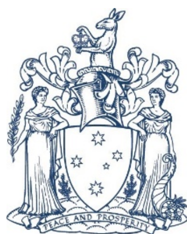

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 000554

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

****Amended pursuant to section 76 of the Coroners Act 2008**[1]*

Findings of:	Coroner Simon McGregor
Deceased:	KDR[2]
Date of birth:	March 1969
Date of death:	29 January 2021
Cause of death:	1(a) Neck compression 1(b) Hanging
Place of death:	Old Lake Bunga Road, Lakes Entrance, Victoria, 3909
Key words:	Family violence intervention order, Latrobe Regional Hospital, Lake Bunga, Royal Commission into Victoria's Mental Health Care System

[1] A correction has been made to paragraph 18 of this coronial finding in which the deceased was incorrectly named.
[2] This finding has been de-identified by order of Coroner Simon McGregor to replace the names of the deceased and their family members with pseudonyms of randomly generated three letter sequences to protect their identity and redact identifying information.

INTRODUCTION

1. On 29 January 2021, KDR was 51 years old when he was found deceased in circumstances suggestive of suicide. At the time of his death, KDR lived in Swan Reach.

2. KDR met his partner, CJL, in 2007. Their relationship was characterised by multiple episodes of domestic violence.[3] During their time together, KDR made numerous threats of suicide however he was reluctant to seek ongoing professional help, despite a diagnosis of depression and anger/stress issues for which he attended counselling in 2016.[4] His sister, LKZ, stated that KDR had previously attempted suicide several times in the context of relationship breakdowns.[5]

THE CORONIAL INVESTIGATION

3. KDR'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.

4. 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.

5. 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.

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

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[3] Coronial brief, statement of CJL dated 28 April 2021, pages 14-16.

[4] Coronial brief, statement of CJL dated 28 April 2021, page 17; statement of Angela Hartneil dated 22 July 2016, page 404, 409.

[5] Coronial brief, statement of LKZ dated 26 July 2021, page 96.

7. This finding draws on the totality of the coronial investigation into the death of KDR 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.[6]

8. In considering the issues associated with this finding, I have been mindful of KDR's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006* (Vic), in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

9. On 17 January 2021, Victoria Police members removed KDR from the family home following a physical altercation with CJL and served him with a Family Violence Intervention Violence Order (**IVO**) which excluded him from the family address. Despite the order, KDR continued to contact CJL and posted a video online threatening suicide, as well as reattending the home several days later.[7]

10. On 22 January 2021, KDR attempted to contact CJL again. She contacted police who called KDR and spoke to him for an extended period, during which time he threatened suicide but would not reveal his location. Police members eventually convinced KDR to speak to Mental Health Triage services who assessed his suicide risk as immediate.[8]

11. A triangulation of his phone was commenced by police which indicated that KDR had travelled interstate to Albury. At that point, the triangulation was ceased, and carriage of the matter was handed over to NSW police who located KDR in Albury on 23 January and transported him to the Albury Emergency Department as a compulsory patient.[9]

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[6] 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.

[7] Coronial brief, statement of CJL dated 28 April 2021, page 18.

[8] Coronial brief, statement of Gillian Kerr dated 30 March 2022, page 50.

[9] Coronial brief, statement of Senior Constable Patrick Shegog dated 2 March 2021, pages 37-38; statement of Sergeant Scott Gray dated 48.

12. During KDR's mental health assessment, he denied symptoms of depression or psychosis and stated that his children were protective factors in his life. KDR was assessed as being a low risk to himself and others and was discharged to his sister's address in Albury with a plan to attend his local doctor to complete a mental health care plan.[10] KDR later left his sister's residence unexpectedly and travelled back to Victoria.[11]

13. On 24 January 2021, KDR posted another video threatening suicide. That evening, KDR contacted one of CJL's employees and told him that he intended to commit suicide. CJL called police who eventually located KDR in Nowa Nowa and transported him to Latrobe Regional Hospital (**LRH**) for assessment as compulsory patient.[12] During his time at LRH, KDR underwent a mental health assessment during which he acknowledged the videos he had posted online but stated that they were the result of cumulative feelings of frustration and victimisation and denied any ongoing suicidal ideation.[13]

14. During his assessment, KDR admitted to a previous attempted suicide in 2006 by overdose but told the clinician that he was remorseful about the attempt, stating that it was "pathetic".[14] KDR also cited protective factors in his life including his children, his friends, and the hope that he would reconcile with CJL in the future.[15]

15. At the conclusion of the assessment, KDR did not fit any statutory criteria for ongoing confinement and/or treatment[16] and, at approximately 1.00am, KDR was released from LRH and charged by police with breaching his IVO. He was then bailed to an address in Canberra. Police members offered KDR referrals to mental health services however he declined their services.[17]

16. KDR then attended the family address with police constables to collect some personal items before leaving, telling police members that he intended to attend a job interview interstate. At the time, police members stated that KDR appeared happy.[18]

[10] Coronial brief, statement of Dr Shivani Panda dated 10 February 2021, pages 43-45.
[11] Coronial brief, statement of LKZ dated 26 July 2021, page 96.
[12] Coronial brief, statement of CJL dated 28 April 2021, pages 19-20.
[13] Coronial brief, statement of Stephen Bradley dated 15 February 2021, pages 67-69.
[14] Coronial brief, statement of Stephen Bradley dated 15 February 2021, page 69.
[15] Coronial brief, statement of Stephen Bradley dated 15 February 2021, pages 67-69.
[16] Coronial brief, statement of Stephen Bradley dated 15 February 2021, page 70.
[17] Coronial brief, statement of First Constable Jenna Coppa dated 3 February 2021, page 34.
[18] Coronial brief, statement of CJL dated 28 April 2021, page 21; statement of Senior Constable Patrick Shegog dated 2 March 2021, pages 38-39.

17. On 29 January 2021, KDR attempted to contact CJL who refused to speak to him.[19] At approximately 2.15pm, a passer-by observed what appeared to be a male hanging by his neck on Old Bunga Road in Lake Bunga.[20] The passer-by called police who attended the location and discovered KDR hanging from a tree in an unresponsive state.[21]

18. The police members cut KDR down and began resuscitation attempts prior to the arrival of Ambulance Victoria paramedics who continued resuscitation however they were unsuccessful, and KDR was verified as deceased at 4.25pm.[22]

Identity of the deceased

19. On 29 January 2021, KDR, born 17 March 1969, was visually identified by his friend.

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

Medical cause of death

21. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 1 February 2021 and provided a written report of his findings dated 11 February 2021.

22. The post-mortem examination revealed findings consistent with the stated circumstances.

23. Toxicological analysis of post-mortem samples identified the presence of midazolam, likely administered as part of pre-hospital resuscitation attempts.

24. Dr Bedford provided an opinion that the cause of death was from 1 (a) neck compression.

25. I accept Dr Bedford's opinion.

FAMILY CONCERNS

26. I note that, in her statement dated 28 April 2021, CJL expressed concerns that KDR had not received an appropriate level of care from mental health clinicians or Victoria Police members regarding his mental health needs.

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[19] Coronial brief, statement of CJL dated 28 April 2021, page 22.
[20] Coronial brief, statement of Luke Gibson dated 25 May 2022, page 87.
[21] Coronial brief, statement of Senior Constable Chelsea Maxwell dated 17 March 2021, pages 30-31
[22] Coronial brief, statement of Senior Constable Chelsea Maxwell dated 17 March 2021, pages 30-31; Ambulance Victoria Verification of Death form dated 29 January 2021.

27. Whilst I acknowledge and understand CJL's frustrations with the mental health care system, there are specific statutory requirements for initiating compulsory mental health treatment in Victoria under section 29 the *Mental Health Act 2014* (Vic). During KDR's Safety Awareness and Planning assessment conducted on 24 January 2021 at LRH, he was deemed to represent a low risk of suicide or deliberate self-harm, as well as an ongoing medium risk of vulnerability and, hence, did not satisfy the legislative requirements of section 29 and could not be held as a compulsory patient under an Assessment Order.

28. After careful review of the circumstances, I am satisfied that the relevant authorities appropriately exercised their responsibilities under current legislation and provided a reasonable and appropriate level of care to KDR, given the circumstances.

FINDINGS AND CONCLUSION

29. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[23] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was KDR, born March 1969;

    b) the death occurred on 29 January 2021 at Old Lake Bunga Road, Lakes Entrance, Victoria, 3909, from *neck compression*; and

    c) the death occurred in the circumstances described above.

31. Having considered all of the available evidence, I am satisfied to the requisite standard that KDR intentionally took his own life. I note his ongoing suicidal ideation as well as previous suicide attempts in similar contexts, as well as the lethality of means chosen.

[23] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

COMMENTS

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

32. Whilst KDR was unable to be treated as a compulsory patient under current legislation, it does not mean that CJL's frustrations are not well-founded. In 2019, the Royal Commission into Victoria's Mental Health Care System was established after the Victorian Government recognised that the system was failing to support people living with mental illness or psychological distress, families, carers and supports, as well as those working in the system. On 2 March 2021, the Royal Commission's final report was tabled in Parliament and includes 65 recommendations which the Victorian Government has committed to implementing over the following 10 years.

33. I note that several recommendations of the Royal Commission identified the need to ensure that mental health services are able to provide centrally-coordinated 24-hours a day crisis response services, expand crisis outreach services, and improve the ability of emergency departments to respond to mental health crisis, as well as ensuring that emergency services are able to access appropriate mental health services in a timely manner for individuals suffering from time-critical mental health crises.

34. Whilst KDR was reluctant to engage with mental health services prior to his decision to take his life on 29 January 2021, I am hopeful that the recommendations made by the Royal Commission and subsequent actions planned and taken by the mental health system will be able to assist others in similar situations who are experiencing mental health crises, thereby avoiding similar occurrences in the future.

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

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.

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

CJL, Senior Next of Kin

Amie Herdman, Ambulance Victoria

Cayte Hoppner, Latrobe Regional Health

Senior Constable Scott Donnan, Victoria Police, Coroner's Investigator

Signature:

Coroner Simon McGregor

Date: 26 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.