IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 4117

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of TESSA MICHELLE BALLAM

Delivered On:	30 March 2022
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	11 October 2021 to 20 October 2021 28 February 2022 to 4 March 2022
Findings of:	Coroner Phillip Byrne
Coroner's Assistant:	Senior Constable Premala Thevar, Police Coronial Support Unit instructed by Ms Rachel Quinn of the Coroners Court of Victoria
Representation	Ms Karen Argiropoulos and Mr Liam McAuliffe of counsel representing the Ballam family, instructed by Ms Alexis Bebbington of Bebbington Lawyers Ms Carmen Currie and Ms Kathleen Crennan of counsel representing Myer Pty Ltd, instructed by Ms Madeleine Armstrong of Sparke Helmore Lawyers Mr Robert O'Neill of counsel representing Mr Trent Lethlean, instructed by Joel Zyngier of Gilchrist Connell Mr David Oldfield of counsel representing Ms Jade Collins, instructed by Ms Melissa Dreher and Ms Anna Codlin of Seyfarth Shaw LLP Mr Tony Trood of counsel for Mr Leonard Kocavic, instructed by Mr Vincent Azzopardi and Ms Fiona Jenkins of Tony Hargreaves & Partners Lawyers Mr Glenn Barr of counsel representing WorkSafe Victoria, instructed by Ms Rebecca Johnston-Ryan of WorkSafe Victoria

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2015 4117**

FINDING INTO DEATH WITH INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

I, PHILLIP BYRNE, Coroner having investigated the death of TESSA MICHELLE BALLAM
AND having held an inquest in relation to this death on 11 October 2021
find that the identity of the deceased was TESSA MICHELLE BALLAM
born on 22 October 1983
and the death occurred on 15 August 2015
at 3/105 Osborne Street, South Yarra, Victoria 3141

from:

I (a) NECK COMPRESSION IN THE CIRCUMSTANCES OF HANGING

Pursuant to section 67(1) of the **Coroners Act 2008** I make findings with respect to **the following circumstances**:

BACKGROUND

1. Tessa Michelle Ballam, who the family have indicated they would prefer me to refer to as Tessa, was 31 years old at the time of her death and resided alone at 3/105 Osborne Street, South Yarra. Tessa was a highly intelligent young woman who had, relatively proximate to her death, successfully completed a certified practicing accountant qualification. Tessa was employed by Myer Pty Ltd (**Myer**) as an assistant accountant in the Merchandise Finance.
2. Unfortunately, Tessa had long-standing mental health issues, having previously been diagnosed as suffering from depression, anxiety and bulimia nervosa. Tessa experienced recurrent suicidal ideation and had a history of one previous suicide attempt. Tessa, having been referred by her General Practitioner, Dr Ben Webb, consulted clinical psychologist Dr Aileen Alegado which resulted in thirteen sessions with Dr Alegado from 12 May 2014 to 1 December 2014.

BROAD CIRCUMSTANCES SURROUNDING DEATH

3. On the afternoon of 14 August 2015 Tessa had spent approximately two hours in a performance management meeting with her line manager Ms Jade Collins and Mr Trent Lethlean of the Myer human resources department. At about 6:30pm after the meeting a work colleague Ms Michelle Svabec phoned Tessa enquiring as to how the meeting went. Tessa told Ms Svabec that she considered the meeting "didn't go well," she was on the way home and would call her back when she got home. Tessa returned Ms Svabec's call at about 7pm, reiterating that she felt the meeting did not go well and claiming that although she had the opportunity to respond to the issues raised she considered Ms Collins and Mr Lethlean "didn't listen" and "didn't take any of her responses into account." Interestingly, Tessa told Ms Svabec that she understood the outcome of the meeting was to develop an action plan to address the work issues raised.

4. At about 10am on Saturday morning 15 August 2015 Ms Svabec contacted another work colleague Ms Lucy Divic, who had been Tessa's support person at the performance management meeting, to get her perspective of how the meeting went. Ms Divic stated that Tessa had "done really well and had answered questions well."

5. After a number of attempts to contact Tessa to no avail, Ms Svabec made contact with Tessa's mother Ms Jules Ballam and ascertained Tessa's address. Presumably becoming somewhat concerned for Tessa's wellbeing Ms Svabec and her husband attended the Osborne Street address and, assisted by a neighbour, gained access to the complex and attended at Tessa's apartment. They knocked on the door but got no response. Ms Svabec advised Ms Divic of their attendance but, presuming Tessa may just be out for the day, left. Ms Svabec again tried to call Tessa that evening but got no response.

6. At about 2:30pm on Saturday 15 August 2015 Ms Holly Ward, a friend of Tessa's since school days in New Zealand, was contacted on Facebook by Tessa's mother Jules who told her she had tried to ring her daughter but the calls went answered. Ms Ballam asked Ms Ward if she would go to the apartment and check on Tessa's welfare. After her husband Nicholas Du Mez arrived home, the couple attended the Osborne Street apartment, where again a neighbour enabled access to the apartment block. Getting no response to their calls Ms Ward and Mr Du Mez gained access to the apartment and, no doubt to their horror, observed Tessa hanging from a noose attached to the staircase.

7. A call to the 000 emergency number resulted in the timely attendance of Ambulance Victoria paramedics and Victoria Police members, including the coroner's investigator,

Senior Constable Lauren Hand of Prahran Police. At the scene statements were taken from Ms Ward and Mr Du Mez, and Ms Ward completed a formal Statement of Identification.

REPORT TO THE CORONER

8. Tessa's death was reported to the coroner and I took carriage of the investigation into Tessa's death. Having considered the circumstances and having conferred with a forensic pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), I concluded autopsy was not necessary to establish the cause of Tessa's death, and directed an external only post mortem examination with ancillary tests. The directed post mortem was undertaken at VIFM by Forensic Pathology Fellow Dr Victoria Francis who in a subsequent report advised Tessa's untimely death was due to:

I(a) : NECK COMPRESSION IN THE CIRCUMSTANCES OF HANGING

Toxicological analysis of a post mortem blood specimen demonstrated a blood/alcohol concentration of 0.14 g/100mL; no other common drugs or poisons were detected.

RELEVANT LAW – THE ROLE/FUNCTION OF THE CORONER

9. The starting point is section 67 of the *Coroners Act 2008* which provides the core findings a coroner is required, if possible, to make:

1 (a) The identity of the deceased;

1 (b) The cause of death; and

1 (c) The circumstances in which death occurred.

1 (a) and 1 (b) are uncontroversial in this and most matters; the complexities arise in seeking to comply with 1 (c) and that is certainly in this case a complex, difficult task for reasons I will seek to articulate later in this finding.

10. Keown v Khan,[1] a decision of the Victorian Court of Appeal, represents a landmark judgement which, in my opinion, provided much needed guidance to Victorian (and other) coroners. His Honour Mr Justice Callaway adopting a statement contained in the report of the Brodrick Committee (UK) Report[2] said:

[1] (1999) 1 VR 69
[2] Report of the Committee on Death Certification And Coroners (1971) (UK) ("The Brodrick Report" Cmnd. 4810)

"In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination of blame."[3]

Again quoting the Brodrick Committee (UK) Report, His Honour noted:

"In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceeding which affords to others the opportunity to judge an issue and one which appears to judge the issue itself."[4]

11. So while not laying or apportioning blame a Coroner should endeavour to establish the CAUSE, or CAUSES, of a death; the distinction is fine but real. As Callaway J.A. described it in Keown v Khan:

"In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was in breach of a recognised duty, but that is the only sense in which para. (e) mandates an inquiry into culpability. Adopting the principal recommendation of the Norris Report, Parliament expressly prohibited any statement that a person is or may be guilty of an offence. The reasons for that prohibition apply, with even greater force, to a finding of moral responsibility or some other form of blame."[5]

12. I have found the dichotomy between finding cause of death on one hand and finding or apportioning fault, blame or culpability on the other difficult to articulate. Quite recently, in a judgement of the New Zealand Court of Appeal, I saw as good an explanation of the conundrum as I have seen. In the Coroners Court v Susan Newton & Fairfax New Zealand Ltd[6] reference is made to *Laws NZ*, Coroners. At paragraph 28 under the heading of "blame", the following statement appears:

"It is no part of the coroner's function to apportion blame for the death. The coroner must however be able to go beyond the mere cause of death if the coroner is to serve a useful social function, and must establish so far as is possible, the

[3] (1999) 1 VR 69, 75
[4] (1999) 1 VR 69, 75
[5] (1999) 1 VR 69, 76
[6] [2006] NZAR 312

circumstances of the death. The implicit attribution of blame may be unavoidable in order for the coroner to ascertain or explain how the death occurred in the wider events that were the real cause." (my emphasis)[7]

Unfortunately, often the implied attribution of fault is lost on a lay party who expected a more strident denouncement in circumstance where an adverse finding is made against someone they see as responsible for the death.

13. Causation goes to the heart of the matter. It has been the subject of considerable judicial attention and discussion in the coronial context.

14. In Chief Commissioner of Police v Hallenstein, Hedigan J observed:

"The issues of causation and contribution have bedevilled philosophers for centuries and have attracted consideration by superior courts in all jurisdictions and places for more than a century. The inclination to expound, in an authoritative way, the connection between human behaviour and consequences has proved seductive. The estimation of the nature and extent of this connection may be described as the evaluation of "contribution". The law has also espoused minimalism in attempting definition of the causative or contributing effect of conduct. Nearly 50 years ago, a powerful High Court (Dixon CJ, Fullagar and Kitto JJ) described causation as "all ultimately a matter of common sense" adding for good measure that "in truth the conception in question is not susceptible of reduction to a satisfactory formula." Fitzgerald v Penn (1954) 91 CLR 268, 278.

In E and MH March v Stramare, (1991) 171 CLR 506 the High Court of Australia considered the fundamentals of causation in the negligence context. The statements of principle in relation to causation are, in my view, applicable to the concept of contribution within the Act, as it is concerned with the causes of death and who contributed to it."[8]

15. In March v Stramare (supra) Chief Justice Mason observed:

"What was the cause of a particular occurrence is a question of fact 'which must be determined by applying common sense to the facts of each particular case'."[9]

[7] [2006] NZAR 312, 320
[8] (1996) 2 VR 1
[9] (1991) 171 CLR 506, paragraph 17

For an act or omission to be the cause, or one of several causes, of a death the connection between the act and/or the omission and death must be logical, proximate, and readily understandable; not illogical, strained or artificial. In theory it is a difficult and complex concept but one which, in my view, is manageable in practice.

16. The Coroners Act does not provide a general mechanism for an open ended enquiry into the merits or otherwise of the performance of government agencies, private institutions or individuals. In Harmsworth v The State Coroner[10], Justice Nathan broached the subject of the limits of a coroner's power and observed that the power of investigation is not "free ranging", commenting that unless restricted to pertinent issues an inquest could become wide, prolix and indeterminate. Significantly he added:

> *"Such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc. Such an inquest could certainly provide material for such comment. Such discursive investigations are not envisaged nor empowered by the Act they are not within jurisdictional power."*[11]

17. The relevant principle was recently re-stated in the Full Court of the Supreme Court of the Australian Capital Territory in R v Coroner Maria Doogan; ex-parte Peter Lucas - Smith and ors.[12]

18. In Doomadgee & Anor v Deputy State Coroner Clements[13] Mr Justice Muir commented that coroners are not 'roving Royal Commissioners.' He added:

> *"It is significant also that the rules of evidence do not bind a coroners court and that it may inform itself in any way it considers appropriate. That does not mean that there are no constraints at all on coroners in relation to the gathering of evidence. The evidence relied on by the Coroner must be relevant to the matters within the scope of the coronial inquiry."*[14]

19. I endeavour to heed His Honour's timely advice in relation to 'roving Royal Commissioners.' As we coroners are not bound by terms of reference I suggest we should be assiduous to ensure we don't move into matters with insufficient nexus to the cause of death.

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[10] (1989) VR 989
[11] (1989) VR 989
[12] (2005) ACTSC 74 (8 August 2005)
[13] (2005) QSC 357
[14] (2005) QSC 357, paragraph 35

I seek to apply what I refer to as the Callaway J dichotomy, distinguishing between causal and/or contributing factors on one hand, and "background circumstances" on the other.

20. The issue of standard of proof is relatively noncontroversial in theory, but in complex factual situations its application can be challenging. The classic statement on the issues is contained in Briginshaw v Briginshaw[15] where Dixon J, as His Honour was then, stated:

> *"…reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. 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 issue 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."*[16] (my emphasis)

21. When I examine the evidence, I am required to reach conclusions without the not inconsiderable benefit of retrospection. To do so I endeavour to put myself 'in the shoes' of the person/s whose performance is the subject of criticism, with the knowledge that person/entity had or should have had at the relevant time. Again, in theory reasonably achievable, but in practice a significant intellectual challenge.

THE COURSE OF THE CORONIAL INVESTIGATION

22. In initial discussion with the Coronial Admissions and Enquiries Office (**CA&E**) Mrs Ballam raised concerns about bullying in the workplace. She was advised to formalise these concerns in writing. Mrs Ballam submitted quite comprehensive written concerns which were followed by further extensive correspondence particularising her concerns.

23. Being aware that WorkSafe were investigating the circumstances surrounding Tessa's death and subsequently being advised the Director of Public Prosecutions had laid criminal charges under the *Occupational Health and Safety Act 2004* against Myer I left my investigation in abeyance pending the outcome of the prosecution.

24. In late September 2015, having received Dr Francis' report of the directed external only post mortem examination together with a toxicology report, I had my registrar at the time request from the coroner's investigator a coronial brief of evidence. The request was accompanied

[15] (1938) 60 CLR 336
[16] (1938) 60 CLR 336, pp 362-3

by the material submitted by Mrs Ballam with a further request that those concerns be addressed when compiling the brief.

25. The matter lay in abeyance until September 2019 when I was advised that the WorkSafe prosecution was 'discontinued' prior to evidence being called. I do not know, nor need to know, why the prosecution did not proceed after pre-trial submissions. The mere fact that it was not going to proceed was sufficient for me to reactivate/enliven my investigation. Having been provided with the WorkSafe brief, a voluminous two volume document, and being assured both briefs had been provided to both the family and Myer, through their then-solicitors Sparke Helmore Lawyers, I asked that the matter be listed for a Mention/Directions hearing early in the new year.

26. The matter came on for Mention hearing on 12 February 2020 in the form of an open court hearing. Ms Carmen Currie of counsel appeared for Myer; Mr and Mrs Ballam attended in person, having travelled from New Zealand. I invited the couple to the bar table to facilitate dialogue and ensure the matters they wished to raise would be included in the transcript of the hearing. Mrs Ballam was the primary spokesperson for the family. She confirmed the family had been provided with the two briefs of evidence. In broad terms Mrs Ballam reiterated many of the concerns the family had about the performance of Jade Collins, Trent Lethlean and Len Kocovic, the content of their respective statements, and the circumstances surrounding the performance management meeting of 14 August 2015.

27. Having heard both Mrs Ballam and Ms Currie I indicated that I would take the matter to inquest. A discussion followed in relation to what witnesses would be called at the proposed formal request with Mrs Ballam nominating several witnesses she believed would assist in my investigation. Following these discussions, I settled a tentative list of witnesses and had some broad discussion as to the scope/parameters of the proposed inquest.

28. As I said this matter had for a variety of reasons followed a tortuous path which was compounded by the impact of the COVID-19 pandemic during which traditional court hearings could not be held. It became clear the inquest could not proceed in the traditional manner, but would have to proceed by way of Webex.

29. The matter finally was listed to commence on 11 October 2021. At the hearing the Ballam family were represented by Ms Karen Argiropoulos of counsel; Myer by Ms Carmen Currie of counsel; Ms Collins by Mr David Oldfield of counsel; Mr Lethlean by Mr Robert O'Neill; and Mr Kocovic by Mr Tony Trood of counsel.

THE EVIDENCE

30. Over the following eight days I heard evidence from Mrs Ballam, Stephen Jeffries, Allan Bell, Bill Luong, Joshua Joseph, Lucy Divic, Michelle Svabec, Len Kocovic, Jade Collins, Trent Lethlean, and Dr Aileen Alegado. Ms Collins, Mr Lethlean and Mr Kocovic gave evidence after, upon applications by their respective counsel under the 'protection' of s 57 of the *Coroners Act 2008*. Unfortunately, we did not get through the list of witnesses and the matter was adjourned into the new year.

31. The inquest was relisted for five days commencing 28 March 2022 with the same legal representatives for the interested parties. Dr Alegado completed her evidence followed by evidence from Ms Anna Palmer, Associate Professor Peter Doherty and Professor Matthew Large with the fifth day, Friday, set aside for oral submissions.

32. My primary focus is whether, as claimed on behalf of her family, Tessa's death was, at least in large part, as a result of heightened risk of suicide/self harm due to:

    - The deteriorating workplace relationship with her line manager Jade Collins;
    - The claimed failure of Trent Lethlean and Len Kocovic to provide to Tessa appropriate support when she advised them that her relationship with Jade Collins was problematic to the extent it was causing her distress, and when it became obvious the relationship was "fractured," to escalate the issues of concern; and
    - The timing and conduct of the performance management meeting on 14 August 2015.

33. From my perspective, adopting what I will call the Callaway J analysis in Keown v Khan, I am required to consider whether any act by Myer or its employees departed from, or failed to reach, a recognised norm or standard, and/or whether any omissions on their part were in breach of a recognised duty to the extent it could reasonably be seen as a causal or contributing factor in Tessa's death. Although it is not my role to consider whether an act or omission by Jade Collins, Trent Lethlean or Len Kocovic represented a breach of the *Occupational Health and Safety Act 2004* per se, the issues I am considering are, in the main, much the same; fundamentally I examine the issues from a different perspective.

34. I do not of course consider these issues in a vacuum; it is imperative I consider them in the context of the prevailing circumstances. Perhaps the principal prevailing circumstance is that in their dealings with Tessa in the several months prior to the meeting, those whose performance is the subject of criticism were not aware of Tessa's long standing mental

health issues, especially her recurrent suicidal ideation, let alone the previous suicide attempt. Quite understandably, Tessa chose not to divulge/disclose that history, so that her fragility was not understood.

35. Again, from my perspective, the evidence of Associate Professor Doherty and particularly Professor Large had 'muddied the waters.'

36. Ms Palmer and Associate Professor Doherty, who reviewed and adopted the report of Dr. Cotton, were highly critical of Ms Collins, Mr Lethlean, Mr Kocovic and Myer generally. Those two reports were prepared for the proposed prosecution of Myer on the basis on the body of material provided by WorkSafe without actually hearing from those who provided statements to the WorkSafe investigation; in effect desktop reviews. While it may seem trite, that is in stark contrast to the position I am in where I have had the benefit not only of examining those statements/reports, but also considering the prevailing circumstances after hearing viva voce evidence from the major players, and assessing the weight to be attached to their evidence after those witnesses have been skilfully cross-examined by counsel for the family and counsel for those whose performance had been the subject of strident criticism. The whole exercise demonstrates the benefit of the coronial process in endeavouring to establish the facts surrounding the death under investigation. I think it fair to say that after cross-examination several witnesses retreated at least to some degree from their initial position; more on that later.

37. I am mindful of an observation of Batt J in Keown v Khan where he said:

> *"Finally, I desire to make some comments with regard to the record of investigation. There is no doubt that coroners may discuss the evidence and explain their findings. But I have the impression that at any rate more contentious inquests coroner's reports have of late tended to be prolix. At least as a general rule, that is unnecessary."*[17]

I suspect His Honour was concerned that in some cases critical findings of fact were difficult to identify when enmeshed in basically irrelevant background circumstances and minutia often far removed from the causal factors that warranted attention. I raise this issue because I do not propose in this finding to relate chapter and verse the evidence of all witnesses, but I shall merely explain in shortish detail the bases upon which I have reached

[17] (1999) 1 VR 69, 79

conclusions on the matters I have previously indicated have been the primary focus of my investigation.

Jade Collins' management of Tessa and the involvement of Trent Lethlean and Len Kocovic.

38. Ms Collins became Tessa's line manager in late 2014. Her previous line manager was Mr Stephen Jeffries. I understand it was Ms Collins' first time managing so that the role would be new to her. I think it fair to say the management style of Mr Jeffries, who seems to have got on well with Tessa, was somewhat different to that of Ms Collins; likely more casual and less demanding. However, while he was managing Tessa Mr Jeffries also had issues with her performance and discussed his concerns with her.

39. It should not be overlooked that Ms Collins' fundamental role was to manage Tessa. It seems that after what I will refer to as a 'honeymoon period' the working relationship between Tessa and Ms Collins progressively deteriorated until by at least July through to 14 August 2015 the relationship was 'fractured.' It was submitted that Ms Collins did not provide mentoring or coaching.

40. In that regard, by July 2015 there was virtually no engagement between Tessa and Ms Collins which would facilitate meaningful support, let alone coaching. Although Tessa and Ms Collins sat opposite each other a point was reached where extraordinarily they mainly communicated by email rather. In those circumstances meaningful support or coaching was at best problematic.

41. As I stated earlier, on behalf of Tessa's family there were three main areas of claimed inadequate/suboptimal management by Myer employees Jade Collins, Len Kocovic and Trent Lethlean that were said to have heightened Tessa's risk of self-harm and consequently contributed to her death. I propose to deal with the first two together as from my view they are intrinsically entwined.

42. In January/February 2015 Jade Collins at a regular 'catch up' meeting raised with Tessa issues of punctuality and missing deadlines for some work completion dates. It is reported Jade Collins suggested Tessa engage in Myer's Employee Assistance Program. Tessa did not take up the offer. However, in March Tessa approached Steven Jeffries, her previous line manager, to discuss the ongoing work relationship difficulties with Jade Collins and in confidence stated she had previously suffered anxiety, but the issue had resolved. Steven Jeffries was made redundant and left Myer in May 2015.

43. In May 2015 Tessa complained to Jade Collins that their working relationship remained problematic suggesting she was being treated like a child rather than a professional. On 10 July 2015 Tessa again complained to Jade Collins about her management style, saying she could no longer work with her, claiming to being discriminated against and not being treated with respect. Jade Collins conferred with her line manager Len Kocovic, and Trent Lethlean of Human Resources. That day Tessa emailed Ms Rita Marshman in Employee Relations seeking guidance as to whom she should more formally raise her concerns about the further deteriorating work relations with Jade Collins. Ms Marshman apparently referred the email from Tessa to Trent Lethlean who forwarded a copy of Tessa's email to Len Kocovic. Later that day Trent Lethlean responded to Tessa suggesting she initially raise her concern with Len Kocovic.

44. On 14 July 2015 Tessa met with Len Kocovic and Trent Lethlean elaborating upon the issues, maintaining that Jade Collins was not supportive and was in effect mismanaging her. It was planned that Len Kocovic would take a role of something akin to a moderator in an endeavour to improve the working relationship between Tessa and Jade Collins. The tensions remained unresolved. On 4 August 2015 Jade Collins and Tessa held their regular meeting where the unresolved issues were again discussed.

45. Following this meeting on 5 August 2015 Tessa emailed Len Kocovic[18] stating that after the meeting the previous day, which she found threatening, she felt "in shock and physically sick". In response Len Kocovic spoke with Tessa in a private meeting which lasted for some 30 minutes during which Tessa claimed not to be sick, but "fine." In evidence it was put to Len Kocovic that the email contained information that should have been a 'red flag' demanding far more intervention. Len Kocovic maintained that having spoken with Tessa on several occasions subsequently to the email of 5 August 2015, noting their interaction and Tessa's general demeaner, he did not consider he should further intervene or escalate the matter.

46. Because of its significance there is a theme running through the constellation of events that precipitated the performance management meeting of 14 August 2015 which requires close attention. In considering the performance of Jade Collins, Len Kocovic and Trent Lethlean it must be firmly borne in mind that all three were <u>not</u> aware of Tessa's long standing mental health history, nor aware that in the latter part of 2014 Tessa had been receiving quite extensive therapy/treatment from Dr Aileen Alegado, Tessa's psychologist. In that regard

[18] Exhibit 'I'

Tessa did not divulge that history to Len Kocovic or Trent Lethlean and in my view, it was not open to them to interrogate Tessa on that issue; at least at that time, privacy appropriately prevailed.

47. Others have considered and commented upon the performance of Jade Collins, Len Kocovic and Trent Lethlean with the benefit of hindsight which puts an entirely different complexion on the issues of contention.

48. While Jade Collins' management of Tessa quite obviously impacted Tessa's psychological wellbeing, I do not accept that it 'crossed the Rubicon' to the extent it was unreasonable, harsh, harassing or bullying. It must be said that managing Tessa would be challenging in light of her undisclosed psychological condition. It was submitted that the manner in which Jade Collins gave viva voce evidence, her demeaner demonstrated or confirmed her management style was unsympathetic, confronting, overly harsh and without any empathy towards Tessa's situation. That is a long bow to draw and I do not accept that contention. It has to be borne in mind it is entirely likely it was the only time Jade Collins has given evidence in a court of law, been cross-examined by experience counsel in circumstances where she is being blamed, at least in part, for Tessa's death.

49. Similarly, without knowledge of Tessa's fragility due to the undisclosed mental health issues, I do not believe the performance of Len Kocovic or Trent Lethlean can reasonably be criticised. In evidence Trent Lethlean rightly conceded that had he been aware of Tessa's mental health history things would likely have been different with a more sympathetic approach to managing Tessa; in fact he went as far as to state that had he been fully cognisant of those matters a performance management meeting would not have been held.

Performance Management Meeting of 14 August 2015

50. After discussions between Jade Collins and Trent Lethlean at 9am on the morning of 14 August 2015 Tessa was advised that in light of the unresolved issues between her and Jade Collins, and Tessa's perceived continued under performance, a formal Performance Management Meeting would be scheduled for 4pm that day. It is conceded that the short period between being advised of the meeting and the time it was proposed to commence was not in line with Myer's policy, which provided that at least 24 hours' notice should be given. This departure from policy was resolved in discussions between Trent Lethlean and Tessa during the morning with Tessa indicating she would prefer the meeting proceed rather than be postponed. On behalf of the family it is submitted that not only was the notice given too

short, but it was inappropriate to conduct a Performance Management Meeting on a Friday afternoon.

51. My focus is upon the manner in which the meeting was conducted which was the principal basis of complaint on behalf of the family. The only attendees at the Performance Management Meeting were Tessa, accompanied by a support person Ms Lucy Divic a colleague of Tessa, Jade Collins and Trent Lethlean.

52. There is some contention in relation to Ms Divic's claim she was not allowed to intervene to advocate for Tessa or take notes during the Performance Management Meeting and was told if she continued to intervene she would be asked to leave. I don't propose to seek to resolve that issue for several reasons, the main one being that Ms Divic did in fact intervene and raised concerns that if the whole raft of issues of concern were put to Tessa at the same time, rather than separately, it would make it virtually impossible for Tessa to give reasoned responses. The decision was then taken to put each of the many concerns to Tessa individually so that she could better respond to each one. In any event, Ms Divic remained at the Performance Management Meeting throughout. Ms Divic in evidence maintained her position that the meeting took the form of an interrogation with no empathy displayed towards Tessa.

53. Furthermore, it is claimed the record of the meeting prepared by Trent Lethlean, which was not taken contemporaneously as the original handwritten notes unfortunately were not retained, demonstrated that the Performance Management Meeting was unfairly harsh, unnecessarily aggressive and accusatory. The very nature of a Performance Management Meeting, where an employee's under performance is the very crux of the process will generally necessarily be difficult and presumably stressful even to a person who is psychologically robust; it is the 'nature of the beast.'

54. My primary focus is not only whether the meeting went beyond the bounds of what could be considered appropriate, but particularly whether Tessa was given ample opportunity to respond to the criticism levelled and whether at the conclusion of the meeting it was reasonable to proceed to a first warning. It is to be borne in mind that that morning before the meeting Trent Lethlean had advised Tessa her position was not in jeopardy.

55. On Friday evening 14 August 2015, after the Performance Management Meeting, Michelle Svabec spoke by phone with Tessa who told her the Performance Management Meeting didn't go well as Ms Collins and Mr Lethlean didn't take her responses into account. Tessa advised that it was proposed an "action plan" be developed. Ms Svabec phoned Lucy Divic

on Saturday morning to get her perspective as to how the meeting went and interestingly was told that Tessa had done really well and had answered the questions well.

56. I do not accept the Performance Management Meeting was an "appalling harsh, oppressive interrogation"; I am satisfied Tessa was not only given the opportunity but did respond to the various issues of concern raised as they were individually put. To claim the record of the meeting demonstrates the meeting was aggressive and harsh is again to draw a long bow.

57. I am further satisfied that to proceed to issuing a first warning was a reasonable step in light of the continuing deterioration in the working relationship between Tessa and Jade Collins and the failure to achieve significant progress in Tessa's work performance.

58. However, I feel obliged to say that while an action plan was to be developed, with coaching and support provided to Tessa by Jade Collins, it was highly unlikely to be successful when the working relationship was by that time fundamentally dysfunctional with little chance of it being repaired whilst there was virtually little real engagement between the two; but believe it reasonable to try the action plan.

59. The matter does not end there. I turn to consider the events of 2015, particularly through June to August 14, from a totally different perspective; from the lens through which Tessa viewed those events. I describe this as the second phase of my investigation and finding.

60. A significant issue of contention is whether, as well as Tessa's previously diagnosed mental health conditions namely depression, anxiety, and bulimia, she suffered Borderline Personality Disorder. I readily concede reaching a conclusion on that particular issue is far beyond my knowledge and on that basis, I am required to examine the evidence of those who have the qualifications and experience to provide an opinion. In this case there is a level of a disagreement/contention between the psychiatrists Associate Professor Doherty and Professor Large, which I need to try to resolve.

61. In my view, in relation to resolving that contention it is noteworthy that Tessa's psychologist, Dr Aileen Alegado, an experienced clinical psychologist, was the only clinician who had the advantage of actually undertaking thirteen sessions with Tessa up until the latter part of 2014, whereas Associate Professor Doherty and Professor Large did not, for obvious reasons, have that opportunity. Professor Large in evidence commented that "patient presentation is the cornerstone of diagnosis."[19]

[19] Transcript p. 326

62. I propose to rely upon Chief Justice Mason's analysis in March v Stamare. It is a matter upon which the application of common sense, often based to a large extent on one's life experiences, will provide the answer whether the constellation of events leading to and including the Performance Management Meeting of 14 August 2015 were contributing factors in Tessa's decision to intentionally take her own life.

63. It is for that reason, having heard just how debilitating Borderline Personality Disorder is, that I need to seek to come to a conclusion, on balance whether Tessa actually suffered this insidious, difficult to treat, condition. I have found forming a concluded view on this issue very challenging and even more difficult to articulate the bases upon which I have formed a view.

64. After thirteen consultations with Tessa, Dr Alegado diagnosed Borderline Personality Disorder and conveyed that to Tessa at the last consultation on 14 December 2014. Dr Alegado, said she expected Tessa would re-engage in therapy in the new year as she, Dr Alegado considered the issues were not resolved and she considered Tessa's serious psychological condition required ongoing treatment. Several attempts by Dr Alegado to contact Tessa with a view to resuming therapy were unsuccessful resulting in Dr Alegado providing a final discharge report dated 8 April 2015 to Tessa's GP, Dr Webb. In response to a question from Ms Argiropoulos, Dr Alegado accepted she could not comment upon Tessa's psychological condition in the intervening period between 14 December 2014 and 14 August 2015.

65. The basic thrust of Ms Argiropoulos' cross-examination of Dr Alegado was to challenge Dr Alegado's diagnosis of Borderline Personality Disorder. In answer to a question I put to her Dr Alegado stated she was confident that her diagnosis was valid, but conceded there was a "possibility" it was a misdiagnosis, adding that prior to the final consultation on 14 December 2014 Borderline Personality Disorder had been her "working hypothesis." Under further questioning by Ms Argiropoulos, Dr Alegado accepted that in her report to Worksafe she referred to "borderline personality traits" and conceded she was "open to" the alternative diagnosis of borderline personality traits, which she accepted fell short of what I will call a 'full blown' diagnosis of Borderline Personality Disorder.

66. I was somewhat confused by Dr Alegado's response to Ms Argiropoulos and asked Dr Alegado if she was "retreating" from her earlier claim that she considered her initial diagnosis was valid. So that nothing is lost or misconstrued in the translation I include here an excerpt from the transcript of Dr Alegado's evidence. She said:

"At the time, I believed Tessa met the criteria for borderline personality disorder, but it was a working hypothesis that, em, I (indistinct words) access to – year, I think – it's personality disorders, as you have said, is, kind of, very hard to diagnose and it's also something that we would not want to label someone as having such diagnosis because they usually tend to stick. Um, and so to get that wrong can be quite, um, disruptive or it could, kind of, um, create a – a stigma towards the person. Um, in – in this case, when I had checked with Tessa that working diagnosis, I felt positive and confident because she was so receptive and related to, um, the symptoms, end of discussion, at the time."[20]

67. Ms Argiropoulos took her questioning further suggesting to Dr Alegado that another reason her diagnosis might not be valid was because in coming to her diagnosis she, Dr Alegado, made her diagnosis in the absence of any psychometric testing. Ms Argiropoulos also put to Dr Alegado that a variety of prior life events, which are often seen in people with Borderline Personality Disorder, such a childhood trauma, were not present in Tessa's case.

68. In his re-examination of Dr Alegado, Mr O'Neill sought leave to put several additional questions to Dr Alegado that he claimed arose from Ms Argiropoulos' examination of Dr Alegado; I gave him leave. In broad terms he sought to claw back what had appeared to be retreat by Dr Alegado from her initial position. In response to a question from Mr O'Neill, Dr Alegado said whether Tessa suffered Borderline Personality Disorder, or borderline personality traits, the treatment therapy provided would be similar, but more importantly she accepted the contention that irrespective of which diagnosis was correct Tessa would still have the "thought patterns of potentially reading a negative view of herself into other people's interactions with her."

69. In answer to a direct question from Ms Currie, Dr Alegado stated that as she expected Tessa to continue therapy with her so that her diagnosis of Borderline Personality Disorder was a "working diagnosis" consistent with Tessa's presentation over multiple therapy sessions. She added Tessa appeared to be accepting of the diagnosis which tended to explain some of the issues she, Tessa, had been experiencing.

70. At the completion of the examination Dr Alegado asked could she add something, of course I was happy for Dr Alegado to do so; she said:

[20] Transcript pp. 48-49

"I just wanted to say that, um, and I know for a fact that I was Tessa's longest therapist, or psychologist, I believe. I don't think that she's actually had, um, anyone that saw her for about that time that I saw her. So, I was quite confident that when we had that discussion, I had the rapport with her to have that conversation that felt safe."[21]

I am not sure what Dr Alegado sought to convey, but in any event that comment does not particularly assist my deliberations one way or another.

The Evidence of Professor Matthew Large

71. The fundamental premise put forward by Professor Large was that the workplace issues involving Jade Collins, Len Kocovic and Trent Lethlean were, for all intents and purposes, irrelevant to Tessa's decision to intentionally take her own life. Initially at least, he maintained that Tessa took her own life solely due to her suffering Borderline Personality Disorder. I include an excerpt from his report; he wrote:

"Summary of Opinion

Tessa Ballam had a complex psychiatric history that can be reasonably characterised as including a depressive disorder (most likely Major Depressive Disorder), an anxiety disorder (with prominent social anxiety), and an eating disorder (Bulimia Nervosa). The underlying diagnosis was considered to be Borderline Personality Disorder. Ms Ballam had a history of suicidal thoughts and behaviours. She died by hanging while intoxicated and within 24 hours of a performance management meeting at her workplace. The performance management meeting cannot be reasonably held to be a causal factor in her death."[22]

72. Examining the evidence Professor Large, both his report and viva voce evidence, the significance of making a finding on the issue of whether Tessa suffered from Borderline Personality Disorder is thrown into even sharper focus.

73. In this case whether Tessa suffered from Borderline Personality Disorder is in contention, so I believe I need to make a formal finding on the issue. I accept that whether Tessa did or did not suffer from Borderline Personality Disorder is a determination upon which I, of necessity, need to rely on expert evidence. In seeking to resolve the contention I again make the point that Dr Alegado, an experienced psychologist, was the only clinician to engage in

[21] Transcript p. 68
[22] Coronial brief volume 2 p. 1327

face-to-face consultations with Tessa, having thirteen sessions with her in the latter part of 2014, at the final session diagnosing Tessa as suffering from Borderline Personality Disorder. Her diagnosis was challenged by Ms Argiropoulos, primarily on the basis Dr Alegado did not undertake a variety of tests that it is suggested should be undertaken to enable a valid diagnosis to be made. In examination Dr Alegado retreated to some degree and, as I understand her evidence, accepted that Tessa may have suffered from borderline personality traits. It seems to me the traits identified are in reality the manifestation of the symptoms of Borderline Personality Disorder and it is those symptoms which are significant.

74. In viva voce evidence Professor Large said that although Borderline Personality Disorder is in some ways a "problematic diagnosis" he considered it "more likely than not"[23] Tessa met the criteria for Borderline Personality Disorder, but added that he didn't consider much hinged on whether she had borderline disorder traits or Borderline Personality Disorder. I think it fair to say, to some degree, Professor Large modified his opinion on that matter under cross examination in viva voce evidence; I will return to that issue later in this finding. In any event, Dr Alegado's diagnosis was, in large part at least, supported by Professor Large.

75. I do not believe Associate Professor Doherty took issue with these diagnoses.

76. I conclude the weight of evidence, by a clear margin, leaves me comfortably satisfied that unfortunately Tessa, as well as suffering from depression and anxiety, did suffer from Borderline Personality Disorder, a condition which Professor Large described as a distressing, chronic, lifelong condition which even with therapy generally only modest improvement can be achieved.

77. Having reached the concluded view that Tessa did suffer from Borderline Personality Disorder, I now turn to consider whether, as claimed by Professor Large, the workplace issues were basically irrelevant to Tessa's decision to take her own life, or were a significant factor in that decision.

78. In considering whether the workplace issues were causal or contributing factors in Tessa's suicide, I think it appropriate to examine some of the questions posed to Professor Large in the letter of engagement by solicitors for Myer and his responses to those particular

[23] Transcript p. 323

questions. Rather than me seeking to encapsulate both the questions and the responses, I propose to include in this finding the relevant excerpts:

> *"First, Ms Ballam had multiple well-established suicide risk factors including various mental disorders, chronic suicidal ideas, previous suicidal behaviour, and alcohol intoxication. These risk factors must be considered to most salient to her suicide.*
>
> *Second, the performance management meeting cannot be rationally seen as reaching such a threshold of stress so as to be regarded as an important suicide risk factor.*
>
> *Third, it is clear that Ms Ballam had a very significant degree of distress before she was informed of the performance management meeting. Julie Ballam reports that Ms Ballam felt hopeless the previous evening, on 13 August 2015.*
>
> *The suicide of Ms Ballam was not a reasonably foreseeable consequence of the performance management meeting of 14 August 2015."*[24]

I accept Professor Large's final comment in relation to foreseeability, and it has not been suggested otherwise.

79. As stated, Professor Large's initial argument that the workplace issues were basically irrelevant to the decision Tessa took to end her own life was, as I understood him, predicated upon his view that those workplace issues were of moderate psychosocial severity only, not sufficiently stressful to be contributing factors in her death. He drew a distinction between such things as a relationship breakdown, loss of employment, being charged with a serious criminal offence; all matters which objectively would obviously heighten the risk of suicide. Over the years I have seen each of those, and other serious stressors, at play in suicide investigations.

80. Ms Argiropoulos pursued with Professor Large his contention that the workplace issues were basically irrelevant, and it was Tessa's underlying psychological condition that impacted her mental health and heightened risk of suicide. As Ms Argiropoulos' examination continued I got the impression Professor Large was retreating to some degree from his original position. I enquired of Professor Large whether my impression was correct. In answer to my question Professor Large conceded he should perhaps have used the expressions "predominantly" or "more likely"[25] in relation to the issue of whether

[24] Paragraph (b) at pages 1357 – 1358 of the coronial brief
[25] Transcript page 329

Tessa's death was solely due to her mental health conditions. I concluded Professor Large had refined his position somewhat in relation to what I see as a critical issue.

81. As stated earlier in this finding, I concluded that in the absence of any knowledge of Tessa's significant underlying mental health history, and excluding hindsight, the issues surrounding the management of Tessa by Jade Collins and the involvement of Len Kocovic and Trent Lethlean was objectively reasonable and appropriate and was not a causal or contributing factor in the decision Tessa took to end her own life.

82. As stated earlier, the matter does not end there, it is also necessary to consider the workplace issues from a totally different perspective. When one considers those issues through a different lens, Tessa's perspective, a very different picture evolves.

83. I accept Professor Large is a vastly experienced psychiatrist and has undertaken extensive research in relation to virtually all aspects of suicide. He has had numerous papers published in the literature on the subject. Professor Large also has current clinical experience in the treatment of those presenting with serious mental health issues.

84. When I come to consider whether subjectively, from Tessa's perception, the workplace issues impacted her mental health leading to a heightened risk of self harm I do so through this different lens and apply to the facts the common sense test as enunciated by Chief Justice Mason in March v Stramare[26]. I do not think it necessary to revert to specialist scientific knowledge or experience to determine that issue.

85. Having heard the evidence, particularly that of Dr Alegado and Professor Large, it strengthened my view that Borderline Personality Disorder is indeed a debilitating, insidious condition which can result in chronic low self esteem, emotional dysregulation, negative perceptions of how one is viewed by one's peers, misinterpretation of events, feelings of despair, hopelessness, unhappiness and, as described by Professor Large, a tendency for negative fixation and "catastrophic thinking."[27] I concluded many of these manifestations of Borderline Personality Disorder were present with Tessa over a significant period, particularly in the few months prior to her death.

86. I suggest these recurring issues are particularly pertinent when one considers them through the lens that Tessa viewed the workplace issues. While objectively the issues may not appear to be major life stressors, I conclude that subjectively, in light of her complex mental condition, particularly Borderline Personality Disorder resulting in a tendency to

[26] HCA 12 (1991) 171 CLR 506
[27] Transcript p. 1353

catastrophise, they were contributing factors in relation to heightened risk of suicide. One of the principal reasons I have come to that conclusion is the temporal connection – the timing – of Tessa's suicide. Even though she had experienced recurrent suicidal ideation over a long period of time, Tessa took the fateful decision not 24 hours after the Performance Management Meeting of the afternoon of 14 August 2015.

87. While it is notoriously difficult to predict when an individual with mental health conditions is at risk of crossing the suicide threshold, the risk is significantly heightened when that individual is intoxicated. Professor Large gave evidence that his research clearly demonstrated that the level of intoxication established in Tessa's case by toxicological analysis of post mortem specimens resulted in a "remarkably elevated risk of suicidal behaviour."[28] That view accords with my own observations having investigated more suicide deaths than I care to remember.

88. In my experience in this jurisdiction, I have formed the view, particularly when the subject is intoxicated, that the fateful decision to take one's own life is very often a decision taken on impulse, making it even more difficult to predict when the threshold may be crossed.

89. I have found penning this finding very challenging. I was concerned that my analysis of the evidence and the conclusions reached could be viewed as involving an internal contradiction. However, in the final analysis I believe the conclusions reached, when viewed through the different lenses, are compatible.

90. In relation to Tessa's state of mind in the period proximate to her death the evidence of her colleague Ms Michelle Svabec is important. Ms Svabec said that on several occasions in July/August Tessa had told her she would lose her job and was having trouble sleeping. The telephone conversation between the two at about 7pm on 14 August 2015 only an hour or so after the Performance Management Meeting is a significant conversation because it is the nearest thing to being contemporaneous with the tragic event which followed. Again, Tessa told Ms Svabec she thought her career with Myer was over and the prospect of getting a job elsewhere was limited because of the matters raised at the completion of the Performance Management Meeting. It is noteworthy that Tessa's version of how the Performance Management Meeting went was in stark contrast with the view expressed by Ms Divic that at the meeting Tessa had done really well and had responded well to the issues of concern put to her by Jade Collins.

[28] Transcript p. 1354

91. The most troubling statement made to Ms Svabec by Tessa was her comment that the only way to get back at Jade was to kill herself. I view this as a prime example of "catastrophic thinking" which Professor Large stated was one of the significant manifestations of Borderline Personality Disorder.

92. There is no compelling direct evidence that Jade Collins berated, threatened, yelled at or belittled Tessa in the presence of other staff; to the contrary in viva voce evidence Ms Michelle Svabec conceded those allegation were almost exclusively founded upon comments, both verbal and via text messages, conveyed to her by Tessa; yet another example of Tessa's interpretation of events from her skewed perception, another manifestation of Borderline Personality Disorder.

93. I am satisfied that subjectively the workplace issues were so significant in Tessa's mind that they represented contributing factors in her fateful decision.

94. The two principal findings I have made, viewed through the fundamentally different lenses, are founded upon my assessment of the whole body of evidence having had the benefit of hearing viva voce evidence involving cross-examination of the witnesses, not just from the statements prepared in support of the WorkSafe prosecution. In that regard many of these views and opinions are based upon an incomplete knowledge of what in fact transpired in relation to critical matters, so that weight to be attached to those opinions is, at best, lessened.

95. Save for the expert evidence given in relation to whether Tessa did or did not suffer from Borderline Personality Disorder my findings are not founded upon the so-called expert opinions but are based upon the application of common sense to the facts as I have found them.

FINDING

96. I formally find that Tessa Michelle Ballam died at 3/105 Osborne Street, South Yarra between 10pm on 14 August and 2:30pm on 15 August 2015, I cannot be more precise, when in distress and anguish due to her serious mental conditions and compounded by intoxication, she tragically took her own life in the circumstances described above.

DISTRIBUTION OF FINDING

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

- Ms Jules Ballam, Senior Next of Kin
- Myer Pty Ltd
- Mr Trent Lethlean
- Ms Jade Collins
- Mr Leonard Kocavic
- WorkSafe Victoria
- Senior Constable Lauren Hand, Coroner's Investigation, Victoria Police

Signature:

PHILLIP BYRNE
CORONER
Date: 31 March 2022