IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 1704

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF JOHN KENNARD

Findings of:	Coroner Simon McGregor
Delivered on:	20 April 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria, 3006
Inquest Hearing Dates:	29 March 2022
Counsel Assisting:	Lindsay Spence Principal In-House Solicitor Coroners Court of Victoria
Chief Commissioner of Police:	Paul Lawrie of Counsel instructed by Victorian Government Solicitor's Office

I, Coroner Simon McGregor, having investigated the death of John Kennard, and having held an inquest in relation to this death on 29 March 2022 at Melbourne, find that:

- the identity of the deceased was John Kennard born on 30 March 1980;
- the death occurred on 5 April 2019 at Royal Melbourne Hospital, Parkville, Victoria;
- from 1(a) Injuries sustained in a fall from a height

in the following circumstances:

BACKGROUND:

1. John Kennard, aged 39 years, passed away on 5 April 2019 after falling from the fourth-floor balcony of his apartment whilst attempting to escape from Victoria Police Officers who had attended to execute a bench warrant for his arrest.

2. On 30 August 2017 Mr Kennard appeared before Melbourne Magistrates' Court where he was sentenced on thirteen counts of theft from shop (shopsteal), a count of commit indictable offence whilst on bail and two other offences, with an aggregate 8 months imprisonment to be served by way of a Drug Treatment Order. Subsequent to this sentence Mr Kennard failed to appear at a Drug Court Hearing on 16 November 2017 where a Warrant to Arrest (Bench Warrant) was issued.

3. Further the warrant was endorsed 'NOT TO BE RELEASED ON BAIL'. In a covering letter from Melbourne Prosecutions it was noted that '*The Warrant has been endorsed by the Drug Court Magistrate, and the arrested person is not to be released from custody except by a Drug Court Magistrate. The arrested person is not entitled to apply for bail pursuant to the Bail Act 1977 (Vic) ("the Act"), as the Act only applies to a person accused of an offence. The person arrested is no longer accused of an offence; they have pleaded guilty to the offence and have been sentenced to a term of imprisonment served in the community on a DTO*'.

4. There are no recorded contacts between Victoria Police and Mr Kennard between 30 August 2017 (initial sentence date) until his death on 5 April 2019. Management of the warrant was initially assigned to Senior Constable COX however upon his transfer out of Southbank Police Station, it was reallocated to Senior Constable Kane. Mr Kennard's address was recorded on the LEAP system at 402/660 Elizabeth St as far back as 1 April 2016.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Mr Kennard's death constitutes a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as he resided in Victoria and his death appears to have been unnatural and unexpected.[1] Mr Kennard was also immediately before his death a person placed in custody or care[2] and I was therefore required to conduct an inquest into his death pursuant to section 52 of the Act. In the circumstances, I considered it appropriate to hold a summary inquest which occurred on 29 March 2022.

6. At the time of Mr Kennard's death, Victoria Police Officers were part-way through execution of a bench warrant for his arrest. Section 64 of the *Magistrates Court Act 1989* authorised a police officer to arrest Mr Kennard and bring him before a bail justice or the court within a reasonable time of being arrested to be dealt with according to law. During the conversation with Mr Kennard, First Constable O'Shannessy informed him '*the reason why we're here today John is because police have an outstanding warrant for your arrest because you missed court*'. Whether Mr Kennard at that point was under arrest is immaterial, the circumstances that followed clearly fall within the definition of '*a person who a police officer is attempting to take into custody*'. In these circumstances Mr Kennard was '*a person placed in custody or care*' at the time of his death pursuant to sections 3 and 52 of the Act, thereby mandating that an inquest be held into his death.

7. At the hearing, a summary of the evidence was provided to the Court by Principal In-House Lawyer, Lindsay Spence. The individual witnesses who provided statements in the brief were not required to give evidence at the inquest as, after carefully considering all of the material in the brief, I was satisfied that there were no factual disputes or controversies which remained unresolved. The Chief Commissioner of Police was also given an opportunity to make submissions in relation to the evidence.

8. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[3] The role of the Coroner is to independently investigate reportable deaths to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[4] Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

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[1] *Coroners Act 2008*, s4.
[2] *Coroners Act 2008*, s4(2)(c).
[3] *Coroners Act 2008* s 89(4).
[4] *Coroners Act 2008*, preamble and s 67.

9. It is not the role of the Coroner to lay or apportion blame, but to establish the facts.[5] It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation,[6] or to determine disciplinary matters.

10. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

11. For coronial purposes, the phrase "*circumstances in which death occurred*,"[7] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

12. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings, and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" mandate.

13. Coroners are also empowered:

    a. to report to the Attorney-General on a death;

    b. to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    c. to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.

14. These powers are the machinery provisions by which the prevention role is advanced.

15. Victoria Police assigned Detective Sergeant Wayne Nixon to be the Coroner's Investigator for the investigation into Mr Kennard's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

16. This Finding draws on the totality of the material obtained in the coronial investigation of Mr Kennard's death, that is, the Court File, the Coronial Brief prepared by the Coroner's

[5] *Keown v Khan* (1999) 1 VR 69.
[6] *Coroners Act 2008*, s 69 (1).
[7] *Coroners Act 2008*, s 67(1)(c).

Investigator and further material obtained by the Court, together with a transcript of the Inquest hearing.[8]

17. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[9] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[10]

18. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[11] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

19. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved.[12] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[13]

IDENTITY OF THE DECEASED

20. On 10 April 2019, Mr Kennard's body was identified by fingerprint comparison and identification.[14]

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

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[8] From the commencement of the Act, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the *Coroners Act 2008*.
[9] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[10] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[11] (1938) 60 CLR 336.
[12] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.
[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J.
[14] Statement of Identification, Inquest Brief, p189.

MEDICAL CAUSE OF DEATH

22. On 6 April 2019, Dr Joanna Glengarry, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination upon Mr Kennard's body. In a report dated 19 August 2019, Dr Glengarry made the following comments:[15]

> The post-mortem CT scan showed no skull fracture. There was possible ligamentous injury at the atlanto-occipital junction and there was basal subarachnoid haemorrhage and a lesser amount of bilateral convexity subarachnoid haemorrhage. Haemorrhage around the upper cervical spine was evident. Imaging of the torso showed right posterior and lateral rib fractures, left lateral rib fractures and a sternal fracture. There were bilateral haemopneumothoraces. Imaging of the pelvis showed an open book fracture through the pubic symphysis, right superior and inferior pubic rami fractures, left sacral fracture, a left acetabular fracture and right sacral fracture. Imaging of the spine showed left lumbar transverse process fractures. Imaging of the legs showed fractures of the right proximal tibial and fibular, proximal left femur, left ankle (tibia, fibular, talus), left foot (3rd and 4th metatarsals), and tarsals. Imaging of the arms showed bilateral distal humerus fractures.
>
> At the time of my examination, I was shown CCTV footage of the deceased impacting the ground. The images showed a very rapid descent with a primary impact to the feet and subsequent second impact to the rest of the body. The injuries sustained are more than sufficient to have resulted in this man's death and the pattern of injuries is entirely in keeping with the descent of the body to the ground with a feet-first impact as depicted in the CCTV footage.

23. Toxicological analysis detected methadone, diazepam, olanzapine and cannabis in the blood and urine. Morphine, codeine, methylamphetamine and amphetamine were detected in the urine only.

24. Dr Glengarry formulated the cause of death as:

> 1(a) Injuries sustained in a fall from a height

[15] Statement of Forensic Pathologist Dr Glengarry, Inquest Brief, pp114-115.

25. I accept Dr Glengarry's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

26. On 5 April 2019 at 6.00am Senior Constable Kane commenced her shift at Southbank Police Station. Whilst clearing her emails she read an email received from A/Sergeant Hugo in respect of an outstanding warrant in respect of John Kennard. Senior Constable Kane gave evidence that '*I have had no previous dealings with John Kennard. I was allocated this file as the original informant moved police stations*'. Senior Constable Kane accessed the LEAP system and located the specific warrant within her active warrants allocation.

27. Approximately 8.00am Senior Constable Kane sent a text message to her colleague, First Constable O'Shannessy that read

> '*Mate is there any chance you can do me a favour and attend an address for a warrant enquire I'm getting chasers for? It's 402/660 Elizabeth st – even just speaking to building manager to see if male lives there?'*

28. Approximately 8.10am First Constable O'Shannessy had a telephone call with Senior Constable Kane that lasted four minutes. During that telephone conversation First Constable O'Shannessy indicated that she would conduct the warrant check as requested. First Constable O'Shannessy gave evidence that '*I then asked her about the person she needed arrested on the outstanding bench warrant. Senior Constable Kane gave me the name of the person which was John Kennard and that he had one warning flag for psychiatric issues from 2016 on LEAP. Senior Constable Kane said the bench warrant was for a fail to appear for a drug court matter*'.

29. At the conclusion of the telephone call First Constable O'Shannessy and Constable Donaldson started to make their way towards Mr Kennard's last known addresss. First Constable O'Shannessy was driving and therefore Constable Donaldson performed a number of checks on LEAP in respect of Mr Kennard.

30. First Constable O'Shannessy and Constable Donaldson arrived at 660 Elizabeth Street, Melbourne at 8.49am. The premises were government funded housing and crisis accommodation named Launch Housing. After speaking with the building receptionist and signing in, the Officers were escorted by Launch Housing Coordinator Greg Cole up to Mr Kennard's room on the fourth floor.

31. Upon arriving First Constable O'Shannessy listened to see if she could hear anyone inside the apartment but couldn't hear anyone. She then knocked three separate times and on the third time called out '*Mr Kennard, can you answer the door please*'. Mr Kennard opened the door after which the following conversation occurred

FIRST CONSTABLE O'SHANNESSY	*What's your name?*
JOHN KENNARD	*John*
FIRST CONSTABLE O'SHANNESSY	*John Kennard?*
JOHN KENNARD	*That's me*
FIRST CONSTABLE O'SHANNESSY	*The reason why we're here today John is because police have an outstanding warrant for your arrest because you missed court, are you aware of this?*
JOHN KENNARD	*Yes*
FIRST CONSTABLE O'SHANNESSY	*It's an easy process John, we'll go down to the station and get you a new court date and if we're not busy we can give you a lift back here afterwards*
JOHN KENNARD	*Can you give me a minute to get dressed?*

10. Mr Kennard then closed the door of his apartment.

11. In respect of Mr Kennard's presentation First Constable O'Shannessy's formed the opinion '*when I spoke to John I observed he seemed calm and nothing gave me concern for his welfare. He seemed compliant and was going to come with us. I can't recall what exactly he needed to do that he needed two seconds but it could've been to change clothes … … I was standing approximately a metre away from John. When John opened the door it was fully opened and he held the door open with his hand'.*

12. In Constable Donaldson's opinion '*his demeanour was good, by that I mean he wasn't aggressive or anything … … He didn't appear to be drug or alcohol affected. He then asked if he could get changed. To the best of my memory, while at the door he was wearing dirty old track pants or pyjamas and I think an old shirt. I don't think he had shoes on*'.

13. A number of minutes later Greg Cole received a transmission on his portable radio from Launch Housing employee Zoe Fitzgerald that Mr Kennard had jumped. As a consequence of that transmission First Constable O'Shannessy went back to Mr Kennard's apartment door and yelled out '*Open the door*'. Greg Cole has then used a key fob to access Mr Kennard's apartment and entered followed closely behind by First Constable O'Shannessy to find the apartment unoccupied.

14. Officers then went to the apartment balcony and upon looking down observed Mr Kennard face down and not moving on the roadway in front of the building complex. Officers then left the apartment closing the door behind them and went downstairs via the internal fire stairwell and located Mr Kennard in Berkeley Street who was unconscious suffering critical injuries. A number of Launch Housing employees were already on-scene rendering first aid assisted by a number of members of the public until Ambulance Victoria Paramedics took over soon after. Mr Kennard was conveyed to Royal Melbourne Hospital where he was unable to be revived and declared deceased.

15. A Critical Incident was declared, and crime scenes cordoned off with both First Constable O'Shannessy and Constable Donaldson undergoing mandatory drug and alcohol testing.

16. Officers from the Major Crime Scene Unit (MCSU), Forensic Services Department attended the location and conducted a forensic crime scene examination. Leading Senior Constable HRADEK made the following observations:

    a. 660 Elizabeth Street was a multi-level accommodation complex that was located on the east side of Elizabeth Street. The rear of the building backed onto Berkeley Street which ran parallel with Elizabeth Street, between Pelham and Queensberry Streets.

    b. Unit 4.02 was located on the fourth floor of the building. The balcony of the unit was located in Berkeley Street, above the footpath, near the entrance doors.

    c. A number of items were located on the footpath and road below the balcony of the unit including two areas of what appeared to be bloodstaining on the road and footpath and a Nike Shield sports runner (size UK 8.5/left).

d. Unit 4.02 was located at the east end of the building, above Berkeley Street and was accessed via a single front door, fitted with an electronic key. The unit was an open plan design comprising a kitchen, dining area, lounge area and bedroom. The toilet and bathroom were part of an enclosed area located off the bedroom on the west side.

e. The balcony was located off the lounge room at the rear of the unit. Access to the balcony was possible via an open sliding aluminum door. A wind down blind fitted above the inside of the door was drawn down near the floor. The balcony was fitted with a galvanised metal railing 1.15 metres high. The top of the balcony railing was located at a height of 14.5 metres above street height. A tan coloured fitted double bed sheet was located on the railing immediately outside the open sliding door. The sheet had been folded loosely around the top rail with a section of sheet hanging on the outside of the rail and the remaining length of sheet hanging lose on the inside of the balcony rail. A number of marks were located on the flat metal railing, beneath the top rail.

COMMENT

17. The Police members were part-way through execution of a bench warrant, having confirmed Mr Kennard's identity, and having informed him they possessed a warrant for his arrest. Mr Kennard then requested that the Police members give him a minute to get dressed which they agreed to, and he closed the door of his apartment with the members waiting in the corridor outside. Mr Kennard subsequently fell to his death after attempting to climb down from his fourth floor balcony.

18. The *Victoria Police Manual – Policy Rules – Persons in police care or custody* states '*the following principles that underpin the management of persons in police care or custody. Members who have responsibilities in relation to persons in care or custody, as outlined in this policy, must apply these principles:*

- *The overarching consideration is the safety, security, health and welfare of the person in care or custody.*

- *Each person in police care or custody must be treated as an individual, having regard to their specific risks and needs. It must not be assumed that all persons need to be managed as high risk.*

- *Decisions about how a person is managed and what amenities they are given access to must balance the person's welfare, dignity and human rights against any risk to their safety and security, or the safety and security of others, including police members.*

- *Persons must be continually monitored and assessed, particularly in respect of their medical condition, risk of self-harm, risk of harming others and security risk.*

19. Mr Kennard was aware that the sole reason for the attendance of the Police members was to place him under arrest and convey him to be dealt with in accordance with the warrant. The Police members in allowing Mr Kennard to return back inside his apartment, unaccompanied and with the door closed, completely compromised their ability to continually monitor and assess Mr Kennard. They had no means of ascertaining the precise conduct that Mr Kennard was engaging in, whether that be in fact changing his clothes or alternatively some other conduct that posed a much more significant risk to either himself or to the Police members.

20. A review of the CCTV footage from the corridor outside Mr Kennard's apartment shows that the Police members arrived at the apartment at 8.58.53am. It further shows that by 9.00.00am the initial verbal interaction with Mr Kennard had concluded. The Police members subsequently remained outside the apartment for at least the following three (3) minutes prior to Mr Cole receiving a broadcast in respect of Mr Kennard falling from the balcony. For that three-minute duration the Police members were entirely compromised in respect of either monitoring or assessing Mr Kennard's conduct.

21. The Chief Commissioner submitted that the Police members assessed Mr Kennard's demeanour, found him to be calm and cooperative, not aggressive or abusive, and did not appear to be drug or alcohol affected. On their initial assessment Mr Kennard was compliant and the members had no immediate concerns for his welfare, or that he was a flight risk. The Chief Commissioner also submitted that as the members had no immediate concerns for Mr Kennard's welfare, the members appropriately ensured that his dignity and privacy were balanced against any potential risk that he may have posed in returning to his apartment unaccompanied to get changed in private.

22. Whilst I appreciate that the Police members' initial risk assessment of Mr Kennard identified no concerns, their subsequent conduct deprived them entirely of any ability to conduct any ongoing risk assessment of Mr Kennard. In these circumstances it is difficult to understand how the Police members were able to continually satisfy themselves as to Mr Kennard's safety, security, health and welfare, as well as to their own safety.

23. Further it is noted that Mr Kennard had criminal convictions for armed robbery (August 2010), escape from youth training centre (June 2000) and escape from prison/police gaol (November 1999), all of which raise issues germane to risk assessment. There is no evidence available that the Police members were aware of Mr Kennard's prior history or that Senior Constable Kane had advised First Constable O'Shannessy of these convictions in their telephone conversation earlier that morning.

24. It is further noted that contained within the Inquest Brief, is a statement from Mr John ANDERSON, support worker for Launch Housing who gives evidence '*I was aware that Mr Kennard had an outstanding warrant and was wanted by the Police. This was for drug court and Mr Kennard was well aware that he was facing an 18 month sentence. Because Mr Kennard was still using heroin he was well aware that he could never meet the conditions of drug court and therefore would be imprisoned. We spoke about this dozens and dozens of times … … the fact that he may have tried to escape the police doesn't surprise me given his concern in going back to prison*'.

25. I reject the Chief Commissioner's submission that it was appropriate to allow Mr Kennard to return inside his apartment unaccompanied to preserve his dignity and privacy in circumstances where his arrest was to be the eventual outcome. First Constable O'Shannessy (female officer) was partnered that shift with Constable Donaldson (male officer). In the circumstances it would have been prudent to have had Constable Donaldson enter the apartment (with First Constable O'Shannessy immediately outside to render assistance if required), thereby facilitating Mr Kennard being continually monitored and assessed, whilst still preserving his dignity and privacy.

26. Ultimately I reject the Chief Commissioner's submission that the members' conduct complied with the overarching consideration of the Policy, being that 'safety, security, health and welfare of the person in care or custody'. For the reasons stated above, the alternative conduct I have posited would have much more substantially complied with the management principles defined within the *Victoria Police Manual – Policy Rules – Persons in police care or custody*.

27. Had Mr Kennard been continually monitored and assessed, it is less likely that he would have engaged in the conduct that he did, namely attempting to escape from lawful custody (or if he had done so, immediate preventative action could have been taken), although given his antecedents, it cannot be said to the *Briginshaw* standard that he would certainly not have pursued the course of action that he did.

28. Whilst Mr Kennard took the decision to engage in the conduct that he did and contributed to his own death in attempting to escape from custody, he did so in circumstances where the Police members had placed themselves in an ineffectual position, neither monitoring nor assessing him.

29. Whilst this investigation has revealed prevention opportunities and room for improvement, it cannot be said to the relevant standard that this was a preventable death.

FINDINGS AND CONCLUSION:

30. Having held an inquest into the death of Mr Kennard, I make the following findings, pursuant to section 67(1) of the Act:

    a. the identity of the deceased was Mr John Kennard born on 30 March 1980;

    b. the death occurred on 5 April 2019 at Royal Melbourne Hospital, Parkville, Victoria from injuries sustained in a fall from a height;

    c. that the death occurred in the circumstances set out above.

31. I convey my sincerest sympathy to Mr Kennard's family.

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

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

Senior Next of Kin, Fadia Kennard

Chief Commissioner of Police, Mr Shane Patton APM.

Detective Sergeant Wayne Nixon, Coroner's Investigator.

Signature:

CORONER SIMON McGREGOR

CORONER

Date: 20 April 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 inquest. 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.