IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 005578

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Mr BB
Date of birth:	28 October 1990
Date of death:	10 October 2020
Cause of death:	1(a) MULTIPLE INJURIES SUSTAINED IN A FALL FROM A HEIGHT.
Place of death:	Intersection of Spencer Street and Little Collins Street, Melbourne, Victoria, 3000
Catchwords:	Family violence; intimate partner homicide; murder-suicide

INTRODUCTION

1. On 10 October 2020, Mr BB was 29 years old when he was found deceased after an apparent suicide. At the time of his death, Mr BB lived at Unit 5 of 323 Church Street Richmond with housemates.

2. Mr BB was born and raised in Auckland, New Zealand with his parents and younger brother. His parents describe him as being a healthy, quiet and laid-back child who was very easy to raise. He was a hard worker and dedicated to his school-work and extracurricular activities which included water polo and soccer. During high school, Mr BB met his first long-term girlfriend who he was in a relationship with for nine years.

3. Mr BB attended Auckland University where he earned a double degree in property and commerce. He did not report any stress or pressure, remaining very diligent in his studies. After graduating, he started a job in real estate and moved in with his long-term girlfriend. There were no issues in his relationship other than normal disagreements. Mr BB's family got along well with his girlfriend. Mr BB and his girlfriend amicably separated in 2017, and he returned home to live with his parents.

4. In January 2018 Mr BB visited Melbourne, Australia with a view to relocating. He returned home to Auckland for a short time and secured a job in Melbourne with CBRE as a building manager.

5. In July 2019, Mr BB presented to his treating General Practitioner (**GP**) with concerns about his mental health, particularly that he felt lethargic and his housemates had noticed he was withdrawn. Dr Hugh Leslie performed a K10 distress assessment to which he received a score of 16, which is under the threshold for diagnosing any distress. Mr BB declined a Mental Health Care Plan at this time.

6. In December 2019, Mr BB returned to his treating GP having had a bad reaction to smoking marijuana the weekend before. Mr BB's treating GP performed another K10 distress assessment, showing a result of 18, above the threshold for distress of 17. He was assessed as not being suicidal and no evidence of risk to others. Mr BB was referred to psychologist who diagnosed Mr BB with anxiety and low mood.

7. Mr BB's treating psychologist noted that Mr BB had a recent history of panic attacks and a period of low mood, with Mr BB describing the trigger to be problems in a recent relationship with a close friend, that changed to a romantic relationship. Mr BB described longer term

difficulty with anxiety and depression symptoms in the context of his stressful job and long work hours. Mr BB's treating psychologist noted that Mr BB had made good progress and had reported confidence in using the coping tools he had developed during their sessions.

8. In June 2020, Mr BB met Ms AA on a mobile dating application.

9. Due to COVID-19 lockdowns, Ms AA and Mr BB's relationship progressed very quickly. The couple would go on regular dates and stay together at each others' residence after knowing each other for only two to four weeks. Ms AA described to a friend that she felt very spoilt but felt it was "*full on*" given the length of the relationship.[1]

10. Ms AA never reported any significant concerns about Mr BB to close family or friends, she felt it was easy to be in a relationship with him, that he treated her well and kept her grounded.

THE CORONIAL INVESTIGATION

11. Mr BB's death was reported to the Coroner's Court of Victoria 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.

12. 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.

13. 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.

14. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr BB'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.

[1] *Coronial Brief*, Statement of FM dated 22 October 2020, 93

15. This finding draws on the totality of the coronial investigation into the death of Mr BB 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.[2]

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

Circumstances in which the death occurred

16. On the evening of 4 October 2020 Mr BB had a conversation with his housemates about his and Ms AA's relationship. Mr BB discussed his past relationships and Ms AA's past relationship history and was questioning how meaningful their relationship was.[3] He felt he was putting a lot of effort into their relationship, and it wasn't being reciprocated. He was extremely upset and frustrated about the situation and complained to his housemates about his circumstances.[4]

17. On 6 October 2020, Ms AA disclosed to her housemate that she had recently had an argument with Mr BB regarding her relationship history. Mr BB responded in a passive aggressive manner, crying and continuing to raise the topic with her.[5] However, two days later, Mr BB spent the evening at Ms AA's home and appeared to be happy and content together

18. On Friday 9 October 2020, Mr BB picked Ms AA up from her home in Prahran so that they could attend an 'American Football' themed birthday gathering at Mr BB's residence on 323 Church Street, Richmond, Victoria. Ms AA was in good spirits and had done her makeup for the occasion.[6] The group shared a meal and drinks while watching the AFL and continued the celebrations by drinking and dancing in the living room.

19. Guests on the evening described Ms AA as *'quite drunk'* and observed Mr BB to be *'a little more possessive'* and *'looking for attention from [Ms AA] more than usual'*.[7]

20. Ms AA and Mr BB proceeded to bed in Mr BB's room at around 11:30pm. At some time between 11:30pm on 9 October 2020 and 3:00am on 10 October 2020, Mr BB awoke, retrieved

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[2] 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.

[3] *Coronial Brief,* Statement of Mr FF dated 10 October 2020, 78

[4] *Coronial Brief*, Statement of Mr GG dated 10 October 2020, 88

[5] *Coronial Brief*, Statement of Mr HH dated 22 October 2020, 98

[6] *Coronial Brief,* Statement of Mr FF dated 10 October 2020, 80

[7] *Coronial Brief,* Statement of Mr GG dated 10 October 2020, 89; Statement of Mr GG dated 10 October 2020, 80

a 7.5kg weight plate from the rooftop of the apartment and returned to his bedroom. He repeatedly struck a sleeping Ms AA to the head with the weight plate, causing serious injuries resulting in her death.[8]

21. Following the fatal assault, Mr BB fled on foot to 120 Spencer Street Melbourne, where he worked as the building manager. CCTV footage shows Mr BB using his swipe card to enter the building via the loading bay and proceed via the goods lift to the twenty-third level at 3:08 am, 10 October 2020.[9]

22. At 3:18am, Mr BB contacted '000' and requested police attendance at Unit 5 of 323 Church Street Richmond, telling the phone operator:

> *"I've just murdered my girlfriend … … Ms AA … … I grabbed a seven – like, a – like, a weight plate and I hit her. I struck her over the head probably about three to four times. I don't know if she's deceased but I presume so."*[10]

23. The event was subsequently dispatched to Victoria Police units in the area. At approximately 3.20 am, Police members attended the 323 Church Street, Richmond address and began a search of the premises for Ms AA. Ambulance paramedics and police members located Ms AA's body and determined her to be deceased at 3.45 am.[11]

24. Mr BB was informed by Sergeant Watt at 3:58am that Ms AA had been located deceased. At 4:01am, the available evidence suggests that Mr BB jumped to his death from the twenty-third floor of 120 Spencer Street building.

25. At 4.04am, multiple Police units receive notifications to attend the intersection of Little Collins Street and Spencer Street in the Melbourne CBD. At 4.05am, Police units arrive at the intersection and observe Mr BB's deceased body on the length of road immediately outside the main entrance to the 'Savoy Hotel'. Police determined that the injuries to Mr BB's body were incompatible with life.

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[8] *Coronial Brief,* Exhibit 12 – 000 Phone Call transcript 10 October 2020, 231-233
[9] *Coronial Brief,* Exhibit 10 – CCTV footage 120 Spencer Street, Melbourne, 228
[10] *Coronial Brief,* Exhibit 12 – 000 Phone Call transcript 10 October 2020, 231-233
[11] *Coronial Brief*, Statement of Samuel Jones dated 1 January 2021, 118

Identity of the deceased

26. On 14 October 2020, Coroner Leveasque Peterson completed a Form 8 determination of identity of the deceased who was confirmed to be Mr BB, born 28 October 1990.

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

Medical cause of death

28. Forensic Pathologist Dr Sarah Parsons from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 12 October 2020 and provided a written report of her findings dated 6 November 2020.

29. The post-mortem examination revealed multiple skull fractures, rib and spine fractures, and upper and lower limb fractures.

30. Toxicological analysis of post-mortem samples detected blood ethanol at a level of 0.07g/100ml.

31. Dr Parsons provided an opinion that the medical cause of death was 1 (a) MULTIPLE INJURIES SUSTAINED IN A FALL FROM A HEIGHT.

32. I accept Dr Parsons' opinion.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

33. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by an intimate partner is particularly shocking, given that all persons have a right to safety, respect and trust in their most intimate relationships.

34. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr BB and Ms AA was one that fell within the definition of '*de facto partner'*[12] under that Act. Moreover, Mr BB's actions in fatally assaulting Ms AA prior to his own death constitutes '*family violence'*.[13]

[12] Family Violence Protection Act 2008, section 9
[13] Family Violence Protection Act 2008, section 8(1)(a)

35. In light of both deaths occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[14] examine the circumstances of Mr BB and Ms AA's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[15]

36. There was no evidence however to suggest that there were concerns of reported or unreported family violence between the couple in the lead up to the fatal incident. The main conflict reported by close friends of both parties was that they were at odds in relation to the long-term status of relationship. In the lead up to the fatal incident, Ms AA was questioning whether to remain in the relationship which was in stark contrast to Mr BB's serious commitment to Ms AA and the relationship.[16]

37. At the time of the couple's death, the services that were involved with the couple were primarily focused on their health needs and there were no prevention opportunities identified in the provision of these services.

COMMENTS

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

Victoria Police and the triangulation of Mr BB's mobile phone prior to the fatal incident

38. Following the fatal assault, Mr BB fled on foot to 120 Spencer Street Melbourne, where he worked as the building manager. Mr BB contacted '000' and requested police attendance at Unit 5 of 323 Church Street Richmond, telling the phone operator:

> *"I've just murdered my girlfriend … … Ms AA … … I grabbed a seven – like, a – like, a weight plate and I hit her. I struck her over the head probably about three to four times. I don't know if she's deceased but I presume so."*[17]

[14] 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

[15] 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

[16] *Coronial Brief*, various statements of close associates of Mr BB and Ms AA detailing conflicting long term relationship aspirations of the couple.

[17] *Coronial Brief,* Exhibit 12 – 000 Phone Call transcript 10 October 2020, 231-233

39. The event was subsequently dispatched to Victoria Police units in the Richmond area and ambulance paramedics and police members located Ms AA's body and determined her to be deceased at 3.45 am.[18]

40. At 3.23am, Mr BB's call was transferred to Sergeant Watt, a Police Communication Liaison Officer (**PCLO**) who continued on the call with Mr BB until the fatal incident.[19]

41. Sergeant Watt's evidence in his statement to the Court was that during the call with Mr BB, he "*read in the chronology that a female had been located deceased, and that Ambulance Victoria were to move into the address*".[20] He then recalls speaking to the second on call PCLO to organize a triangulation of Mr BB's phone due to the fact that: *"At this point; we one had one (1) deceased female, and a caller who had mentioned he was going to commit suicide."*[21]

42. In order for a triangulation to be requested, the requirements under section 287 of the *Telecommunications Act 1997 (Cth)* require police officers to believe on reasonable grounds that there was a serious and imminent threat to life. The process of requesting a mobile phone triangulation requires the PCLO to contact the Police Shift Manager (PSM) at the Police Communication Centre (**D24**) and complete a request form (VP1501) which is sent to the On-Duty Inspector to assess and then authorise the triangulation request.[22]

43. Senior Sergeant Terry was the assigned PSM on duty on the evening of the fatal incident. In a supplementary statement to the Court, Senior Sergeant Terry confirms that he received a call from second on call PCLO at 3.50am asking about a triangulation for Mr BB's phone. After a careful review of the audio recording provided to the Court, the audio suggests that Sergeant Senior Sergeant Terry was not told that Mr BB was at risk of imminent harm (suicide) and no triangulation request was formally made to or processed at D24.[23]

44. Mr BB was informed by Sergeant Watt at 3:58am that Ms AA had been located deceased. At 4:01am, the call between the two parties terminates and shortly after Mr BB jumped to his death from the twenty-third floor of 120 Spencer Street building.

45. The available evidence indicates that there was only an approximate 11 minute window between 3.50 am and 4.01 am to perform a triangulation. Whilst the evidence confirms that no

[18] *Coronial Brief*, Statement of Samuel Jones dated 1 January 2021, 118
[19] *Coronial Brief,* Exhibit 12 – 000 Phone Call transcript 10 October 2020, 240
[20] *Coronial Brief*, Statement of Sergeant Stuart Watt dated 20 October 2020, 137
[21] Ibid
[22] Statement of Senior Sergeant Nicholas Terry dated 31 July 2021, 1; Supplementary Statement of Senior Sergeant Nicholas Terry dated 14 October 2021, 2
[23] Audio recording evidence provided to the Court by Victoria Police of a call between Sergeant Filipov and Senior Sergeant Terry commencing at 3.50am on 10 October 2020.

triangulation occurred, I note that it is highly unlikely that police would have had any real or material opportunity to locate Mr BB within this timeframe even if a triangulation was attempted.

46. Having reviewed the transcript and audio of the call between Mr BB and Sergeant Watt, I am of the opinion that Sergeant Watt in an extremely difficult and stressful situation, followed all the general principles enunciated within the PCLO training and police policy. I commend Sergeant Watt for his attempts to assist Mr BB prior to the fatal incident.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr BB, born 28 October 1990;

    b) the death occurred on 10 October 2020 at 630 Little Collins Street, Melbourne, Victoria, 3000, from MULTIPLE INJURIES SUSTAINED IN A FALL FROM A HEIGHT.; and

    c) the death occurred in the circumstances described above.

48. Having considered all of the circumstances, I am satisfied that Mr BB intentionally took his own life.

49. I convey my sincere condolences to Mr BB's family for their loss.

50. Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

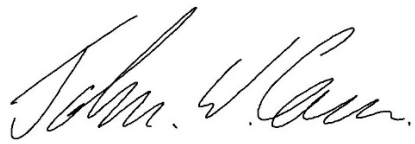
Mr I and Mrs J, Senior Next of Kin

Ms Kate Davey, Victorian Government Solicitor's Office

Unit Manager, Civil Litigation Unit, Victoria Police

Detective Senior Constable Richard Smith, Coroner's Investigator

Signature:



Judge John Cain
STATE CORONER
Date : Tuesday, April 19, 2022

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.