IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2019 7105**

# FINDING INTO DEATH WITHOUT INQUEST

*Form 38 Rule 63(2)*

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

***Amended on 19 August 2022 pursuant to section 76 of the Coroners Act 2008 (Vic)***[1]

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| Findings of: | Coroner Katherine Lorenz |
| Deceased: | YGE [redacted] |
| Date of birth: | [redacted] |
| Date of death: | 28 December 2019 |
| Cause of death: | 1(a) Hanging |
| Place of death: | Neighbourhood Justice Centre, 241 Wellington Street, Collingwood, Victoria, 3066 |

[1] Amendments are indicated in the footnotes.

## INTRODUCTION

1. On 28 December 2019, YGE was [redacted] years of age when he was found deceased by a security guard in the courtyard of the Neighbourhood Justice Centre (**NJC**) in Collingwood, Victoria.

2. YGE had a long history of mental illness including major depressive disorder, suicidality and illicit substance use. He also had a significant forensic history. He was intermittently engaged in mental health support provided through the NJC in partnership with St Vincent's Mental Health.

3. In early 2019, YGE separated from his long-term partner with whom he had two children. At the time of his death, he was subject to a final family violence intervention order (**FVIO**) in protection of his former partner and their two children. The FVIO was made at the NJC in February 2019 and precluded him from contacting them and attending their home. On 12 December 2019, he was arrested by Victoria Police for persistent breaches of the FVIO.

## THE CORONIAL INVESTIGATION

4. YGE 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.

5. I took carriage of this investigation from Coroner Spanos in February 2021 when I was appointed as a Coroner.

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 Senior Constable Edward Roberts (**SC Roberts**) to be the Coroner's Investigator for the investigation of YGE death. SC Roberts conducted inquiries on

my behalf, including taking statements from witnesses – such as family, the forensic pathologist, investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of YGE, 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

10. On Saturday, 28 December 2019, at around 3:00am, YGE entered the courtyard of the NJC[3] from over a wall and hung himself in the centre of the courtyard with a rope which he looped around his neck and affixed to a tree on a raised embankment.

11. He was found a few hours later by a security guard who arrived at the NJC[4] for work at about 11:16am. It was immediately apparent to the guard that YGE was deceased. Emergency services were notified and arrived quickly. Ambulance Victoria paramedics confirmed YGE deceased at 11:36am.

12. Victoria Police conducted a search of the courtyard and located a backpack containing a wallet with various identification cards belonging to YGE. The backpack also contained drug paraphernalia and a Spirax notebook with the words "*Read within notes! to ppl Re: Death*" handwritten on the front cover. The notebook contained lengthy handwritten suicide notes to family members.

13. Hand-written messages were also found on one the walls of the courtyard. The messages included "*EVIL PPL WORK HERE*" and "*How many innocent relationships with innocent Dads do kids innocent kids – have to lose to serve Rosie Batte?*".

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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] Amended: "NJC" substituted for "NCJ".

[4] Amended: "NJC" substituted for "NCJ".

**Identity of the deceased**

14. On 30 December 2019, YGE [redacted], born [redacted], was identified via fingerprint identification.

15. Identity was not in dispute and required no further investigation.

**Medical cause of death**

16. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 30 December 2019 and provided a written report of his findings dated 1 January 2020.

17. The post-mortem examination revealed a parchmented ligature mark encircling the neck in keeping with the reported history of hanging. Dr Bedford commented that hanging causes death by obstruction of the airways and blockage of blood flow to and from the brain.

18. Toxicological analysis of post-mortem samples detected 6-monoacetylmorphine, morphine, codeine and delta-9-tetrahydrocannabinol. These results are consistent with the recent use of heroin and cannabis.

19. Dr Bedford formulated the medical cause of death as *1 (a) Hanging.*

20. I accept Dr Bedford's opinion.

**FURTHER INVESTIGATIONS**

21. Coroner Spanos referred this matter to the Mental Health and Disability (MHD) and Family Violence (FV) teams of the Coroners Prevention Unit (**CPU**)[5]. The scope of the mental health review was to examine the mental health contacts proximate to YGE [redacted]'s death and the scope of the FV review was to look at the availability and adequacy of family violence supports.

[5] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

22. CPU advised that the MHD investigation team did not identify any concerns with the care and treatments provided to YGE by St Vincent's Mental Health through the NJC[6], Mercy Health or his GP.

23. CPU commented that in August 2019 YGE commenced treatment for a MMD and opioid replacement therapy which he appeared to have been compliant with until proximate to his death. It was noted that on 28 November 2019, YGE obtained one month's supply of desvenlafaxine, however the post-mortem toxicology did not show the presence of desvenlafaxine or the opioid replacement therapy Suboxone, which suggested he had not been taking them prior to his death. It is unclear precisely when and why YGE self-ceased these medications.

24. On review of the available evidence, CPU advised that the FV team did not identify any concerns with the family violence support provided to YGE prior to his death.

25. I accept the advice of the CPU.

**COMMENTS**

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

27. A review of the Victorian Suicide Register (**VSR**) suicide data of People Who Inject Drugs (**PWID**), supports that this group is a vulnerable cohort. As part of its review, CPU prepared a VSR Data and Research Summary which indicated that 46% of this cohort were associated with family violence and in these circumstances, there was a decrease in formal mental health diagnoses and contact with mental health and other services in the year and six months prior to their death.

28. The data showed PWID and suicide, when compared to all suicides:

    a) Experienced an average age of death 10 years earlier than all suicide deaths
    b) Experienced higher rates of unemployment
    c) Experienced higher rates of mental ill health
    d) Experienced a higher rate of formal diagnosed substance use disorder
    e) Experienced more frequent contact with health services in the year prior to death
    f) Experienced higher treatment contacts in the six weeks prior to death
    g) Had a history of more frequent threats to self-harm and suicide

[6] Amended: "NJC" substituted for "NCJ".

29. The data showed 46% of the suicides of PWID had evidence of perpetrating family violence. This cohort:

    a) Had less formal mental ill health diagnoses
    b) Experienced less contact with services
    c) Experienced more legal stressors
    d) Made more verbal threats to suicide.

30. The less formal mental ill health diagnoses may reflect less contact with health and other services rather than an absence of mental ill health.

31. Excluding cases with evidence of family violence as adults and/or around the time of death, 54.04% (234) of this cohort had a recorded significant trauma event including childhood abuse (sexual and/or psychological and/or emotional), parental or sibling death, and suicide of a family member.

32. Of the 433 suicide deaths identified in the Data and Research Summary, 38.7% (n=168) had children, of which 42.2% (n=71) had expressed distress about not being able to access their children and/or custody stressors. Of these 71.83% (51) were males.

33. Given the engagement that this cohort has with support services, consideration of the needs of this cohort should be reflected in the practice advice and training provided to professionals who may come into contact with a perpetrator of family violence.

34. The Victorian Government is committed to ongoing work to address family violence among the community and the Data and Research Summary outcomes and the finding into [redacted]YGE[redacted]'s death will provide an opportunity to learn about the specific circumstances of suicides of people who inject drugs and are perpetrators of family violence.

35. To this end, I directed that Family Safety Victoria (**FSV**) be provided with a copy of the VSR Data and Research Summary. FSV advised that it had not previously had access to this data set or similar data.

36. FSV said that it was "committed to ongoing review of family violence evidence to inform best practice development, and believes the data provided is valuable to this end". FSV explained that the data set provided "would support FSV to further understand perpetrator risk profiles in relation to the co-occurrence of drug use, mental illness and suicidality and the risks of homicide, homicide-suicide and suicide of family violence victim survivors, as well as

perpetrators". FSV also noted that the data would be "useful to inform current interventions regarding changed or escalated risk to victim survivors and to perpetrators themselves, and in the design of future perpetrator initiatives."

## RECOMMENDATION

37. Pursuant to section 72(2) of the Act, I make the following recommendation:

    a) Family Safety Victoria review the data regarding the suicide of people who inject drugs and who are perpetrators of family violence and use this data to inform the development and review of perpetrator interventions going forward.

## FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was YGE [redacted], born [redacted];

    b) the death occurred on 28 December 2019 at Neighbourhood Justice Centre, 241 Wellington Street, Collingwood, Victoria, 3066, from hanging;

    c) the death occurred in the circumstances described above; and,

    d) having considered all of the circumstances, particular the lethality of the means chosen, I am satisfied that YGE [redacted] intentionally ended his own life.

39. 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.

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

    WVK [redacted], Senior Next of Kin

    Simon Cooke, Mercy Hospitals Victoria Ltd

    Senior Constable Edward Roberts, Coroner's Investigator

Signature:


Coroner Katherine Lorenz

Date : 5 August 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.