IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 002571

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Mr Y
Date of birth:	[redacted] 1973
Date of death:	On or about 14 May 2020
Cause of death:	1(a) NECK COMPRESSION BY LIGATURE SUSPENSION
Place of death:	[redacted], Meadow Heights, Victoria, 3048
Catchwords:	Family violence; suicide

This finding has been de-identified by order of Coroner Sarah Gebert to replace the names of the deceased and their family members with pseudonyms to protect their identity and to remove identifying information,

INTRODUCTION

1. Mr Y, born [redacted] 1973, was 46 years old at the time of his death. He was born in Iraq and migrated to Australia with his wife, Ms L and their eldest daughter, Miss R in 2013. Mr Y and his wife had a further son, Master G, in 2015 after arriving in Australia.

2. At the time of his death, Mr Y was excluded from the marital home due to the conditions of a Family Violence Intervention Order (**FVIO**) and was separated from his wife and children. He was mainly employed at an [redacted] manufacturing company in Campbellfield.

3. Mr Y was reported by close family and relatives to consume alcohol and smoke cigarettes on a daily basis.

4. On 14 May 2020, Mr Y was found deceased in the garage of the family home in Meadow Heights, Victoria.

THE CORONIAL INVESTIGATION

5. Mr Y'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 Mr Y'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 Mr Y 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 1 May 2020, a FVIO was issued at the Broadmeadows Magistrates' Court, which included a condition prohibiting Mr Y from living at the marital home. Mr Y was not present at the court hearing.[2]

11. On or around the same day, Ms L's brothers, Mr P and Mr H, went to Mr Y's residence. They found him sleeping in bed and he appeared to be intoxicated. Mr P and Mr H reportedly had a discussion with Mr Y where they encouraged him to stop drinking alcohol and resume working. Mr Y said he had a back injury and they encouraged him to see a doctor. Mr Y advised them he did not want to speak anymore and wanted to go back to sleep.[3]

12. On 4 May 2020, Victoria Police attended the marital home to serve Mr Y with the FVIO. However, no one answered the door.[4]

13. On 5 May 2020, Leading Senior Constable David Marchino spoke with Mr Y via telephone and asked him to attend the Broadmeadows Police Station to collect some documents. An interpreter was not used during this interaction. When Mr Y failed to collect the documents, LSC Marchino attempted to contact Mr Y again via telephone with the assistance of a telephone interpreter, however Mr Ydid not answer the phone.[5]

14. The available evidence suggests that this call was likely to have occurred on 5 May 2020 at 12.09 pm as evidenced from the last call incoming/outgoing from Mr Y's phone as retrieved by the Coroner's investigator after the discovery of Mr Y's body.

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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, Exhibit 7, 83-93.

[3] Coronial brief, Statement of Mr P, 17-18.

[4] Coronial brief, Statement of F Visentin, 36.

[5] Coronial brief, Statement of D Marchino, 39; Exhibit 7 – Screenshots of last received phone calls

15. Police attended the marital property numerous times over the following days but were unable to make contact with Mr Y.[6]

16. On 14 May 2020, LSC Marchino contacted Ms L and asked her to attend the marital home to see if Mr Y was present. LSC Marchino advised Ms L to contact him if they found Mr Y so they could attend to serve him with the FVIO.[7]

17. Ms L later attended the home with Mr P and his wife, Ms E on the afternoon of 14 May 2020. They discovered Mr Y hanging by his neck in the shed and contacted emergency services.[8] Mr Y was declared deceased at the scene by attending police members at approximately 3:50pm.[9]

Identity of the deceased

18. On 14 May 2020, Mr Y, born [redacted] 1973, was visually identified by his brother in law, Mr P.

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

Medical cause of death

20. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 15 May 2020 and provided a written report of her findings dated 31 July 2020.

21. The post-mortem external examination revealed:

    a) The body showed findings generally in keeping with the clinical history; and

    b) Post-mortem CT scans showed a fatty liver and an intact laryngeal skeleton.

22. Toxicological analysis of post-mortem samples identified the presence of 0.01 g/100mL of ethanol but no commons drugs or poisons.

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[6] Coronial brief, Statement of F Visentin, 36; Statement of D Marchino, 40; Statement of J Foo, 43; Exhibit 8, 99, 101 - 104.

[7] Coronial brief, Statement of D Marchino, 40.

[8] Coronial brief, Statement of Mr P, 18; Statement of Ms E, 21.

[9] Coronial brief, Statement of S Hill, 46-47; Statement of D Ryan dated 5 May 2020, 50-51

23. Dr Baber provided an opinion that the medical cause of death was 1 (a) Neck Compression by Ligature Suspension.

24. I accept Dr Baber's opinion.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

25. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr Y and Ms L was one that fell within the definition of '*spouse*'[10]. Moreover, Mr Y's actions and behaviour against Ms L leading up to the fatal incident appeared to constitute '*family violence'* under this legislation[11]

26. In light of this death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[12] examine the circumstances of Mr Y's death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[13]

History of family violence between Mr Y and Ms L

27. The available evidence indicates that Mr Y perpetrated family violence against Ms L throughout their marriage. In particular, Ms L stated that Mr Y suffered from alcoholism and was often verbally abusive to her and their children after he had consumed alcohol.

28. The first reported family violence was predominantly emotional and psychological abuse, however Ms L also detailed an incident in 2017 where Mr Y had '*tried to be physically violent'*[14] with her. After this incident, members of Ms L's family spoke to Mr Y and advised him not to engage in such behaviour again.[15]

29. Ms L stated that Mr Y expressed suicidal ideation to her on several occasions in the six months prior to his death, although she was unaware of him making any attempts to do so. This usually occurred after he had consumed alcohol.[16] It is noted that threats of suicide can

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[10] Family Violence Protection Act 2008, section 8(1)(a)
[11] Family Violence Protection Act 2008, section 5
[12] 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
[13] 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
[14] Ibid 13.
[15] Coronial brief, Statement of Ms L, Statement of Mr P, 17.
[16] Coronial brief, Statement of Ms L, 12.

be considered a form of family violence where they are used to torment or intimidate a person.[17] It is unclear from the available evidence whether Mr Y's suicidal ideation was expressed in this manner.

30. It is noted that both Ms L and Mr Y spoke limited English and required an Arabic interpreter when engaging with services.

31. On 29 April 2020, Miss R called '*000'* on behalf of Ms L following an alleged family violence incident between Ms L and Mr Y. When police attended Ms L reported that Mr Y had been consuming alcohol and that they had an argument about Master G's schooling. During this argument Mr Y had reportedly gone into the backyard and then had pulled a sliding door off its railings when he had attempted to re-enter the residence.[18]

32. During their attendance at this incident Victoria Police interviewed both Ms L and Mr Y using Miss R, then aged 11, as an interpreter.[19] First Constable Declan Turner, who attended this incident, noted that this meant that police were '*unsure as to whether we had identified all the offending that had been occurring*.'[20]

33. Mr Y appeared to be asleep when police attended the incident. He was awoken by police and interviewed briefly by them, with the assistance of Miss R, before being conveyed to Broadmeadows Police Station to be served with a Family Violence Safety Notice (**FVSN**).[21] The FVSN prohibited him from living or communicating with Ms L and their children. Police engaged a telephone interpreter to serve the FVSN upon Mr Y and explain its conditions to him before he was released from custody.[22]

34. Following this incident Ms L and their children left the marital home to reside with Mr P and his family. They remained living there until the time of Mr Y's death. Mr Y returned to live at the marital home, in contravention of the conditions of the FVSN.[23]

Service provided by DPV Health to Mr Y

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[17] *Family Violence Protection Act 2008* (Vic) s 7.
[18] Coronial brief, Statement of Ms L 13; Statement of D Turner, 25-27; Statement of J Walk, 29-31.
[19] Coronial brief, Statement of D Turner, 26.
[20] Ibid.
[21] Ibid.
[22] Ibid 27.
[23] Coronial brief, Statement of Ms E 21.

35. Following the family violence incident on 29 April 2020, DPV Health received a L17 referral in relation to Mr Y. In response to this referral, they sent Mr Y an information pack via text message on 30 April 2020. This text message was in English despite the L17 referral indicating that Mr Y required an Arabic interpreter.[24]

36. DPV Health have advised the court that the information provided to Mr Y is not available in Arabic, however, DPV Health have subsequently advised that they have reviewed their practices and their current engagement now involves information being delivered via translated SMS using the Victorian Interpreting and Translating Service (**VITS**).[25]

37. DPV Health also advised that they now have a Language Services (Interpreting and Translations) policy which '*stipulates a commitment to providing equitable and responsible services to clients from culturally and linguistically diverse backgrounds, which are offered at no cost and ensures information is provided to clients in their preferred language*.'[26]

38. Since the time of Victoria Police and DPV Health's engagement with Mr Y in April 2020, new practice guidance for services assisting adult perpetrators of family violence have also been released as part of the *Multi-Agency Risk Assessment and Management* framework (**MARAM**) (the perpetrator practice guide).[27] The perpetrator practice guide highlights research on the prevalence of suicide amongst men with a history of interpersonal violence,[28] and notes that perpetrator interventions '*may increase a perpetrator's risk to themselves (from suicide or self-harm).*'[29]

39. The perpetrator practice guide notes that several family violence risk factors can also be risk factors for suicide or self-harm, referring to these as '*common risk factors*.' The perpetrator practice guide stipulates that in '*family violence risk management practice with adult perpetrators...suicide safety planning, or a mental health referral response where the common risk factors are identified, is a standard minimum response across the service system and particularly for specialist practitioners*.'[30]

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[24] DPV Health, email detailing their contact with Mr Y; Department of Families, Fairness and Housing, L17 Portal records in relation to Mr Y, '*Response – attachment 1,*' 3, 8.

[25] DPV Health, additional statement dated 8 August 2021.

[26] Ibid.

[27] Family Safety Victoria, MARAM Practice Guides, *Perpetrator Practice Guides* (Feb 2021).

[28] Family Safety Victoria, MARAM Practice Guides, *Foundation Knowledge Guide* (Feb 2021) 99-101.

[29] Ibid 18.

[30] Ibid 103.

40. The perpetrator practice guide also notes that 'su*icide risk is likely higher at the time of, or directly after, situational stressors occur, and/or if a change within the person's life involves a loss of control or power*,'[31] and highlights that '*people in contact with the legal system, including with police, courts and corrections, are at higher suicide risk*.'[32] The guide notes that there may be an increased risk of suicide in particular situations including: the removal of the respondent from the home or when paperwork is served on the respondent following a family violence notification – this could include a '*caution'* or a family violence intervention order.[33] Further, the perpetrator practice guide stipulates that any risk of suicide and threat to self-harm when engaging with family violence perpetrators '*must be taken seriously and [services] must respond appropriately.'*[34]

41. Services such as DPV Health, who provide a specialist service for male perpetrators of family violence, are required by legislation to align their services to the MARAM. At present, the perpetrator practice guides do not include specific comprehensive guidance for specialist family violence services such as DPV Health, however it is expected that these materials will be released in the coming months. It is expected that DPV Health will be undertaking work to integrate their practice and policy guides to align with the requirements outlined in the new perpetrator practice guides and those due to be released in the future.

COMMENTS

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

Victoria Police – use of children as interpreters in family violence incidents

42. The use of Miss R as an interpreter for Ms L and Mr Y during the family violence incident on 29 April 2020 was contrary to the *Code of Practice for the Investigation of Family Violence* (**Code of Practice**).[35] The Code of Practice 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*.'[36] It provides that where an affected family member

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[31] Ibid.
[32] Ibid.
[33] Family Safety Victoria, MARAM Practice Guides, *Responsibility 3: Intermediate Risk Assessment* (Feb 2021) 124.
[34] Ibid 132.
[35] Victoria Police, *Code of Practice for the Investigation of Family Violence*, (2019) 3rd Ed, V4.
[36] Ibid 70.

is not fluent in English an interpreter '*should be arranged at the earliest opportunity and at every stage of the investigation*'[37] including '*during initial crisis intervention (e.g. at the scene)*'.[38] Further, it expressly notes that '*family members and children should not be used*.'[39]

43. There are several reasons outlined for this, including that it risks causing further emotional distress and trauma for the interpreter, and that '*emotional distress may particularly be caused to children.*'[40] It also notes that using family members and children as interpreters '*degrades the reliability of any evidence gained through a statement.*'[41] This appears to be acknowledged by police members who attended the incident, who noted that due to Miss R interpreting they could not be sure that they had obtained full information about all of the family violence that had been occurring.

44. It is noted that the *Code of Practice* does provide that in '*emergency situations police may seek immediate interpreter assistance from neighbours or persons present*.'[42] However, there is no evidence to suggest that the family violence incident was an emergency situation that warranted using a family member to interpret.

45. The *Code of Practice* outlines that telephone interpreting services are available to the police when they need an interpreter.[43]

46. Victoria Police have confirmed that since the time of this incident there have been several policy changes to strengthen the commitment to not use children as interpreters in family violence cases. The VPMP Family Violence and the VPMG Family Violence have been amalgamated into the VPM Family Violence. The amalgamated document now contains section 3.4 that specifies "*children* ***must not*** *be used as interpreters*".[44] This provides clearer direction from the previous phrasing "*should not*".

Victoria Police – L17 reports and suspect welfare management

47. Following the family violence incident on 29 April 2020, Victoria Police completed and submitted a VP Form L17 (**L17**), which was sent to Berry Street, DPV Health and Child FIRST. The L17 is used to assess the severity of risk of future family violence and includes a range of

[37] Ibid.
[38] Ibid.
[39] Ibid.
[40] Ibid.
[41] Ibid.
[42] Victoria Police, *Code of Practice for the Investigation of Family Violence*, (2019) 3rd Ed, V4, 19.
[43] Ibid.
[44] Victoria Police Manual - Family Violence, 24 January 2022

questions about family violence, children, drug and alcohol use and the relationship and backgrounds of both the affected family member/s and the perpetrator.

48. The L17 risk assessment that was submitted in relation to this incident appears to be largely reflective of the information that was provided to police at the scene. However, Body Worn Camera footage of this interaction shows that when police discussed the option of a FVIO with Ms L, she indicated that Mr Y had previously expressed suicidal ideation. In particular she said that he had previously indicated that if he had to leave the house he would kill himself.[45] This is not reflected in the L17, which marks '*no*' in response to the question '*Has the respondent ever threatened or attempted suicide?*'[46] The use of Miss R as an interpreter may have also concealed any serious suicidal ideation given the limitations of using a child to interpret during a family violence investigation.

49. The L17 is an important tool that is relied on by family violence service providers to determine the urgency and scope of the service they provide to victims and perpetrators of family violence. The fact that the L17 did not record Mr Y's suicidal ideation could potentially have impacted on the risk assessment undertaken by DPV Health, who received the referral, and the response they provided to him. This is discussed above in relation to the DPV Health referral following the 29 April 2020 event.

50. I note that both attending police members documented that throughout their interaction with Mr Y he did not express any suicidal thoughts or ideation and appeared to be in '*good spirits*.'[47]

51. The *Victoria Police Manual Guidelines – Safe management of Persons in Police Care or Custody* provides guidance for police regarding their obligations to ensure the welfare of persons in their care or custody. This document provides that the period following an interview is a time when persons are '*at a higher risk of suicide or self-harm*'[48] and provides guidance for police to follow when risks are identified.

52. When Mr Y was initially taken into custody at Broadmeadows Police Station, the custody sergeant made enquiries with Mr Y about his welfare, however these enquiries

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[45] Coronial brief, Exhibit 1, D Turner Body Worn Ca[redacted]_*fv.mp4*' at 1:20; Exhibit 2, J Walk Body Worn Camera footage, '*fvsn-*[redacted]*.mp4*' at 2:10.

[46] Department of Families, Fairness and Housing, L17 Portal records in relation to Mr Y, '*Response – attachment 1,*' 6.

[47] Coronial brief, Statement of D Turner, 27; Statement of J Walk, 31.

[48] Victoria Police, *Victoria Police Manual Guidelines – Safe management of persons in care or custody* (March 2020) 13

were made in English, did not specifically pertain to his mental health or suicidal ideation, and Mr Y did not appear to understand the questions that were asked of him.[49] An additional statement was obtained from the Acting Sergeant to ascertain whether any further enquiries were made with respect to Mr Y's welfare, and whether an interpreter was used for these enquiries. The Acting Sergeant confirmed that the conditions of the FVSN, the FVSN documents, Mr Y's rights, and the services that he could contact, were explained to Mr Y using an interpreter.[50]

53. The *Victoria Police Manual Policy Rules – Persons in police care or custody*[51] applicable at the time, and currently, provide that when conducting welfare checks custody sergeants should ensure that they are '*meeting the accessibility needs of detainees (for example, tailoring language to ensure understanding or engaging an interpreter if required*).'[52]

54. Whilst several issues have been identified regarding the response to the family violence incident on 29 April 2020, I have not concluded that those matters caused or contributed to the death.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr Y, born ████████ 1973;

    b) the death occurred on or about 14 May 2020 at ████████, Meadow Heights, Victoria, 3048, from Neck Compression by Ligature Suspension; and

    c) the death occurred in the circumstances described above.

56. Having considered all of the circumstances, including the means chosen, I am satisfied that Mr Y intentionally took his own life.

57. I convey my sincere condolences to Mr Y's family for their loss.

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

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

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[49] Statement of R Hodge.
[50] Statement of S White, 1.
[51] Victoria Police, *Victoria Police Manual Policy Rules – Persons in police care or custody* (March 2020 & July 2021).
[52] Ibid 8.

Ms L Senior Next of Kin

Victorian Government Solicitor's Office

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

Detective Senior Constable Jeffery Disken, Coroner's Investigator

Signature:

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SARAH GEBERT

Date: 22 June 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.