IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 001858

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Audrey Jamieson
Deceased:	Mr A[1]
Date of birth:	10 February 1968
Date of death:	13 April 2019
Cause of death:	1(a) HANGING
Place of death:	Bannockburn, Victoria
Keywords:	Family violence; suicide

Amended pursuant to s.76 of the Coroners Act 2008 (Vic) on 12 October 2021 by order of Coroner Audrey Jamieson. Paragraphs 19 and 34 were amended to correct the description of the events. Footnotes 2,6, 39, 43 and 45 were updated to de-identify medical services.

[1] The names of the deceased person and their family members have been redacted and replaced with pseudonyms to protect their identity.

INTRODUCTION

1. On 13 April 2019, Mr A was 51 years old when he was found hanged from a tree in bushland near Old Base Road, Bannockburn, Victoria. At the time of his death, Mr A was recently separated from his wife, Mrs B and their three children.

2. Mr A was involved in a motor vehicle accident when he was 12 years old and suffered a head injury resulting in a mild intellectual disability.[2] This injury was thought to affect the way that Mr A communicated with people and was suspected to worsen his experience of anger.[3]

3. Mr A married Mrs B in 1997 and they had three children together. After Mr A was married, he had two further accidents whilst at work. One of these accidents resulted in a second head injury.[4] It is unclear from the available material whether this injury had any long-term effects on Mr A.

4. Around 2008, Mr A began to demonstrate aggressive behaviours towards work colleagues and was placed on medication '*for his temper issues*.'[5] Information from Mr A's health care provider indicates that Mr A suffered from anxiety and was prescribed Effexor to manage these symptoms up until his death.[6]

5. It was alleged by Mrs B that her relationship with Mr A began to deteriorate in October 2018 when Mr A became '*controlling and possessive wanting to know where I was and who I was with… His relationship with the children had also deteriorated'*.[7]

6. On 28 December 2018, Child Protection received a notification in relation to Child A, alleging that Mrs B and Mr A had verbally abused Child A and called her a derogatory name when she requested to stay with her boyfriend.[8] The report also alleged that Mr A may have '*physically assaulted Child A by hitting her with the back of [his] hand causing a bloody nose'*.[9] The report also alleged that Mr A would throw Child A to the ground when she would '*not do the dishes'*.[10] This notification was ultimately closed at intake stage after it was assessed that there was insufficient information to investigate the allegations further.[11]

---

[2] Deidentified Medical Clinic, Medical Records of Mr A, 5.
[3] Coronial Brief, Statement of Mrs B, 18.
[4] Coronial Brief, Statement of Mrs B, 18.
[5] Ibid, 18-19.
[6] Deidentified Medical Clinic, Medical Records of Mr A, 4.
[7] Ibid, 19.
[8] Child and Family Services Ballarat, Case Records of Mr A, 8
[9] Ibid.
[10] Ibid.
[11] Ibid.

7. On 24 February 2019, Victoria Police attended an incident of family violence purportedly perpetrated by Mr A towards Mrs B and Child A.[12] Mrs B reported that the previous day Mr A had been verbally abusive towards Child A.[13] Mrs B also reported that Mr A then proceeded to verbally abuse Mrs B and raised his hand to her, making her believe that she was going to be struck. When Mrs B returned home the following day, Mr A allegedly '*started to abuse [Mrs B]'*[14] *and 'threatened to damage the car'*[15] but was intercepted by their son. Mr A then allegedly grabbed Mrs B by the throat or chest and raised his arm to hit her, however Mrs B was able to flee the home with her children before this occurred.[16]

8. Victoria Police subsequently issued a Family Violence Safety Notice and applied for a Family Violence Intervention Order (**FVIO**) which was granted in protection of Mrs B and the children. This FVIO included conditions which prohibited Mr A from residing or having contact with Mrs B and their children.[17] Mr A's firearms were also removed and he was charged with two counts of unlawful assault and threat to destroy property.[18]

9. On 27 February 2019, the Geelong Magistrates Court heard an application to vary the FVIO lodged by Mr A to allow him to see and access his children, this was refused and subsequently Mr A lodged an application for a re-hearing set for 26 March 2019.[19]

10. On 26 March 2019, Mr A was supported by a duty lawyer from Victoria Legal Aid at Geelong Magistrates Court however the re-hearing application was withdrawn.[20]

11. On 9 April 2019, Victoria Legal Aid sent a letter to Mr A confirming that the '*intervention application has been withdrawn'* but without any information confirming that the existing FVIO was still in place protecting Mrs B and the children.[21]

---

[12] Orange Door, *1. Original L17 240219*, 6.
[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Ibid; Coronial Brief, Brief of Evidence for 25 February 2019 – Statement of Mrs B, 53.
[17] Orange Door, *1. Original L17 240219*, 6; Coronial Brief, Intervention Order, 74-75.
[18] Coronial Brief, Charge Sheet, 67-68.
[19] Coronial Brief, *Background Facts and Circumstances*, 8.
[20] Coronial Brief, *Letter from Victoria Legal Aid 9 April 2019*, 79.
[21] Ibid.

THE CORONIAL INVESTIGATION

12. Mr A's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

13. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

14. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

15. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr A's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

16. This finding draws on the totality of the coronial investigation into the death of Mr A including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[22]

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

Circumstances in which the death occurred

17. On 13 April 2019, Mr A left a voicemail message for Mrs B stating '*they told me that I am allowed to come home today'*.[23] Mr A then returned to the family home on the same day at approximately 10.10am, but was unable to enter the property as the locks had been changed. At

[22] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[23] Coronial Brief, Statement of Mrs B, 20.

the time of Mr A's attendance, Mrs B and their children were not home and Mr A requested that she return home to let him inside.[24]

18. Upon receipt of these messages, Mrs B contacted police and advised them that Mr A was at the family home.[25] Mr A subsequently spoke with police and informed them that he had a '*letter from Victoria Legal Aid telling him that the FVIO had been dismissed and that he could return to the family home.*'[26] Victoria Police advised Mr A that the FVIO was still in place and that he was not allowed to attend the property. Mr A was also encouraged to speak with a police member when the police member began his shift to review the letter from Victoria Legal Aid.[27]

19. At 1:16pm, Mrs B contacted police again and advised that Mr A had left her a voicemail stating; *"'I love you, I love the kids, If I can't be with you and I can't be with the kids I have to end my life. Sorry*."[28]

20. Following attempts to contact Mr A and triangulate his phone, Mr A was discovered by police, hanging from a tree at approximately 3.52pm.[29] Mr A was pronounced deceased on scene by attending paramedics.

Identity of the deceased

21. On 15 April 2019, Mr A, born 10 February 1968, was visually identified by his wife, Mrs B who signed a formal Statement of Identification.

22. Identity is not in dispute and requires no further investigation.

Medical cause of death

23. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 15 April 2019, reviewed a post-mortem computed tomography (CT) scan and the Police Report of Death, Form 83. Dr Burke provided a written report of his findings dated 16 April 2019.

---

[24] Ibid.
[25] Ibid.
[26] Coronial Brief, Statement of M Tyrrell, 27.
[27] Ibid.
[28] Email to the Court from Mrs B dated 11 October 2021.
[29] Coronial Brief, Statement of C Malthouse, 36.

24. The external examination revealed a ligature abraded injury around[30] the neck, consistent with the history provided in the Police Report of Death, Form 83. There was no evidence of defensive or offensive injuries indicative of suspicious circumstances.

25. Toxicological analysis of post-mortem blood samples identified the presence of Venlafaxine and Desmethylvenlafaxine at therapeutic levels used to treat depression.

26. Dr Burke provided an opinion that the medical cause of death was 1 (a) HANGING.

FURTHER INVESTIGATIONS

27. As Mr A's death occurred in circumstances of recent family violence, I requested that the Coroners' Prevention Unit (**CPU**)[31] examine the circumstances of Mr A's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[32]

28. Mr A's relationship with Mrs B met the definition of '*family member'* under the *Family Violence Protection Act 2008* (Vic) (**FVPA**). The reported behaviour of Mr A towards Mrs B meets the definition of '*family violence'* in the FVPA. Specifically, Mr A was reported to have perpetrated physical assaults on Mrs B, perpetrated emotional and verbal abuse, and used threatening and controlling behaviour.

29. 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 B and their children prior to Mr A's death.

History of family violence between Mr and Mrs B

30. Mr A allegedly perpetrated sexual, physical, verbal and emotional abuse towards Mrs B in the final years of their relationship. Mrs B's children also bore witness to the violence and were direct victims of emotional, verbal and physical violence perpetrated by Mr A.

---

[30] CB, Medical Examination Report of Dr Malcolm Dodd

[31] 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.

[32] 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.

31. Mrs B disclosed to the Bethany Community Support family violence program that Mr A first began to use violence towards her and the children two years prior to his death and that she was very fearful of Mr A.[33]

32. Mrs B also reported that Mr A acted in a jealous and controlling manner towards her, had physically assaulted her in the past and had threatened her with his firearm.[34] Mr A also allegedly told his children that he intended to kill Mrs B.[35]

33. Following the issuance of the FVIO on 26 February 2019, Mr A repeatedly breached the FVIO by sending text messages to Mrs B and calling her. These breaches caused Mrs B significant fear but were not reported to police as Mrs B stated that she did not feel comfortable doing so.[36]

34. Whilst all of Mr A's children were allegedly victims of abuse, Mrs B advised that Child A had experienced significantly more violence from Mr A, alleging that he targeted insults at her and frequently told her that he wished she had not been born.[37] Mrs B also reported that she was aware of three to four occasions in which Mr A had physically assaulted Child A and that she was fearful that Mr A would kill Child A, describing one occasion when Mr A was driving the children home from school and punched Child A in the face, causing her nose to bleed.[38]

Adequacy of service support provided by Mr A's treating GP

35. Mr A regularly attended with General Practitioners (**GP**) at his local medical clinic between 26 April 2017 and the time of his death.[39]

36. On 1 March 2019, Mr A met with his GP, and disclosed that he had been '*accused of domestic violence'*,[40] that he had hit his daughter on the nose and that he had pushed Mrs B and '*punched the car'*.[41] During this consultation the GP completed a General Practice Management Plan and increased Mr A's antidepressant medication from 75mg to 150mg.[42] No further action appears to have been taken in relation to his disclosures of family violence on this occasion.

---

[33] Bethany Community Support, *Summary Details for Mrs B,* 94.
[34] Ibid; Orange Door, *4. TRAM Mrs B*.
[35] Bethany Community Support, *Summary Details for Mrs B*, 105.
[36] Ibid, 103.
[37] Orange Door, 3. CRM Records for *Mrs B*, 10.
[38] Email to the Court from Mrs B dated 11 October 2021.
[39] Deidentified Medical Clinic, Medical Records of Mr A.
[40] Ibid, 11.
[41] Ibid, 11.
[42] Coronial Brief, Statement of R Smith, 43-44.

37. On 21 March 2019, Mr A had an appointment with his GP for the purposes of seeking a Mental Health Care Plan (MHCP) which he was provided. During this consultation, Mr A again advised that he had '*pushed'* his wife.[43]

38. On 3 April 2019, Mr A attended upon his GP again and noted that he did not like the counsellor whom he had been referred to and had seen on 20 March 2019 and wished to see another psychologist.[44]

39. During the above appointment, Mr A discussed his use of violence, noting that he gets '*explosive'*[45] at Mrs B, and detailing his unhappiness with Mrs B going out with her friends. Mr A also stated that his wife was '*bossy'*[46] and appears to have claimed that this was unacceptable to him as she was residing in his house. Mr A also admitted again to assaulting Child A. During this appointment Mr A was provided with another copy of the Mental Health Care Plan to access another psychologist.[47]

Concerns regarding the legal assistance provided to Mr A by Victoria Legal Aid

40. Mr A was represented by a Victoria Legal Aid (**VLA**) duty lawyer in his application to vary the FVIO on 26 March 2019.[48] VLA duty lawyers provide '*limited legal services*' which are discreet short-term services where there is no intention to provide ongoing advice. Accordingly, guidance for duty lawyers is focused on the prioritisation and quality of services delivered to clients at court, and there is no specific policy governing written communications after that service is complete. [49]

41. On 9 April 2019, VLA sent correspondence to Mr A advising that the '*intervention application has been withdrawn'*.[50] No further information regarding the order was provided and all other information contained in the letter pertained to attachments for mediation services and an application for the restoration of Mr A's gun license.[51]

42. After Mr A's death, VLA sent a second letter dated 18 April 2019 confirming that his application '*for a re-hearing of the application of Mrs B was withdrawn'*[52] and confirming

[43] Deidentified Medical Clinic, Medical Records of Mr A, 11-12.
[44] Ibid, 12; Body and Mind, Case Record of Mr A.
[45] Deidentified Medical Clinic, Medical Records of Mr A, 12.
[46] Ibid.
[47] Ibid, 12-13.
[48] Victoria Legal Aid, *Statement provided by Hall and Wilcox on 24 August 2020*, 1.
[49] Victoria Legal Aid, *Response dated 19 August 2021,* 2.
[50] Coronial Brief, *Letter from Victoria Legal Aid 9 April 2019*, 79.
[51] Ibid.
[52] Coronial Brief, *Letter from Victoria Legal Aid 18 April 2019*, 143.

that the FVIO was '*to continue for the protection*'[53] of Mrs B and their children. It is unclear why this additional letter was sent, however it provided more comprehensive instruction to Mr A as well as details regarding the penalties for breaching the FVIO.

43. As noted above, it appears that Mr A misunderstood the instructions provided in the first letter and interpreted them as indicating that the FVIO had been withdrawn, leading him to re-attend the family home. From information provided by other services involved with Mr A, it appears that Mr A had difficulty comprehending instructions and legal processes due to his mild intellectual disability.[54] It is possible that these challenges may have contributed to Mr A's misunderstanding of the first letter, however, it is also arguable that the language used in this letter would have also been unclear to neurotypical members of the public.

COMMENTS

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

GP's and family violence training

1. The available evidence indicates that there was limited family violence support provided by the GPs that treated Mr A's in the lead up to the fatal incident. During his attendance with his treating GPs, Mr A disclosed that he had physically assaulted his daughter. GPs are mandatory reporters under the *Children's, Youth and Families Act 2005* (Vic) and are required to make a notification to Child Protection when they believe that a child's safety or wellbeing is at imminent risk.[55] Whilst this may not have been the case in this instance due to Mr A's exclusion from the family home, it is concerning that neither doctor appears to have explored Mr A's access to his daughter or thought to refer Mr A to a support service.

2. The available evidence also raises concern that further support was not provided to Mr A following his disclosure of having used violence towards Mrs B. Despite numerous disclosures, treating practitioners failed to suggest referrals to support services, assess the risk posed to Mrs B and her children or develop a safety plan. Whilst Mr A was engaged with appropriate support at this time, his treating GPs were aware of this and did not make these enquiries.

3. I confirm that since the 2016 Royal Commission into Family Violence, the Multi Agency Risk Assessment and Management (MARAM) Framework was developed to improve guidance for

[53] Ibid.
[54] Bethany Community Support, *Summary Details for Mr A*; Orange Door, *CRM case notes – Mr A*, 6.
[55] *Children's, Youth and Families Act 2005* (Vic) s 182(1)(a).

services to identify and respond to family violence. The MARAM Framework was introduced in 2018 and is in the process of being rolled out across Victoria. The Framework provides services and support workers with guidance on how to identify the presence of family violence, family violence risk and how to respond to the identification of family violence. At present this tool is heavily focused on working with victims of family violence, with further instructions relating to perpetrator responses due to be released in 2021.

4. It is hoped that the roll-out of this tool will work to improve GP identification of and response to family violence. However, unlike publicly funded health services, GPs are not prescribed under the MARAM Framework and so are not legally obligated to align their services with it. This may reduce the positive impact of the MARAM Framework on identification of and response to family violence by GPs.

5. GPs should also be guided by the Royal Australian College of General Practitioners (RACGP) manual *Abuse and Violence: Working With our Patients in General Practice* (also known as the White Book).[56] The White Book provides clinicians with guidance on how to work with perpetrators of violence.[57] This guidance directs clinicians to encourage accountability, prioritize the safety of the woman and children and to identify the most appropriate program or support service for the patient.

6. The White Book was last updated in June 2014, prior to the release of the MARAM Framework and it is unclear when this will next be updated.

7. I note that although the RACGP have developed a six hour online professional development program on family violence for GPs, it is not compulsory for GPs to undertake this or any other continuing professional development family violence training.[58] This, coupled with the fact that GPs are not prescribed under the MARAM Framework, means that gaps within GPs' knowledge and skills in identifying and responding to family violence may persist.

8. In 2015, the then State Coroner, Judge Ian Gray recommended that the RACGP consider the introduction of compulsory family violence training for GPs .[59] Similarly, in 2016 the RCFV noted concerns in relation to the ability of GPs to identify family violence,[60] and recommended the Victorian Government encourage the Ministerial Council to approve standards that facilitate

[56] RACGP, *Abuse and Violence: Working With our Patients in General Practice* (2014), 4th Edition.
[57] Ibid, 11.
[58] RACGP statement in case 2020/3618, dated 4 November 2020.
[59] Case 2009/0447 https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/darceyiris_044709.pdf
[60] State of Victoria, *Royal Commission into Family Violence: Summary and Recommendations* Volume IV, 6.

a mandatory requirement that GPs complete family violence training as part of their continuing professional development.[61] While the Victorian Minister for Health raised this recommendation with the Australian Health Workforce Ministerial Council, the Medical Board of Australia, the RACGP, the Australian College of Rural and Remote Medicine, and the Australian Health Practitioner Regulation Agency,[62] family violence professional development training is still not mandatory for GPs.

Victoria Legal Aid

9. People without legal training often experience difficulty in understanding the court system and orders that are made against them. The additional trauma caused by family violence court proceedings often results in respective parties feeling overwhelmed and confused, reducing their ability to digest information provided to them on the day of court. Sending correspondence to clients after a court proceeding can assist in confirming advice and information given on the day and clarify the client's obligations.

10. In 2016, Victoria Legal Aid produced a research paper titled '*Does providing legal advice to respondents reduce the likelihood of breaching a family violence order?*'.[63] This paper demonstrated the importance of sound legal advice in ensuring that respondents understand the conditions of the FVIO they are subject to and the consequences for breaching such an order.[64]

11. The *Law Institute of Victoria – Professional Conduct and Practice Rules 2005* also stipulate these responsibilities in practice, noting that a legal practitioner must 'communicate effectively with clients'.[65] These provisions are reaffirmed in the *Legal Profession Uniform Law Australian Solicitors' Conduct Rules 2015* which state that 'a *solicitor must provide clear and timely advice to assist a client to understand relevant legal issues and to make informed choices about actions to be taken'.*[66]

---

[61] Ibid, 55.
[62] Victorian Government, *Establish mandatory training for general practitioners in family violence training through professional development* (Web Page) <https://www.vic.gov.au/family-violence-recommendations/establish-mandatory-training-general-practitioners-family-violence>
[63] Victoria Legal Aid, *Does providing legal advice to respondents reduce the likelihood of breaching a family violence order?* (November 2015).
[64] Ibid.
[65] Law Institute Victoria, *Law Institute of Victoria – Professional Conduct and Practice Rules 2005* (commencement date 30 June 2005) r 39.1.
[66] Law Institute Victoria, *Legal Profession Uniform Law Australian Solicitors' Conduct Rules 2015* r. 7.1.

12. I note that VLA duty lawyers have a significant workload, seeing an average of about 300 clients per year, in addition to their ongoing casework.[67] I further confirm that Mr A received advice and assistance from a duty lawyer at the Geelong Magistrates Court who provided '*limited legal services*' which are discreet short-term services where there is no intention to provide ongoing advice.

13. The VLA letter sent to Mr A on 9 April 2019 did not adequately meet the standards for professional communication and did not provide Mr A with adequate information regarding the consequences of a withdrawn FVIO variation application and the restrictions that remained in place.

14. I note that since Mr A's death, the VLA Family Violence Program conducted a small trial where clients were contacted by phone shortly after their hearing to make sure they had understood what had happened in court. Following that trial, VLA is considering adding guidance to the Family Violence duty lawyer practice around post-court communications, including determining who may benefit, and how that communication should take place (e.g. by letter, by phone).[68]

15. VLA has also undertaken further development of its Client Safety Framework (CSF) training, which is now available with separate learning streams for lawyers and other client facing staff in a series of four one-hour e-learning modules, with updated and refreshed content. This training has been informed by lived experience and subject matter experts such as the Magistrate's Court of Victoria, Safe Steps Family Violence Response Centre, No to Violence, lawyers, consultants and community legal education officers from VLA and Independent Mental Health Advocacy Services. The training has a twin focus of family violence and suicide risk, both from the perspective of people who perpetrate, and people who experience, family violence. It informs all interactions with clients, whether or not they are seeking help with a family violence matter.[69]

RECOMMENDATIONS

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

---

[67] VLA response to the Court dated 19 August 2021, 2-3
[68] Ibid, 3-4
[69] Ibid.

1. With the aim of promoting public health and safety, preventing deaths and supporting medical practitioners to address family violence, I recommend that the **RACGP** consider reviewing the White Book with reference to more up-to-date state and territory integrated, multi-agency service response frameworks and common risk assessment tools, such as Victoria's MARAM Framework.

2. With the aim of promoting public health and safety, preventing deaths and supporting medical practitioners to address family violence, I recommend that the **RACGP** consider mandating that GPs attend a fixed amount of continuing medical education (as required by the Medical Board of Australia) per year which includes at least four hours of training and education within a two-year period related to Family Violence (including but not limited to identification, risk assessment or understanding of the relevant frameworks).

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Mr A, born 10 February 1968;

b) the death occurred on 13 April 2019 at Bannockburn, Victoria;

c) I accept and adopt the opinion of Dr Burke and I find that Mr A died from Hanging in circumstances where he intentionally took his own life.

2. I find that Mr A had a complex medical history and several historic head injuries that may have contributed to negative behaviours he exhibited later in life. His relationship with his immediate family was marred by family violence.

3. Pursuant to section 73(1A) of the Act, I order that this finding be published on the internet in accordance with the rules.

4. I convey my sincere condolences to Mr A's family for their loss.

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

Mrs B, Senior Next of Kin

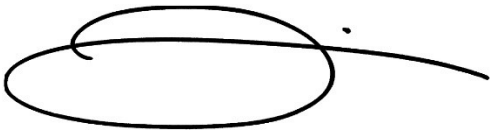
Greg King, Special Counsel, Hall & Wilcox Lawyers

Louise Glanville, Chief Executive Officer, Victoria Legal Aid

Dr Matthew Miles, Chief Executive Officer, Royal Australian College of General Practitioners

Detective Senior Constable Lee Tabbitt, Coroner's Investigator

Signature:



AUDREY JAMIESON

Coroner

Date: 12 October 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.