IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 4185

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**Mr BT[1]**
Date of birth:	**6 January 1991**
Date of death:	**22 August 2018**
Cause of death:	**Hanging**
Place of death:	[redacted] **Bundoora, Victoria 3083**
Catchwords:	**Family violence, suicide, unexpected death**

Amended pursuant to s.76 of the Coroners Act 2008 (Vic) on 10 November 2020 by order of Coroner Audrey Jamieson. Paragraph 59 was amended to de-identify the name of a family member.

[1] 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.

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

1. Mr BT was a 27-year-old man who lived with his parents, at [redacted], Bundoora, Victoria 3803. Mr BT was a carpenter by trade and had two young children from two former relationships. Mr BT had been diagnosed with depression from an early age and had a history of suicidality and suicide attempts.

2. On 21 August 2018, at approximately 11.00pm, Mr BT's parents returned home after an evening out and discovered Mr BT in the backyard hanging from the railings in the patio area. Mr BT was found with a blue air hose tied around his neck and was reportedly unconscious and not breathing. Mr BT's parents called emergency services whilst attempting to resuscitate him, paramedics arrived shortly after and declared Mr BT deceased at 12.10am on 22 August 2018.

3. Mr BT'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 and unnatural.

INVESTIGATIONS

Forensic pathology investigation

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

5. Dr Baber commented that the external examination of the body showed findings in keeping with the clinical history. The postmortem CT scan did not evidence anything significant of note.

6. Postmortem toxicology did evidence the presence of Desmethylvenlafaxine which is a metabolite of Venlafaxine, used in the treatment of depression. The detected amounts were consistent with therapeutic concentration levels.

7. Dr Baber ascribed the cause of death to hanging.

Police investigation

8. Upon attending the Bundoora premises after Mr BT's death, Victoria Police members observed Mr BT lying in the rear yard of the property. Police members continued to process the scene and cut down the ligature believed to have been used by Mr BT.

9. First Constable (FC) Jordan Green was the nominated Coroner's Investigator.[2] At my direction, FC Green investigated the circumstances surrounding Mr BT's 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 BT had a history of suicidality and family violence in his past relationships with his last partner, Ms SF and his former partner Ms SE. Both relationships were marred by Mr BT's suicidality and mental health issues.

11. When Mr BT was 17 years old, one of his close friends died in a motorcycle accident. Mr BT's parents reported that this had a profound effect on Mr BT.

12. In 2011, Mr BT attempted suicide for the first time and was subsequently diagnosed with clinical depression. Mr BT participated in counselling for approximately six months and sought further assistance for his mental health on several occasions following this initial diagnosis. Mr BT was first prescribed anti-depressants at this time following his initial diagnosis of clinical depression.

13. In 2010, Mr BT began a relationship with Ms SE and they had a daughter together, KRB, born on 23 October 2012.

14. Ms SE reported that Mr BT began using methylamphetamines around the time of her pregnancy with KRB. Mr BT's drug use continued following KRB's birth and on 20 December 2012, Ms SE advised him that she wanted to separate. After a period of separation in 2012 they resumed their relationship before ultimately separating in 2015.

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[2] 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. Following his separation from Ms SE, Mr BT initiated family law proceedings seeking to have contact with KRB. During these proceedings, Mr BT met his new partner, Ms SF.

16. Mr BT and Ms SF had one child together,, who was born on 25 July 2017. Mr BT and Ms SF also cared for Ms SF's biological child, LF, born on 25 April 2013, and they had care of KRB five nights per fortnight. Ms SE credits Ms SF's relationship with Mr BT for the increased contact Mr BT had with KRB, noting that '*before her, he couldn't care for KRB on his own.*'

17. In the early stages of Mr BT's relationship with Ms SF's relationship, he accessed mental health treatment, ceased using methylamphetamines and returned to work. Mr BT and Ms SF purchased and moved into a property in Beveridge.

18. Mr BT's niece TX, came into their care in late 2017. TX suffered from mental health issues which exacerbated the stress on Mr BT and Ms SF's relationship as they already had several children in their care.

19. In March 2018, Mr BT and Ms SF began to use methylamphetamines, Ms SF reported her use was sporadic however Mr BT's was sustained. The relationship between Ms SF and Mr BT began to breakdown and Mr BT moved out to live with his parents after a family violence incident on 7 August 2018.

Family violence investigation

20. As Mr BT's death occurred in circumstances of recent family violence, I requested that the Coroners' Prevention Unit **(CPU)**[3] examine the circumstances of Mr BT's death as part of the Victorian Systemic Review of Family Violence Deaths **(VSRFVD)**.[4]

21. Mr BT's past relationships with Ms SE and Ms SF met the definition of de facto partner and '*family member*' under the *Family Violence Protection Act 2008* (Vic) **(the FVPA)**. The reported behaviour of Mr BT towards both his former partners meets the definition

[3] 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.
[4] 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.

of '*family violence*' in the FVPA, specifically in the form of damaging property, emotional and psychological abuse (threatening suicide), threatening behaviour and controlling behaviour.

22. An in-depth family violence investigation was conducted in this case and I requested materials from several key service providers that had contact with Mr BT, Ms SE, Ms SF and their children prior to Mr BT's death.

Family violence towards Ms SE

23. On 21 December 2012 Mr BT purportedly attended where Ms SE was residing, took KRB from her, attended a local train station and threatened to suicide by jumping in front of a train whilst holding KRB. Police were called to this incident and KRB was returned without any physical injury.

24. Following this incident, the parties reunited. Ms SE reported that '*it was easier to be with him than to leave him.*' The relationship continued until March 2015 when they separated but continued to live together. Ms SE reported that Mr BT used coercive control in their relationship and was psychologically abusive.

25. Whilst Mr BT and Ms SE were separated but living together, Ms SE was the primary carer of KRB. On one occasion in April 2015, KRB was left in the care of Mr BT during which time he fell asleep. This caused an argument between Mr BT and Ms SE following which Mr BT attempted to hang himself but Ms SE stopped him.

26. On this occasion Ms SE attempted to contact the Crisis Assessment and Treatment Team (**CAT Team**) but did not contact Victoria Police because she was worried about drug paraphernalia being located and she did not want it to affect her care of KRB.

27. The volatility between Ms SE and Mr BT carried over to the next day when Mr BT was reportedly verbally abusive, damaged property and again threatened suicide.

28. Following their separation in 2015, Ms SE recalled that Mr BT said, '*he would shoot me [sic] or that he would beat the fuck out of me [sic] if I tried to take KRB away.*' Ms SE kept notes of the incidents that occurred and provided this documentation to Victoria Police following the fatal incident.

Family Violence towards Ms SF

29. On 17 June 2018 police attended a family violence incident between Ms SF and Mr BT. On this occasion Ms SF had requested that Mr BT leave following a verbal argument and he had refused. Ms SF's sister called Ambulance Victoria and Victoria Police because Ms SF had reported that she was having an anxiety attack and had trouble breathing. Police and Ambulance Victoria attended however Ms SF sent the Ambulance away. Police made formal referrals for both parties and Mr BT left the house to stay with his parents.

30. From that point on Mr BT resided intermittently between his mother's house and with Ms SF.

31. On 19 June 2018, following a conversation about the breakdown of his relationship with Ms SF, Mr BT reportedly engaged in deliberate self-harm by drinking peroxide. Ms SF discovered this and called an ambulance against Mr BT's wishes. An ambulance took the parties to the Northern Hospital however the couple left before obtaining any treatment.

32. The following day Mr BT engaged with his General Practitioner, Dr Mitrokli, who increased his dosage of anti-depressants and referred him to a psychiatrist with an appointment scheduled for five weeks later.

33. On 27 July 2018, Mr BT threatened suicide again following a discussion with Ms SF regarding the end of their relationship. Following this threat Mr BT went to the Beveridge train station and stood on the train tracks. Ms SF and her sister attended at the train station and were able to convince him to remove himself from the train tracks.

34. Following this incident, Ms SF took Mr BT to see General Practitioner Dr Aughsteen. Mr BT's antidepressant dosage was increased, he was assessed over the telephone by the CAT Team and told that they would be in contact with him the following Monday, 30 July 2018. It is unclear from records provided to the Court whether Mr BT had contact with the CAT Team on that occasion.

35. On 7 August 2018, Mr BT and Ms SF had a verbal argument and Mr BT became verbally abusive and destroyed property. Victoria Police attended and interviewed Ms

SF and Mr BT was arrested and interviewed. Police obtained a Family Violence Intervention Order (FVIO) to protect Ms SF and charged Mr BT with property damage. Victoria Police LEAP[5] records from this incident indicate that Ms SF reported that '*there have been previous incidents of family violence that she did not report to police*' and that Mr BT had mental health issues. The FVIO issued by police excluded Mr BT from the Beveridge property.

36. Mr BT and Ms SF continued to have contact with one another after this incident.

37. On 19 August 2018 Mr BT again threatened to suicide following discussions with Ms SF about their separation. Ms SF was concerned about KRB and TX, who were in Mr BT's care on this occasion, and arranged for Ms SE to come and collect KRB. Ms SE then spoke with Mr BT who agreed she should collect KRB. When Ms SE arrived, Mr BT had already left the property leaving KRB and TX alone.

38. Department of Health and Human Services – Child Protection (**Child Protection**) were notified and their engagement is discussed below. Mr BT indicated to Ms SF via text message that he was going to suicide and then turned his mobile phone off.

39. On the evening of 20 August 2018, Ms SF and Mr BT fought over the telephone. Ms SF told Mr BT that his property was out on the lawn and requested that he come and collect it.

40. On 21 August 2018, Mr BT attended Ms SF's home with police, due to the FVIO that was still in place, to collect his personal property.

41. Ms SF stated that while Mr BT was at the premises with the police, they had an argument about personal property, the argument became heated and the police told Mr BT to go outside. This argument was not reflected in the police statements, which noted only that Mr BT had wanted the television but was informed by them that this would need to be settled at a later date.

42. Police officers noted that Mr BT was not happy that Ms SF had left his clothes outside in the rain and enquired as to whether this would be grounds for him to obtain an FVIO

[5] The Law Enforcement Assistance Program (LEAP) online database is fully relational and stores information about all crimes bought to the notice of police as well as family incidents and missing persons. It also includes details on locations and persons involved.

against Ms SF. The police reported that *'there were no issues or arguments while [they] were there and [they] had no welfare concerns for either party during the property exchange*.' The police waited for Mr BT to leave before they left the residence.

Adequacy of service support provided by agencies to Mr BT and his family

Victoria Police

43. On 7 August 2018 police attended a family violence incident between Mr BT and Ms SF, as described above. On this occasion Ms SF made a report of verbal abuse and property destruction and indicated to police that there had been previous unreported family violence.

44. To prevent the family violence escalating, attending police officers applied for a FVIO protecting Ms SF. The police were informed by Ms SF that Mr BT had mental health issues, and police recorded these concerns in LEAP. Ms SF also informed the police that she had tried to separate from Mr BT the previous week and that he '*got upset and went to train lines in Beveridge in order to self-harm*.' Police also recorded this suicide attempt in LEAP. Police arrested and interviewed Mr BT and he was given a court date of 13 August 2018 in relation to the FVIO. Police also made formal referrals for support for the parties via the VP Form L17.[6] It is understood that the police also made a referral to Child First.

45. The CPU family violence team note that police did not accurately complete the VP Form L17 for this incident of family violence. While the narrative on LEAP contained information regarding Mr BT's mental health, his history of mental health issues and suicide attempt, police did not list these in the VP Form L17 risk factors. Rather these were recorded as unknown.

46. 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.

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[6] 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).

47. The CPU family violence Team also note that significant reforms 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. 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 police officers determine risk, with medium risk matters to be case managed.

48. The L17 Family Violence Portal (the Portal) was developed by the Department of Health and Human Services in partnership with Victoria Police to replace the facsimile-based L17 referral process. The Portal receives family violence reports from Victoria Police (by way of L17 forms), identifies which services should receive this information and makes the referral available to the relevant services. On 27 November 2019, the Portal was upgraded to allow for increased capability. The Portal can now:

    a. receive updates to L17 referrals from Victoria Police

    b. display updates to L17 referrals from Victoria Police; and

    c. bring updates to Portal users' attention for review and acknowledgement

49. In addition to recent changes in the L17 process, in late 2018, Victoria Police also introduced the 'Information and Support Referral' brochure (enclosed), which is to be given to respondents in all cases where either criminal or civil action is being taken by Victoria Police in circumstances of family violence. The brochure provides information on police investigations, court processes, considerations for legal support and counselling and support service information. It has recently been translated into 21 languages.

50. On 21 August 2018 police attended the Beveridge property with Mr BT to assist him with retrieving personal property as the FVIO granted following the incident on 7 August 2018 prevented him from attending the property without police present.

51. There is some inconsistency between the police member's statements in relation to this property retrieval and a statement provided by Ms SF relating to this occasion. Ms SF reported that during this attendance, she and Mr BT argued and that it became '*heated.*'

Police stated that Mr BT had expressed his frustrations at not being allowed to take property which was subject to dispute, and also with the way his personal property had been left outside. However, the two police officers that were present stated that there had been '*no issues, argument or dispute while the police were present*,' and further both officers stated that '*there were no identifiable welfare concerns*.'

52. The attending police officers do not indicate in their statements whether they expressly asked Mr BT about his current mental state on this occasion, however they both noted that they assessed that there were no welfare concerns. It is also unclear whether they reviewed Mr BT's LEAP records, which contained a person warning flag indicating that he had mental health issues and a heightened risk of suicide, prior to assisting with the property exchange.

53. There is nothing in the available material which suggests that Mr BT behaved or spoke in a way on this occasion that indicated that he had suicidal ideation. In the absence of any indicators that Mr BT was a danger to himself or others, the attending members were not required to actively enquire as to Mr BT's mental health state on this occasion.

54. Mr BT's presentation did not appear to warrant action under section 351 of the *Mental Health Act 2014* and supportive action by police on this occasion would have been to provide Mr BT with referrals for mental health support. Such referrals may not have been particularly necessary or effective given Mr BT had already linked in with his general practitioner for mental health support and with men's services through Nexus Primary Health.

Department of Health and Human Services - Child Protection

55. The CPU family violence team requested and examined records provided by the Department of Health and Human Services – Child Protection services (**Child Protection**) in relation to KRB and KB. These records indicate that there were three historical child protection notifications with respect to KRB.

56. The first report occurred on 27 December 2012 when KRB was two months old. The file note from this report indicates that Victoria Police were contacted by Ms SE with concerns for the Mr BT's mental health after he became erratic during an argument over care arrangements. Child Protection determined that no further protective involvement

was required. The report states that '*there were no concerns identified in this matter, no violence or threats.*'

57. The second Child Protection report was made on 27 May 2015. This report was made following conflict between Mr BT and Ms SE regarding care arrangements of KRB. On this occasion Child Protection found there was no significant risk of harm to the child that would warrant further action, that the mother was being proactive and would seek a FVIO and engage in mediation to resolve care arrangements.

58. The third notification related to an event of family violence between Mr BT and Ms SE on 27 November 2015. This involved a verbal argument over care arrangements. This argument occurred at a childcare centre when Mr BT attended to collect KRB although there was no longer an arrangement for him to do so. Police were called on this occasion. No action was taken by Child Protection in relation to this matter because police had made formal referrals to community support organisations by way of a VP Form L17.

59. On 7 August 2018, Child Protection received another notification raising concerns that Mr BT posed a risk to his children and his niece TX. During this notification, Ms SE reported Mr BT's drug usage, recent suicide attempts, family violence episodes and a recent family violence incident that had been witnessed by KRB. Ms SE reported Mr BT's mental health issues and her belief he was not taking medication. Ms SE also reported that KRB had been neglected by Mr BT and had previously been left in the care of her young cousin.

60. Following this report, Child Protection contacted Ms SF, who confirmed that Mr BT was suffering from depression, had been aggressive and that the police had issued an FVIO. Child Protection then spoke to Mr BT's mother who confirmed that Mr BT was '*not doing well.*' Child Protection also confirmed with Victoria Police that there was a current FVIO in place against him, although it is unclear whether it was Ms SF and the children named on the order or only Ms SF.

61. Police further confirmed Mr BT had one criminal charge pending, and four previous family violence incidents they had attended. Victoria Police also relayed to child protection that Mr BT had a red flag for suicide/self-harm and a stable psychiatric condition.

62. It is understood that information regarding the incident on the 7 August 2018 was also sent to TX's Child Protection case manager and team manager, raising concerns regarding Mr BT suitability as carer. A file note suggests that Ms SF had requested that TX go to her grandparent's house where Mr BT was residing, however at the time of making the note they did not know where she was residing.

63. With respect to KRB and KB, Child Protection concluded that their further involvement was not required. They acknowledged the concerns that had been raised however noted that both the mother of KRB and the mother of KB and LB were acting protectively. In Ms SF's case she had reported the family violence matter to the police and had obtained an exclusionary FVIO against Mr BT. Child Protection had confirmed with police that they were aware of the family violence that had been occurring, and police confirmed that they had applied for a FVIO. Child Protection also had confirmation from police that they had flagged Mr BT as a suicide risk.

64. It does not appear from the Child Protection records of both KRB and KB, that Child Protection spoke directly with Mr BT. Rather, Child Protection confirmed with Mr BT's mother that he was residing with her. File notes do not indicate whether Child Protection knew if Mr BT was receiving treatment for his mental health issues, or even whether they had enquired in relation to this.

65. It is arguable that Child Protection did not adequately establish the safety of the KRB, KB and LB prior to closing this report. Child Protection did not seek a copy of Ms SF's FVIO and do not appear to have clarified whether KB and LB were included as affected family members on the FVIO. Instead, the file states that '*the mother has obtained a full IVO against him, mitigating the children's risk of further harm.*' Further, Ms SE did not have a FVIO protecting KRB at the time of Child Protection's closure. Instead, child protection noted that Ms SE was seeking legal advice regarding her next steps and ceased their involvement without knowing what access Mr BT was going to have to his children. Child Protection appear to have made an assumption that because Mr BT was residing with his mother that his mother would be overseeing any child contact, however Child Protection closed the file without making any direction with respect to this.

66. It is arguable by not enquiring into or making a direction as to the type of contact Mr BT was to have with the children and his niece, Child Protection left the four children

vulnerable. Given Mr BT's history of suicidal ideation, his current depression and following the recent break down of the relationship with Ms SF, Child Protection appeared to inadequately assess the risk to the children. However further action by Child Protection in this instance would have been more likely to increase the stressors Mr BT was experiencing, rather than reduce them.

67. Following Ms SE reporting that Mr BT had mental health issues, Child Protection sought confirmation from Ms SF, Mr BT's mother, and the police. They confirmed that Victoria Police had flagged Mr BT's mental health issues, and suicidal ideation, however, they did not determine whether he was receiving treatment, and this is something they should have considered prior to closing the files. Given that Mr BT was linked in with a General Practitioner, psychiatrist and Nexus Mental Health services, this information would not likely have resulted in a different outcome with respect to their closure of the file.

68. Whilst the CPU family violence team noted concerns with respect to the actions taken to protect the children in this matter, those concerns were in respect to the safety of the children as opposed to Mr BT. Child Protection appear to have made sufficient enquiries with respect to Mr BT's mental health issues and whilst they did not enquire as to whether he was linked in with mental health support prior to closure of their engagement, it is unlikely to have been preventative in this case given Mr BT was already linked in with mental health services.

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 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. Victoria Police policies and procedures currently indicate that Family Violence Liaison Officers are responsible for providing quality assurance by monitoring and reviewing VP Form L17 reports and for reporting on VP Form L17 compliance rates. Family Violence Training Officers (currently 21 Senior Sergeants located within each Division across the state) are also required to assist their Family Violence Investigation Unit 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 also address the deficiencies with the members involved and coach/mentor them to ensure future compliance with policy and procedure. It is hoped that these changes will assist in ensuring that attending police officer's complete VP Form L17s to accurately reflect the level of risk of family violence.

4. The investigation has identified that Mr BT had proximate contact with key services prior to his death including Child Protection and Victoria Police. A thorough review of the Victoria Police service contact identified areas for improvement in their processes which are reflected in numerous reforms outlined above.

FINDINGS

1. I find that Mr BT, born 6 January 1991, died on 22 August 2018 at [redacted], Bundoora, Victoria 3083.

2. I find that Mr BT had a complex medical history of mental ill health, including a long history of suicidality, relationship difficulties and substance abuse.

3. I find that Mr BT received medical services from Wallan Medical Centre and Nexus Primary Health proximate to the time of his death and that these services were reasonable and appropriate in the circumstances.

4. I accept and adopt the cause of death ascribed by Dr Yeliena Baber and I find that the cause of Mr BT's death was hanging 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 RW

Mr DB

Dr Neil Coventry, Office of the Chief Psychiatrist

Dr Raju Lakshmana, Goulburn Valley Area Mental Health

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

Ms Jacinta Gibbs, Victorian Government Solicitor's Office

First Constable Jordan Green

Signature:

AUDREY JAMIESON

CORONER

Date: **10 November 2020**