched over leaning against an armchair. Police members continued to process the scene and commence investigations into the death.

9. Detective Senior Constable (DSC) Brett Hampson was the nominated Coroner's Investigator.[1] At my direction, DSC Hampson investigated the circumstances surrounding Mr Davis' death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by family, friends, treating clinicians and investigating officers.

10. During the investigation, police learned that Mr Davis had a history of suicidality and reported family violence with his wife, Mrs Snjezana Davis and their children.

11. Mrs Davis stated that she noticed a change in Mr Davis' personality following the death of her father in 2004.

12. Between 2011 and the time of his death, Mr Davis had been involved in at least five suicide attempts. Statements from family and Mr Davis' medical history indicate that Mr Davis struggled with alcohol until the time of his death.

13. In January 2012, Mr Davis was involved in what was initially believed to have been a motor vehicle accident. He subsequently admitted that he had made a deliberate attempt to suicide by driving into a pole. Mr Davis sustained injuries from this incident that required long term use of pain medication, including Endone and Fentanyl patches.

14. Mr Davis had a history of perpetrating family violence against Mrs Davis and their children. Mrs Davis commented in her statement to the Court that she '*moved out of the marital home on a number of occasions but Hilton was [sic] message me and use emotional blackmail on me that if I didn't return home he would kill himself*'.

[1] 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.

15. Victoria Police were also called to the Corio property in relation to family violence incidents on eight separate occasions. Mrs Davis was listed as the Affected Family Member on four occasions and their youngest son was listed as the primary Affected Family Member on one occasion in 2015. The family violence reported to police during these incidents included verbal and physical abuse.

16. There were also three instances where Mr Davis was listed as the Affected Family Member. Two of these incidents involved alleged verbal abuse by Mrs Davis towards Mr Davis after a heated argument which Mr Davis reported to police. One incident involved a complaint about injuries from assaults that were later determined to be self-inflicted. On 27 July 2015, police issued a Family Violence Safety Notice against Mrs Davis. Details of the incident indicate that parties had argued about Mr Davis's treatment of his son on 25 July 2015 which resulted in a Family Violence Intervention Order made against him. Mr Davis claimed that when he tried to leave the property that Mrs Davis stabbed him in the back of the head. Mrs Davis had left the property by the time the police arrived. LEAP records pertaining to this incident conclude that Mr Davis's wounds were self-inflicted, and that he had a history of using '*his self-harming to gain control over the Resp [sic], even to the point of sending photographs of his self-inflicting injuries to his kids and blaming their Mum for it*'. The VP Form L17 for this incident noted that Mr Davis had a vulnerability of suicidal ideation and attempts of suicide.

Family violence investigation

17. As Mr Davis' death occurred in circumstances of recent family violence, I requested that the Coroners' Prevention Unit (**CPU**)[2] examine the circumstances of Mr Davis' death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[3]

18. Mr Davis' relationship with Mrs Davis met the definition of '*family member'* under the *Family Violence Protection Act 2008* (Vic) (**FVPA**). The reported behaviour of Mr Davis towards Mrs Davis meets the definition of '*family violence'* in the FVPA.

[2] 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.
[3] 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-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community.

Specifically Mr Davis is reported to have perpetrated physical assaults on Mrs Davis, damaged property, perpetrated emotional and psychological abuse (i.e. threatening suicide), and used threatening and controlling behaviour.

19. An in-depth family violence investigation was conducted in this case and I requested materials from key service providers that had contact with Mr and Mrs Davis and their children prior to Mr Davis' death.

Family violence incident on 22 April 2018

20. On 22 April 2018, Mr and Mrs Davis reportedly had an argument during dinner. During this incident, Mr Davis is reported to have followed Mrs Davis to the kitchen where he grabbed her around the throat and pulled her to the ground. Mrs Davis also reported that Mr Davis had slashed her car tyre and that she had fled to her mother's house following the incident.

21. Police were contacted and upon their attendance, Mr Davis stated that he had been the victim of family violence in this instance. Following some disagreement between police, Mr Davis was ultimately identified as the primary aggressor and a Family Violence Safety Notice[4] was issued against him.

22. As Mr Davis appeared intoxicated at the time, police made arrangements for him to attend the following morning to interview him regarding the assault against Mrs Davis. Police allowed Mr Davis to remain at the Corio property because Mrs Davis had left and had informed police that she was intending to reside with her mother following this incident.

23. During the night, Mr Davis sent text messages to family members disclosing his intentions to end his life. The following morning, on 23 April 2019, Mr Davis' youngest son found Mr Davis unconscious and called an ambulance. Mr Davis was pronounced deceased at the scene.

[4] The police can apply for a family violence safety notice if someone needs immediate protection. The safety notice can protect the affected family members before an intervention order application is heard in court.

Adequacy of service support provided by Victoria Police to Mr Davis and his family

24. Following the incident on the 22 April 2018, police completed a VP Form L17[5] and made appropriate referrals to the Family Violence agency Bethany Community Response. Unfortunately, given that the suicide occurred the day after police attendance, there was no time for the referral agency to contact Mr Davis. The VP Form L17 for this incident noted that Mr Davis identified as Aboriginal or Torres Strait Islander and noted that he had a risk vulnerability of depression and mental health issues. The VP Form L17 did not note suicidal ideation or risk of suicide.

25. As stated above, Victoria Police had a number of historical interactions with Mr Davis in relation to his use of violence and mental health. A review of the documents provided to the Court indicates that police had previously recorded Mr Davis as having suicidal ideation and as having attempted suicide. Despite this, not all the VP Form L17 documents completed by police indicate his suicidal ideation as a risk and vulnerability area for Mr Davis. Given that the VP Form L17 completed on 22 April 2018 did not make any reference to Mr Davis' history of suicidal ideation or attempts, it appears that police did not consider this in their assessment or management of Mr Davis on this occasion.

26. Attending police officers confirmed that while compiling the VP Form L17 for the 22 April 2018, they did review the LEAP database. They noted seven previous family violence incidents involving Mr Davis, including two incidents where Mr Davis was identified as the Affected Family Member. Attending police officers stated that they identified three incidents on the LEAP database where suicide attempts had been marked as a risk factor, however they claimed that there was nothing found in the narrative of these incidents mentioning suicide.

27. A careful review of the police LEAP records provided to the Court does confirm that the narrative of incident of 27 July 2015 explicitly states that Mr Davis had '*a significant history of mental health issues, self harming/attempting suicide and abusive and controlling behaviours towards his wife and kid*s.' The narratives of the other two

[5] Victoria Police members who attend a family violence incident can make formal referrals to community agencies and/or reports to Child Protection by completing and forwarding a Victoria Police Risk Assessment and Risk Management Report (L17 referral).

matters from 27 February 2015 and 19 March 2013 reference Mr Davis's depression but do not reference suicidal ideation.

28. Attending police officers stated that upon conferring with Mr and Mrs Davis on the night of 22 April 2018, neither party mentioned suicidal ideation. Attending police officers determined that it was not appropriate to interview Mr Davis because he was intoxicated, and this was supported by the supervising attending Sergeant. The applicable *Code of Practice for the Investigation of Family Violence* and Victoria Police Manual at the time of this incident do not appear to have required police to make any further enquiries on this occasion.

29. The VP Form L17 is an important tool for family violence service providers to determine the urgency and scope of service they provide to victims and perpetrators of family violence.

30. If police had indicated that Mr Davis had a history of suicidal ideation and had previously attempted to suicide, responding agencies would have been able to cater their response to Mr Davis accordingly. A review of Mr Davis's LEAP and VP Form L17 records would have identified this risk factor and may have prompted police to enquire as to his mental wellbeing.

31. In the Inquest into the death of Luke Geoffrey Batty (COR 2014 0855), the then State Coroner, Judge Ian Gray, made the following recommendation:

> *I recommend that the Chief Commissioner of Police amend the Victoria Police Manual and other relevant operating instructions and if appropriate, the Code of Practice for the Investigation of Family Violence to require police officers:*
>
> *a) to provide all completed L17s relevant to an affected person to all relevant agencies operating in the family violence system;*
> *b) completing an L17 to review previous L17s relating to the same offender and where possible to contact the authors of previous L17s to ensure information regarding risk is shared and considered;*
> *c) to check LEAP prior to completion of an L17 to ensure relevant criminal history, or other matters capable of affecting the risk of assessment (including but not limited to other acts of violence with which the perpetrator has been charged, intervention orders obtained by other persons to which the perpetrator is the Respondent) are considered.*[6]

[6] COR 2014 0855, Inquest into the death of Luke Geoffrey Batty, 28 September 2015.

32. In response to recommendation 13b) and 13c), Victoria Police indicated that:

> *Section 3.1.1 of the Code of Practice requires members to consider the history of family violence when assessing risk of future family violence.*
>
> *While this implies an assessment of all previous L17s in order to consider the relevant history, this section of the Code of Practice may be amended to make explicit that police should review previous L17s and other factors that may affect risk.*
>
> *Victoria Police considers the recommendation to require police completing an L17 to contact all previous authors as unfeasible, adversely impacting response time and capacity. Additionally, previous authors may have limited or inaccurate recollection of incidents, given the volume of family violence incidents many police officers respond to.*
>
> *As an alternative to requiring police officers to contact previous authors of L17s, Victoria Police will investigate whether improvements can be made to the quality and depth of information recorded in L17s*.[7]

33. On 29 March 2016, the Victorian Royal Commission into Family Violence (**The Royal Commission**) handed down their report and recommendations. Recommendations 42-44 are relevant to the above coronial recommendation made in the finding into the death of Luke Geoffrey Batty. These recommendations state that Victoria Police undergo further and comprehensive training and establish a Family Violence Centre of Learning. Furthermore, recommendation 44 suggests that Victoria Police should work to ensure compliance with the Code.

34. Significant reforms following the Royal Commission in the family violence sector and among police responses to family violence mean that responding agencies are now required to comply with additional requirements when completing a VP Form L17 in response to a family violence incident.

35. I requested an update from Victoria Police to confirm what specific improvements were made to the L17 process and received a response from Victoria Police[8] stating that a new VP Form L17 Family Violence Report has been devised '*based on factors that coronial findings, international research, LEAP data and the Multi Agency Risk Assessment and Management framework indicate are predictors of future family violence*.'

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[7] Victoria Police response to recommendations arising from the Inquest into the death of Luke Geoffrey Batty.

[8] Victoria Police Response received 3 January 2020

36. Victoria Police confirm that the new police policy requires 39 questions be asked in the VP Form L17, 14 of which are scored, all 39 questions are to be asked every time a report of family violence is taken. The scores help the police officers determine risk, with medium risk matters to be case managed.

37. New police policies and procedures indicate that Family Violence Liaison Officers are also now responsible for providing quality assurance by monitoring and reviewing VP Form L17 reports and for reporting on VP Form L17 compliance rates.[9] Family Violence Training Officers (currently 21 Senior Sergeants located within each Division across the state) are also required to '*assist their FVIU*[10] *in addressing inadequate Family Violence Reports (L17) submitted by frontline or other areas. This includes incorrect scoring, poor narrative, override issues as well as poor or inadequate response to the incident. Family Violence Training Officers will address the deficiencies with the members involved and coach/mentor them to ensure future compliance with policy and procedure*.'[11] It is hoped that these changes will assist in ensuring that attending police officers complete VP Form L17s to accurately reflect the level of risk of family violence.

38. Victoria Police submit that further initiatives have also been implemented including the information sharing of the VP Form L17 with support agencies, including Orange Door[12] safety and support hubs through the Department of Health and Human Services portal, which also hold historical VP Form L17s.

COMMENTS

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

1. I endorse and commend Victoria Police's reforms to their guidelines which highlight the significance mental health plays in family violence. As a result of the *2016 Mental Health Review*, Victoria Police has created and implemented organisation-wide

[9] Victoria Police, Practice Guide- Family Violence Roles and responsibilities, 3 & 4.
[10] Family Violence Investigation Unit – A specialist unit within Victoria Police that responsible for the investigation and coordination of all family violence related incidents across the police service LGAs.
[11] Victoria Police, Practice Guide- Family Violence Roles and responsibilities, 11-12.
[12] The Orange Door is a new way for people experiencing family violence, or who need assistance with the care and wellbeing of children and young people, to access the support they need. They operate across Victoria in various locations, more information can be found online at: https://www.vic.gov.au/contact-orange-door

mandatory online training to increase mental health literacy, de-stigmatise mental health issues, and create a culture where Victoria Police members feel safe and able to reach out for support and provide support. A second component of this training was rolled out in 2020 called '*Responding to Mental Health Incidents'* and is mandated for all frontline police. The training was designed in collaboration with Ambulance Victoria and aims to specifically address how best to respond to incidents involving a person with mental health issues. The training addresses safety for all parties (police, paramedics and the patient) and also includes guidance on referring patients to mental health services.

2. I further endorse the recently updated *Victoria Police Practice Guide - Family Violence* indicates that members should employ several suggested strategies to assist or better identify perpetrators with mental health issues. This can include making a referral to a CAT Team or making further enquiries with the Affected Family Member or Respondent regarding the Respondent's mental health. Further the V*ictoria Police Practice Guide - Family Violence Priority Community Response* highlights the importance of considering mental health issues when investigating family violence. It includes several guidelines including that '*current mental health issues of either party must take priority'* and further that '*police should make a continual risk assessment of the person's mental health*.'

3. I also endorse and commend the reforms to Victoria Police's policies and procedures which acknowledge the importance of cultural sensitivity around family violence. The *Victoria Police Practice Guide – Family Violence Priority Community Response* now provides a specific response to family violence for persons from the Aboriginal and Torres Strait Islander community. These guidelines suggest a framework of understanding for members when responding to family violence incidents involving the Aboriginal and Torres Strait Islander community. For example, providing an understanding of the reluctance of the Aboriginal and Torres Strait Islander community to trust police given historic and current disadvantage and discrimination and lack of culturally appropriate support services. This document recommends providing the option for referrals to Aboriginal and Torres Strait Islander services or mainstreams services to parties, and contains practice suggestions such as gaining trust, enquiring whether all parties involved identify as Aboriginal and Torres Strait

Islander , facilitating an integrated response with other services and understanding that the parties may not wish to access Aboriginal and Torres Strait Islander services. It also provides additional resources for members to refer to in relation to the Aboriginal and Torres Strait Islander community.

FINDINGS

1. I find that Hilton Davis, of Torres Strait Islander descent, born 19 March 1968, died on 23 April 2018 at 16 Moyston Grove, Corio, Victoria.

2. I find that Hilton Davis had a complex medical history of mental ill health, including a history of suicidality, relationship difficulties and alcoholism.

3. I find that Hilton Davis received medical services from Corio Bay Medical Centre proximate to the time of his death and that this service was reasonable and appropriate in the circumstances.

4. I accept and adopt the cause of death ascribed by Dr Matthew Lynch and I find that the cause of Hilton Davis' death was mixed drug (oxycodone and methadone) and ethanol toxicity in circumstances where I find that he intended to end his own life.

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

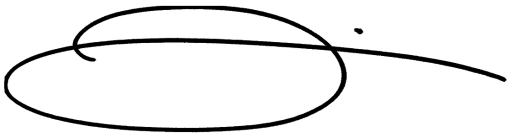
I direct that a copy of this finding be provided to the following:

Ms Snjezana Davis
Senior Sergeant Matthew Watts, Civil Litigation Unit, Victoria Police

Ms Annette Lancy, Acting Chief Executive Officer, Family Safety Victoria

Detective Senior Constable Brett Hampton

Signature:



AUDREY JAMIESON

CORONER

Date**: 16 November 2020**