IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004419

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	KK
Date of birth:	17 August 1981
Date of death:	20 August 2021
Cause of death:	1(a) Full thickness burns to body in the setting of self-immolation
Place of death:	Sunshine Hospital, Furlong Road, St Albans, Victoria, 3021
Keywords:	Family violence; suicide; CALD

INTRODUCTION

1. On 20 August 2021, KK was 40 years old when he passed away in Sunshine Hospital. At the time of his death, KK lived in Victoria with his wife and children.

2. KK was born on 17 August 1981 in Sri Lanka and was Tamil. KK was married to SK and they had three children together who were 18, 15 and 13 at the time of the fatal incident.

3. KK arrived with his family in Australia as an illegal maritime arrival and was released into the community with all family members on a Temporary Humanitarian visa in March 2015. KK applied for a Safe Haven protection visa which was refused on 9 August 2018.

4. KK and his family were on a bridging visa at the time of the fatal incident pending an outstanding judicial review application lodged in the Federal Courts challenging the protection visa refusal. KK was employed as a labourer for a local recycling company.

THE CORONIAL INVESTIGATION

5. KK'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.

6. 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.

7. 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.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of KK'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.

9. This finding draws on the totality of the coronial investigation into the death of KK 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.[1]

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

Circumstances in which the death occurred

10. On 20 August 2021, KK drove to a reserve along Ashton Avenue in St Albans sometime between 8.10am and 9.05am. Along the drive to the reserve, KK stopped by a petrol station and filled a jerry can with petrol.

11. At 9.05am, a resident from a unit on Ashton Avenue, St Albans heard a male in the park screaming.[2] The resident contacted emergency services and Ambulance Victoria paramedics responded finding KK laying on the ground in the park around 9.37am.[3] KK was observed to be covered in burns but was still conscious and was transported to Sunshine Hospital for treatment.

12. KK's burn injuries were significant and he was pronounced deceased at 6.34pm on 20 August 2021.

Identity of the deceased

13. On 20 August 2021, KK, born 17 August 1981, was visually identified by his church pastor.

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

Medical cause of death

15. Forensic Pathologist Dr Joanna Glengarry, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 23 August 2021 and provided a written report of her findings dated 24 August 2021.

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[1] 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.

[2] *Coronial Brief,* Statement of resident living near KK dated 24 August 2021, 91

[3] *Coronial Brief,* Statement of Ambulance paramedic dated 20 August 2021, 84

16. The post-mortem examination revealed the following:

    a) There was no evidence of fractures and intracranial haemorrhage; and

    b) There were extensive full thickness burns with sparing of the anterior face, arms, hands, fingers and soles of the feet.

17. Toxicological analysis of post-mortem samples identified the presence of Morphine, Midazolam, Ketamine and Lignocaine.[4]

18. Dr Glengarry provided an opinion that the medical cause of death was 1 (a) Full thickness burns to body in the setting of self-immolation.

19. I accept Dr Glengarry's opinion.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

Family violence investigation

20. For the purposes of the Family Violence Protection Act 2008, the relationship between KK and SK was one that fell within the definition of '*spouse'*[5] under that Act. Moreover, the fatal incident occurred in the circumstances of proximate '*family violence'*.[6]

21. In light of KK's death occurring under circumstances of proximate family violence, I asked the Coroners' Prevention Unit (**CPU**)[7] to examine the circumstances of his death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[8]

Victoria Police contact with KK in the lead up to the fatal incident

22. On 17 August 2021, KK and SK's daughter TK called Victoria Police to report an incident of family violence, noting that her parents were fighting and that her brother was attempting to separate the parties. During this call, the call taker could hear arguing in the background.

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[4] These substances were likely administered in hospital for pain management and analgesic purposes in light of the burns suffered by the deceased. They were not detected in any concentration level that would have impacted the cause of death.

[5] Family Violence Protection Act 2008, section 8(1)(a)

[6] Family Violence Protection Act 2008, section 5

[7] 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

[8] 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

23. Upon arrival, Victoria Police members could hear arguing from within the house. KK and SK were separated by police and their eldest son 18-year-old HK informed members that KK had hit SK and thrown his phone, causing damage to it.

24. Body Worn Camera Footage of this attendance has been provided to the Court. Footage of the incident indicates that soon after their arrival, police members became aware that KK spoke limited English and he informed them that he spoke Tamil. KK was not provided with an interpreter, and police proceeded to communicate with him in English for the duration of their attendance.

25. Upon being informed by HK that KK had assaulted SK, Victoria Police members arrested KK for recklessly causing injury and physically restrained and handcuffed him. KK became visibly distressed by this and members attempted to explain what was occurring to him in English. KK does not appear to have understood what was occurring and remained distressed and confused. At no point during this incident was KK resistive to arrest or violent towards police members.

26. Upon KK's arrest, HK came over to his father and spoke with him in Tamil before being separated from him by police. Members advised KK that if he '*stopped crying'* they would '*explain what's happening'* and began instructing him to do breathing exercises in an attempt to calm him down.

27. Police members proceeded to search KK and ask questions about his belongings. KK advised that he did not understand what police members were saying to him and police continued to speak with him in English. Police members also spoke with one another in the presence of KK regarding their intention to interview SK, photograph her injuries and to discuss whether SK and the children would provide a statement.

28. Members simultaneously spoke with SK inside the family home in the presence of TK and NK. SK became visibly distressed upon KK's arrest and attempted to go to him. Police escorted SK back inside the family home and began questioning SK, TK and NK together.

29. During this interaction, police did not seek an interpreter and TK began intermittently translating for SK who appeared to speak limited English. Police queried SK as to whether she wished to make a statement and she advised that she did not, however it is unclear whether this was understood by her as translation was not provided.

30. Police then prepared a statement of no complaint on behalf of SK and provided this to her to sign. SK appears to have been unable to understand the document and sought TK's assistance

to interpret its contents. During this interaction, police asked whether an interpreter was required, however the conversation became focused on SK's facial injury and this support was not offered to the family again.

31. A police member then spoke with TK alone, who advised that the violence was ongoing and that she was scared of her father. TK noted that there had been previous attendance by police for a welfare check, however, the Court does not have Victoria Police records and there is no further information relating to this incident in the materials provided. Further investigation of these allegations does not appear to have occurred and TK was advised to contact police if her father became violent again.

32. Members then asked TK to explain the conditions of the Family Violence Safety Notice (**FVSN**) and the criminal and civil proceedings to SK before leaving the address with KK.

33. KK was interviewed by police members at a local police station that same day with a Tamil interpreter. In review of this interview, it appears that police did not attempt to comprehensively explain the civil or criminal family violence process or provide KK with any material to assist his understanding of the process. KK appeared confused during the interview and unclear as to the implications that his behaviour may have on civil and criminal proceedings.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was KK, born 17 August 1981;

    b) the death occurred on 20 August 2021 at Sunshine Hospital Furlong Road, St Albans, Victoria, 3021, from full thickness burns to body in the setting of self-immolation; and

    c) the death occurred in the circumstances described above.

35. The available evidence supports a finding that KK was facing a number of significant life stressors at the time of the fatal incident, including significant stress from his families' migration status and impact of Victoria Police involvement with his family on their ability to remain in Australia.

36. While I have made comments below that appear appropriate to me as they arise from the coronial investigation into KK's death, the available evidence does not support a finding that

there is any causal connection between the circumstances highlighted in the comments and KK's death.

COMMENTS

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

Multicultural considerations during Victoria Police investigations of family violence

37. The Code of Practice for the Investigation of Family Violence (**Code of Practice**) in place at the time of this incident provides clear and detailed guidance around the use of interpreters for members of Culturally and Linguistically Diverse (**CALD**) communities and includes a specific practice note on this topic which outlines the 'risks associated with using children and family members as interpreters, and using the same interpreter for both perpetrator and victim.'[9] It provides that where an affected family member is not fluent in English an interpreter '*should be arranged at the earliest opportunity and at every stage of the investigation'* including '*during initial crisis intervention (e.g. at the scene*)'.[10]

38. Further, Code of Practice expressly notes that '*family members and children should not be used.'*[11] *In iteration of these instructions, the Victorian Police Manual – Family Violence was also updated to contain section 3.4 which specifies that 'children must not be used as interpreters'*.[12] These documents note that using family members as interpreters can risk further emotional distress and trauma for the interpreter, and that '*emotional distress may particularly be caused to children*.'[13] It also notes that using family members and children as interpreters '*degrades the reliability of any evidence gained through a statement*.'[14] Current iterations of these documents provide similar instructions.

39. KK and SK and their children were Tamil asylum seekers residing in Australia with pending immigration proceedings. KK and his family had limited support in Australia and both KK and SK spoke limited English and appeared unfamiliar with the Victorian criminal and civil justice systems. It is also possible that KK and SK experienced fear of police given their asylum seeker

[9] Victoria Police, Code of Practice for the Investigation of Family Violence, (2019) 3rd Ed, V4, 70.
[10] Ibid.
[11] Ibid.
[12] Victoria Police Manual - Family Violence, 24 January 2022.
[13] Victoria Police, Code of Practice for the Investigation of Family Violence, (2019) 3rd Ed, V4, 70.
[14] Ibid.

backgrounds feeling persecution from authorities and their concerns of state sanctioned torture and imprisonment should they return to Sri Lanka.

40. The circumstances of the police family violence investigation on 17 August 2021, raises significant concern with how police engaged with KK and SK on this occasion. The physical restraint, arrest of and interaction with KK without the use of interpreter appears to have caused him significant distress and fear. Similarly, the failure to seek an interpreter for SK and the use of TK as an interpreter was a breach of Victoria Police policies and procedures and worked to increase the distress experienced by both parties and posed a risk to the children's emotional wellbeing.

41. Further statements were provided to the Court from attending police members as to why an interpreter was not sought during this incident.[15] Police members advised that they believed both KK and SK spoke some English and that their level of English comprehension was sufficient for them to understand what police were saying, that Tamil interpreters are difficult to obtain and that SK's children were appropriate interpreters given they were present during the incident, had been exposed to the violence already and were acting as supports to SK.

KK's understanding of the police interview and consequent police actions

42. Review of the interview recording indicates that on several occasions during the interview, police prevented the interpreter from translating KK's responses. On several of these occasions the interviewing member asked the interpreter whether KK's response was relevant to the question they had posed. When the interpreter advised that it was not or was a repeat of a previous response, members did not allow for the interpreter to translate KK's response. In other instances, police did not provide time for the interpreter to translate KK's responses.

43. The available evidence suggests that despite KK's lack of understanding of the Victorian civil and criminal process, investigating members made limited attempts to explain this process to him during the interview and that KK remained confused as to what was occurring at the conclusion of the interview.

44. In the circumstances, KK may have significantly benefitted from additional information in KK's language regarding the civil and criminal family violence process. Access to this

[15] See further statements from attending police members obtained by the Coroner's Investigator.

information may have assisted to mitigate his distress and the confusion he appeared to be experienced on this occasion.

45. It appears from the available evidence that police engagement with KK during the interview process failed to demonstrate an understanding of the needs or experiences of people from culturally and linguistically diverse communities or the challenges these communities may face interacting with police or understanding the criminal or civil family violence process and demonstrates a need for further education and training.

46. Her Honour is aware that Victoria Police recently launched the *Cultural and Linguistically Diverse Inclusion Action Plan 2023-2024*. Whilst this plan seeks to increase Victoria Police's capacity to respond to communities from a range of cultural backgrounds, the plan appears to focus solely on the recruitment of Culturally and Linguistically Diverse police members and measures to facilitate this.

47. Victoria Police have also developed an information sheet for families titled '*'Family Violence: What Police do'*. This document has been translated into 13 languages excluding Tamil and provides individuals with information relating to the civil family violence process. Victoria Police have also advised that they have developed Family Violence Quick Guides for various priority communities to support police members in developing a greater understanding of family violence in these communities.

48. Whilst the above initiatives are important in engaging culturally and linguistically diverse communities, it remains unclear whether members are provided with any training or additional resources to assist them in in responding to people from various cultural backgrounds or who have no or limited English comprehension.

49. The 2021 Australian Census indicates that 30 per cent of Victorians were born overseas, with 27.6 per cent of Victorian's speaking a language other than English at home.[16] As a service that possesses a position of authority within the Victorian community and intersects with people's lives, often in moments of crisis, it is critical that members are provided with the training and resources necessary to equip them to respond sensitively to individuals who may have experienced and/or have fear of police persecution; who come from a range of cultural backgrounds; and who may not speak English as a first language. Embedding these skills within Victoria Police may assist in increasing reporting of incidence of violence, may reduce

[16] Victorian Government, 'Discover Victoria's diverse population', <https://www.vic.gov.au/discover-victorias-diverse-population>.

escalation following police attendance and may reduce the trauma that police involvement can cause to these communities.

50. I convey my sincere condolences to KK's family for their loss.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

SK KK, Senior Next of Kin

Rachel Quinn, Senior Solicitor, Victorian Government Solicitor's Office

Lauren Callaway, Assistant Commissioner, Family Violence Command, Victoria Police

Dr Narelle Watson, Director of Quality, Safety and Patience Experience, Western Health

Detective Leading Senior Constable Jayden Gebbie, Coroner's Investigator

Signature:

Deputy State Coroner

Date: 30 October 2023

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.