IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006836

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Mr PNF[1]
Date of birth:	[redacted] 1961
Date of death:	22 December 2021
Cause of death:	1(a) Neck compression 1(b) Hanging
Place of death:	[redacted]
Keywords:	Suspect welfare, risk assessment, child sexual assault allegation, elevated risk of self-harm and suicide following police interview, Victoria Police Manual, health-led response.

[1] This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased and other persons related to or associated with the deceased, with a pseudonym of a randomly generated letter sequence for the purposes of publication

INTRODUCTION

1. On 22 December 2021, Mr PNF was 60 years old when he was located deceased in circumstances consistent with suicide. At the time of his death, Mr PNF lived in [redacted] with his wife of 41 years, Mrs MLE.

Medical History

2. In 1990, Mr PNF was diagnosed with Type 2 diabetes mellitus. According to Mrs MLE, much of Mr PNF's stress *'originated from his diabetes'* and she noticed his wellbeing was directly affected by his blood sugar levels.

3. On 3 December 2021, Mr PNF visited one of his regular general medical practitioners (**GP**). The GP noted that Mr PNF's blood sugar levels were elevated, and his diabetic control marker was worsening. Mr PNF was commenced on insulin therapy, in addition to his pre-existing diabetes medications.

4. Mr PNF experienced periods of low mood and was prescribed the anti-depressant, fluoxetine, though evidence does not indicate he received a formal diagnosis of depression. Mr PNF's son believed his father suffered from depression, but it was never openly discussed. Mrs MLE further stated that he had attended upon a counsellor but did not find it helpful and discontinued attendance.

5. At the time of his death, Mr PNF was not engaged with any mental health treatment. Evidence indicates that Mr PNF did not describe any suicidal ideation to his GPs or others.

THE CORONIAL INVESTIGATION

6. Mr PNF's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

7. 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.

8. 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.

9. Victoria Police assigned a member to be the Coronial Investigator for the investigation of Mr PNF's death. The Coronial Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family members, the forensic pathologist, treating clinicians and investigating police members – and submitted a coronial brief of evidence.

10. A colleague initially held carriage of the investigation into Mr PNF's death until it came under my purview in July 2023 for the purposes of finalising the investigation, seeking additional investigative steps to be taken, and handing down this finding.

11. This finding draws on the totality of the coronial investigation into the death of Mr PNF 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]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

12. On 11 November 2021, the Central Gippsland Sexual Offences and Child Abuse Investigation Team (**SOCIT**) learned that Mr PNF's granddaughter had made an allegation of sexual assault against him.

13. On 21 December 2021, at approximately 4:19pm, two SOCIT members attended his residence and spoke with Mr PNF. They informed him of the allegation, at which time Mr PNF telephoned Mrs MLE and informed her. The members transported Mr PNF to the [redacted] Police Station for interview.

14. As a member prepared the interview room, Mrs MLE and her son, Mr XVP, arrived at the station. Another member spoke with Mrs MLE and Mr XVP and explained the interview and investigation process. According to the SOCIT member, she informed Mrs MLE that *'Mr PNF would need support'.*

[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.

15. At 5:49pm, the interview concluded. SOCIT members explained to Mr PNF that the *'investigation was ongoing and that he was not being charged with anything on that day'*. Mr PNF expressed concerns over potential damage to his reputation and was assured by the SOCIT members that their investigation would be kept confidential.

16. As per standard procedure, a Family Violence Safety Notice was put in place to prevent Mr PNF from contacting his granddaughter.

17. The SOCIT members escorted Mr PNF to the front of the police station, where Mrs MLE and Mr XVP were waiting. One of the members provided Mr PNF with her telephone number and encouraged him to contact her if he had any questions. According to the other member, Mr PNF spoke about his upcoming plans and *'in no way did he suggest that he was going to do anything to hurt himself'*.

18. Upon their return home, Mrs MLE recalls that Mr PNF *'sat in the lounge chair, with his head in his hands, crying'*. Mrs MLE extended her support to him and recalls he was considerably upset for the remainder of the night.

19. The following morning, on 22 December 2021, at approximately 10:30am, Mrs MLE left home to run some errands. At approximately 1pm, she returned home and located a note on the kitchen table which read, *'gone for a long walk see you soon'*. Mrs MLE found this odd and telephoned Mr PNF. She *'heard [Mr PNF's phone] coming from the shed'* and upon entering, located Mr PNF suspended, by the neck, using an electrical winch.

20. Alerted by Mrs MLE's screams, a neighbour ran to the property and contacted emergency services. At approximately 1:10pm, Ambulance Victoria paramedics arrived and shortly after, at 1:15pm, declared Mr PNF deceased.

21. Victoria Police attended the residence and located a copy of the Family Violence Safety Notice in Mr PNF's bedroom. On it was the annotation, *'I didn't do this 100%'*. This was echoed in a Facebook message sent to his sons stating that, while he denied the allegations, '*the fall will be too much*'.

IDENTITY OF THE DECEASED

22. On 22 December 2021, Mr PNF, born [redacted] 1961, was visually identified by his wife, Mrs MLE, who completed a formal Statement of Identification.

23. Identity is not in dispute and required no further investigation.

MEDICAL CAUSE OF DEATH

24. Forensic pathologist Dr Paul Bedford (**Dr Bedford**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of Mr PNF on 23 December 2021. Dr Bedford considered the Victoria Police Report of Death for the Coroner (**Form 83**) and post-mortem computed tomography (**CT**) scan and provided a written report of his findings on 24 December 2021.

25. The post-mortem examination revealed a parchment ligature furrow around the neck.

26. Toxicological analysis of post-mortem samples detected the following compounds:

Fluoxetine	~ 0.2 mg/L
Norfluoxetine	~ 0.07 mg/L
Doxylamine	~ 0.03 mg/L

27. Dr Bedford provided the opinion that the medical cause of death may be reasonably formulated as 1(a) *Neck Compression* and 1(b) *Hanging* without the need for autopsy.

28. I accept Dr Bedford's opinion.

VICTORIA POLICE MANAGEMENT OF MR PNF

29. On the basis that Mr PNF's death occurred proximate to an interview with Victoria Police which concerned allegations of child sexual assault, I turned to consider whether the SOCIT members who engaged with him acted in accordance with relevant Victoria Police standards.

Actions of Victoria Police when engaging with Mr PNF

30. The Victoria Police Manual (**VPM**) is the primary source of policy rules and guidance on most facets of operational policing. In addition to VPM chapters on topics like 'arrest,' 'interviews' and 'safe management' of people in police care or custody, the management of suspects of sexual offences by Victoria Police members is governed by a VPM chapter entitled 'Sexual Offence Investigations' (**the VPM**). The VPM, dated June 2021 and which was in force at the time of Mr PNF's death, identifies that when suspects become aware of investigations being undertaken by Victoria Police, they are at an increased risk of suicide and

self-harm. *'[S]hortly before or after police interview'* is identified as a period of heightened risk.[3]

31. Further guidance is provided by other documents including the Code of Practice for the Investigation of Sexual Crimes (**the Code**), Crime Investigative Guidelines and through training provided to Victoria Police members, including specialised education for SOCIT members relating to the management of sexual offence investigations.

32. It is known by Victoria Police that suspects may present a higher risk of suicide and self-harm around the time of police interview due to *'a lack of prior criminal histories or contact with the justice system, a significant loss of reputation, fear of prison life, rejection from family, and community and the unfamiliarity with the legal process'.*

33. Accordingly, the VPM establishes guidelines regarding member conduct when interacting with such suspects, to identify when suspects are at an appreciable risk of self-harm and/or suicide and to intervene as appropriate.

34. Evidence provided by the SOCIT members who interacted with Mr PNF on 21 December 2022 shows that some but not all of the VPM requirements were met.[4] For the purposes of this discussion the SOCIT members will be known as **SOCIT Member 'A'** and **SOCIT Member 'B'**.

35. Two of the requirements of the VPM are that: (i) police members conduct a *'thorough risk assessment by asking informal questions and responding to the outcome of that assessment'*; and (ii) that police members consider *'the suspect's welfare after the interview Ensure [sic] they have been provided a copy of the Information and Support referral brochure'.*

Risk assessments and contemporaneous notes

36. Regarding the requirement that Victoria Police members conduct a *'thorough risk assessment'* of a suspect's wellbeing, I note that the VPM does not specify the questions that ought to be put to the suspect, nor does it outline any criteria to evaluate the suspect's *'risk'.*

[3] The VPM chapters on 'Interviews,' section 2.5 and 'Safe management of persons in police care or custody,' section 4.6 identify that this period of heightened risk of suicide and self-harm is relevant to suspects of other (non-sexual) offences as well.

[4] The VPM contains several specific requirements relating to suspect welfare, however, I do not consider they are in issue in this case. For instance, the VPM recommends that members avoid arrest by appointment or using calling cards to mitigate the heightened risk of self-harm/suicide to suspects once they become aware they are the subject of a child sexual assault. The evidence indicates that the SOCIT members adhered to this component of the VPM when dealing with Mr PNF.

37. For completeness, I note that the Code provides some direction regarding the questions a police member may pose:

> *'Informal questions regarding how the person is feeling, what personal supports they have in place, and an awareness of the potential impact this may have on the person's life can assist the interviewer to make a more accurate risk assessment'.*

38. However, compliance with the Code is not mandatory; its guidance contextualises the VPM requirements.

39. I acknowledge that conducting risk assessments forms part of the Victoria Police foundational training, and that members ought to exercise professional judgement when performing them as part of their duties. For these reasons, being prescriptive about the questions to be asked in a risk assessment may prevent police members from tailoring their approach and assessment to the circumstances of the suspect and the investigation.

40. However, given that risk assessments are a requirement of the VPM, and Victoria Police members are also required to maintain a record of their operational duties, it is concerning that no risk assessment of Mr PNF was documented at the time. The contemporaneous notes of both SOCIT members were brief and recorded procedural steps (though SOCIT Member 'B' noted Mrs MLE was '*distraught*'). The notes made after each member had learned of Mr PNF's death were more detailed but similarly procedural and contained neither any explicit risk assessment nor description of Mr PNF (or interactions with him) from which one might infer an assessment of risk had occurred. In the absence of contemporaneous (or nearly contemporaneous) evidence of risk assessment, when considering whether the SOCIT members conducted a satisfactory risk assessment, I had to rely upon statements provided by them more than two months after their interactions with Mr PNF.

41. In the statements provided, neither of the SOCIT members explicitly refer to performing a risk assessment of Mr PNF. The statements do suggest the members adopted the informal approach to gathering information about risk recommended in the Code and that the members apparently concluded that Mr PNF was not *'at risk'*.

42. According to SOCIT Member 'A', they *'asked [Mr PNF] how he was feeling after the interview, to which he replied that he didn't know how he felt. [Mr PNF] told [them] he was worried about his name being mud'.* They continued that:

'During the time I spent with [Mr PNF] whilst he was in custody, in no way did he suggest that he was going to do anything to hurt himself. He spoke to me about future plans such as attending his upcoming night shifts and what he was going to cook for dinner that night. He left the station with his wife and son and it was apparent he was well supported by family'.

43. At my request SOCIT Member 'B' provided a supplementary statement dated 8 November 2024 which focused on Mr PNF's welfare needs. SOCIT Member 'B' explained that Mr PNF's welfare needs included that: (i) Mr PNF was an older gentleman with no prior interactions with Victoria Police and no criminal history; (ii) he was *'surprised and anxious'* when informed of the allegations; and (c) he *'appeared'* concerned by the allegations, principally regarding the risk of reputational damage.

44. SOCIT Member 'B' concluded:

'I do not recall [Mr PNF] appearing in a distressed manner at any time before or after the interview on 21st December 2021. In my observations, he did not exhibit usual symptoms that I would attribute to someone being distressed. [Mr PNF] did seem concerned about his circumstances and what the allegations would mean for his reputation.'

45. I will return to the utility of demeanour as an indicator of suicidality below, and flag at this juncture that I will make a recommendation contemporaneous recording of risk assessments.[5]

46. However, at this juncture I note for completeness the 'limited action police can take in response to welfare concerns' highlighted in submissions made on behalf of the Chief Commissioner of Police (**CCP**), which were provided to me in the course of a natural justice process in which the CCP was provided with notice of my proposed adverse comments, and given the opportunity to respond to the same.[6]

[5] For completeness, I note in a previous finding on the issue of suicides of persons investigated for child sexual offences – the Finding without Inquest into the Death of EK, which is discussed at length below, I wrote: *'I am of the view that (when followed) the policies and procedures identify and address the relevant risk factors of self-harm and suicide in a manner that provides guidance while allowing for members to exercise professional discretion. In the context of my prevention role as a coroner, and at this stage, I have not been able to identify any significant further opportunities for Victoria Police to improve their policies and practices in this area.'* In light of Mr PNF's death, which brings to the fore a different range of issues and contemplations, I have now been able to identify further opportunities to enhance the Victoria Police management of suspects of child sexual offences and consider that apposite recommendations may assist to fill these gaps.

[6] *See resulting* Submissions on behalf of the Chief Commissioner of Police dated 30 September 2025.

47. Therein, it was emphasised by the CCP, and I accept, that, in the absence of the high threshold for intervention under the *Mental Health Act* 2014,[7] even if police members do identify 'a *potential* increased risk of suicide or self-harm,' their role is 'welfare, support and referral'.[8] Further, if the suspect 'chooses not to seek support or engage services, police have no alternative powers to respond to welfare concerns.'[9]

48. While noting these limitations, I consider there is still room for improvement to existing processes that may enhance police members' ability to address suspect welfare considerations for persons being investigated for child sexual assault-related offences, which I outline below.

Information and Support referral brochure

49. The VPM requires that police members provide suspects with the *'Information and Support Referral'* brochure (**the brochure**). It contains contact details for several mental health services along with instructions to contact emergency services if the recipient is *'at immediate risk of harm to [themselves] or others'.*

50. In a statement provided by SOCIT Member 'B', they state that they *'did not provide [Mr PNF] with a copy of the Information and Support Referral brochure'* and that this was an *'oversight'.*

51. When this *'oversight'* was recognised by SOCIT Member 'B' – on the same day – they *'reflected on [their] actions with [Mr PNF] that day, and [they] recall being satisfied at the time that [they] had thoroughly discussed with [Mr PNF] the information contained in the brochure'.*

52. In their supplementary statement to the Court, SOCIT Member 'B' provided additional information about the welfare support they provided to Mr PNF and his family.

53. SOCIT Member 'B' explained that the support they provided was in response to the welfare needs outlined above. These included to: (i) give Mr PNF as much information about the investigation process as possible including that he would not be charged that day; (ii)

[7] The *Mental Health Act* (MHA) 2014 was in force at the time of Mr PNF's death. The police apprehension power contained in s351 of the MHA required the member to be satisfied that as a result of a person's mental illness, the person needed to be apprehended to prevent serious and imminent harm to the person or another person,'
[8] Submissions on behalf of the Chief Commissioner of Police dated 30 September 2025 (emphasis in original).
[9] Submissions on behalf of the Chief Commissioner of Police dated 30 September 2025.

discussing with him *'what support services could assist with legal or welfare issues'*;[10] and (iii) e-referrals available to Mr PNF.

54. When speaking with Mrs MLE, SOCIT Member 'B' recalled:

> *'We discussed support for [Mr PNF] and I told [Mrs MLE] and [Mr XVP] that he would need support from his family, given the nature of the allegations and that they had come from his granddaughter'.*

55. While there is evidence that SOCIT Member 'B' discussed *'support services'* with Mr PNF and his family, it is unclear which specific services were canvassed and whether the rationale for highlighting support for 'welfare issues' was conveyed. There is no evidence that Mr PNF was provided contact details for anyone other than SOCIT member 'B'.

DISCLOSURE OF THE RISK OF SUICIDE AND/OR SELF HARM

56. The VPM identifies that suspects of child sexual offences are at an increased risk of suicide and/or self-harm. However, it does not require that the existence of this risk be communicated to suspects and/or their families. From the VPM, and the conduct of the SOCIT members, there appears an unwillingness to explicitly acknowledge the nature of the risk Victoria Police's welfare obligations seek to mitigate.

57. Victoria Police acknowledges the important role of families in providing support to suspects. The VPM identifies that members must *'offer to contact a nominated support person on behalf of the suspect'*. More specifically, SOCIT Members 'A' and 'B' recalled their numerous interactions with Mrs MLE and Mr XVP including to impress upon them the importance of their support for Mr PNF: *'I told [Mrs MLE] and [Mr XVP] that [Mr PNF] would need the support from his family (. . .)'.*

58. Despite being alerted to their crucial role in supporting Mr PNF, Mrs MLE and Mr XVP were not informed of the key risk among the cohort to which Mr PNF now belonged despite numerous discussions of *'welfare support'.* Even if they had been provided with the brochure, it does not explicitly identify the increased risk of suicide and/or self-harm. With respect to welfare, it states:

[10] I note that SOCIT member 'B' stated, *'I cannot recall listing the specific support services, however, usual practice is for me to discuss this in these circumstances'.*

'Being subject to a police investigation may cause you to feel isolated, confused and stressed about your situation. It may also be difficult for you to share what is happening with your family or friends, or seek their support.

Initiating contact or seeking referrals to mental health professionals during such times can assist you by providing a confidential space to express concerns and seek assistance in how to cope'.

59. Upon receipt of the brochure, a suspect or their nominated support person may erroneously conclude that isolation, confusion and stress are the extent of the wellbeing challenges suspects might confront.

60. That suspects of child sexual offences and their nominated support person(s) are not specifically advised of the risk of suicide and/or self-harm is additionally concerning in light of suicides among this cohort. Statistics demonstrate that in a group of 100 suicides of men suspected of child sexual offences, only 30% of them previously experienced mental ill health compared to 50% of the general male suicides in Victoria.[11] Further, the majority of suspects suicide after learning of the investigation despite not having previously experienced mental ill health and/or suicidality. Without being advised of this particular risk, it may not occur to nominated support persons especially if the suspect has not previously experienced mental ill health and/or suicidality.

61. If suspects, and/or their nominated support person(s), are not alerted to the increased risk of suicide and/or self-harm shortly before or after police interview (and at other points in the criminal justice process) they are left ill-equipped to identify signs the suspect might be unsafe and to escalate concerns to health professionals if and/or when they arise.

62. In the course of the natural justice process, the CCP submitted to the Court that '*there are clear and deliberate reasons why this information cannot be shared with nominated persons or included in the brochure. This would disclose that the person is being investigated for child sexual offences. Not including this information ensures that a person's privacy is maintained*'.

63. While I accept the premise of this submission, I note that the brochure is drafted in general terms to ensure its relevance to people being investigated for a broad range of offences, and consider that the nature of the risk (i.e. the potential for a heightened risk of suicide and/or

[11] According to data 2009-2022 obtained by the Coroners Prevention Unit of the Coroners Court of Victoria, discussed further below.

self-harm in the course of being investigated and/or charged by police) rather than the type of offence that ought to be disclosed to anyone other than the suspect, where the suspect has not themselves disclosed to their nominated support person the nature of the investigation.

64. In Mr PNF's case, his wife *was* in fact aware of the specific type of offence he had been charged with but there was no requirement for police to advise her of Mr PNF's resultant heightened risk of suicide and/or self-harm.

65. I will make an apposite recommendation regarding the importance of informing suspects and their families of the increased risk of suicidality and/or self-harm.

DEMEANOUR IS AN UNRELIABLE INDICATOR OF SUICIDALITY

66. As evidenced by their statements, SOCIT Members 'A' and 'B' did not believe that Mr PNF was 'at risk' of suicide and/or self-harm during their interactions on 21 December 2022. These beliefs were informed primarily by the members' interpretation of Mr PNF's demeanour and the content of his speech: *'I do not recall [Mr PNF] appearing in a distressed manner'*.[12]

67. It is apparent from the SOCIT members' recollections that they considered Mr PNF's behaviour to be entirely congruent with those of an individual being informed they are the subject of a child sexual offence investigation. SOCIT Member 'B' considered it was *'expected in the circumstance'* that Mr PNF would appear *'surprised and anxious'*. Mr PNF's repeated expressions of concern about his reputation elicited from the SOCIT members (appropriately) an attempt to *'alleviate'* these concerns by reassuring him the investigation would be confidential. However, the SOCIT members did not interpret his concern as potentially indicative of heightened risk of harm.

68. I have noted that SOCIT members ascribed Mr PNF's demeanour and comments to the *'circumstance'* particularly when he presented with several of the indicia associated with increased risk of self-harm/suicide highlighted in Victoria Police guidance materials. Further, SOCIT Member B's comment, *'[Mr PNF] did not exhibit usual symptoms that I would attribute to someone being distressed'*, prompts one to wonder what presentation might have

[12] Submissions made on behalf of the Chief Commissioner of Victoria Police dated 30 September 2025, noted that SOCIT Member B's use of the term 'distress' was a 'direct response to the Court's question.' The phrase used was 'stated distress after the interview' in response to paragraphs 31-32 of SOCIT Member B's first statement which referred to Mr PNF's 'expressed concerns.' It is nonetheless significant that the SOCIT members appear to have been looking for overt signs of distress and did not interpret his apparent "anxiety" and spoken "concern" as distress or an indication that he may be at heightened risk of harm.

provoked them to identify "distress" and/or heightened risk of self-harm or suicide. Overt displays of emotion – such as crying, hyperventilation etc – are not prerequisites of distress nor is the absence of such displays a reliable predictor of a lack of distress (or risk of harm).

69. In the course of the natural justice process, the CCP submitted that it cannot be said that SOCIT member 'B''s assessment of demeanour and outward signs of distress were the only indicators relied on to make their assessment. The CCP noted that the SOCIT members recognised Mr PNF anxiety and concern, and '*it appears that they did not form the view that Mr PNF was at imminent risk of self-harm or suicide during their interactions with him on 21 December 2021 based on the totality of their interactions with him*'. However, while a range of factors may have been considered, I consider that the SOCIT members' statements demonstrate that Mr PNF's demeanour played a key role in their perception of his risk.

70. This brings into sharp relief, in my view, the limitations of demeanour as an indicator of suicidality, and in relation to which I am reminded of Coroner Spanos'[13] discussion in the 2008 Finding with Inquest into the Death of Georgia Lopiccolo (**2008 Finding**), which involved a death in police custody.[14]

71. Her Honour wrote regarding the Victoria Police assessment of Ms Lopicollo's suicide risk:

> *'It was abundantly clear at Inquest that Ms Lopiccolo's* ***demeanour****, or rather the way she appeared to the various police members who came into contact with her on 21 July 2005, was* ***crucial to their assessment of her suicidality*** *or the risk that she would harm herself. Without exception, they testified that although at times distressed, upset or crying, they found her demeanour congruent with the situation she found herself in, that is being arrested, being subjected to a full body search, being denied bail and facing the prospect of incarceration.'* (emphasis in the original)

72. On the use of 'demeanour' as a tool to assess an individual's suicidality, Coroner Spanos observed:

> *'In the first place* ***demeanour is not a good indicator of suicidality*** *or self-harming intent. Without being more specific, there are any number of coronial findings which evidence the 'predictable unpredictability' of suicide, and the inability or failure of Psychiatrists, Psychologists, Psychiatric Nurses, close family members and friends of*

[13] As her Honour Deputy State Coroner Spanos was then.
[14] Finding with Inquest into the Death of Georgia Lopiccolo handed down on 20 February 2008, COR 2005 2579. Accessible here. For the sake of clarity, I note that Ms Lopiccolo was not alleged to have committed any sexual offence.

people who have taken their own lives, to anticipate the act of suicide. Police members cannot be expected to fare any better than clinicians, but they will inevitably come into contact with people with mental health issues, or people without mental health issues but in stressful situations. Some part of their ongoing professional development could be usefully targeted to meeting these challenges.' (emphasis original)

73. Notwithstanding the significant improvement in the training Victoria Police provides its members since the 2008 Finding, it is concerning that an individual's demeanour persists as an apparently persuasive measure of their perceived risk of suicide or self-harm among (some) police members.[15] I agree with Coroner Spanos' comments and emphasise that in many circumstances, suspects can tactically conceal their distress and/or suicidality such that they appear *'well'* to third parties, including medical and mental health practitioners.

74. The SOCIT members' assessment of Mr PNF does not appear to account for the likelihood that suspects may act differently in their presence, indeed that they may downplay or conceal their distress to avoid it being interpreted as guilt or culpability. Mr PNF's behaviour significantly shifted later in the night when he was with his family and, by any standard, distressed – Mrs MLE and Mr XVP recount:

'[Mr PNF] then just cried. And cried. And cried'

'I could hear it in Dad's voice and I could see it in his face that he was torn to pieces'.

75. While I acknowledge that Mr PNF was not crying (nor had he made any explicit reference to self-harm or suicide) while at police station, there was otherwise several indicia of distress and potentially heightened risk of harm. There is no evidence that the SOCIT members turned their minds to consider that an individual's demeanour at a singular point in time, can be misleading and is not a reliable indicator of their suicidality.

THE PREVALENCE OF SUICIDE AMONGST INDIVIDUALS INVESTIGATED FOR CHILD SEXUAL OFFENCES

76. Mr PNF's death forms part of a pattern of suicides among people suspected of child sexual offences. At the outset, I seek to make clear that in this finding, I do not make any comment on the veracity of the allegations against Mr PNF, noting the limitations of the coronial jurisdiction insofar as coroners cannot make findings of criminal or civil liability.

[15] I note my colleague Coroner Audrey Jamieson's very recent discussion of similar matters in the Finding with Inquest into death of Wendy Ann McCabe handed down on 13 November 2025, COR 2021 006480, available here.

Accordingly, I have noted only that his death occurred in connection with his notification of the SOCIT investigation into allegations of child sexual assault made against him.

77. On 25 October 2024, I delivered my finding into the death of Mr EK, who suicided shortly before a scheduled interview with SOCIT members.[16]

78. In that finding I referred to statistics compiled by the Coroners Prevention Unit[17] that demonstrate that between 2009 and 2022, there were 150 suicides of people being investigated for sexual offences – 100 of these investigations related to alleged offending against children and all individuals were male.

79. It is well-known that there are certain times during the police investigation that suspects are at a greater risk of suicide or self-harm. Of the 100 suicides of individuals suspected of child sexual offences, approximately one third occurred within a week of the suspect becoming aware of the police investigation, as occurred in Mr PNF's case.

80. In contrast to suicides in other circumstances – where there is often an element of mental ill health – there was a startlingly low prevalence of the same amongst the male suspects that suicided (approximately 30% compared to over 50% in the general population of Victorian male suicides). While evidence indicates that Mr PNF suffered from low mood and was prescribed an anti-depressant, family members and medical practitioners have noted in statements that he never reported suicidal ideation.

81. As part of the investigation into Mr EK's death, I considered the role of Victoria's healthcare system to manage the risk of self-harm and/or suicide among this demographic. In the United States, the Central District of California's US Pretrial Services Offices established the Sharper Future program in collaboration with local courts and mental health services. The program's aim is to manage symptoms of anxiety, depression and suicidality among sexual offence defendants in the community awaiting trial, through a range of modules and programs including crisis intervention, support group sessions, healthy coping skills classes, and cognitive behaviour therapy. The Sharper Future program was established in 2005, and in 2012 a detailed evaluation was published. Key findings demonstrated that participation among

[16] Finding into Death Without Inquest relating to the death of Mr EK (a pseudonym) (COR 2019 002791). Available here.
[17] The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety; as well as staff who support coroners through research, data and policy analysis.

defendants was high, the program had a generally positive impact on defendants' daily functioning, and no participants suicided.

82. In a 2021 systematic review examining international research on suicidal behaviour among people accused or convicted of child sex abuse or indecent image offences, the Sharper Future program was the only therapeutic intervention that the authors could identify. The authors of the systematic review concluded that there is a need to explore:

> *'[…] the potential for increased co-working between law enforcement, custodial staff, and mental health services to develop a pathway to identity risk of suicide and support CSA [child sex abuse] and IIOC [indecent images of children] offenders'.*

83. I remain of the view, as I was at the time I handed down the finding into Mr EK's death, that Victoria Police has been responsive to Victorian coroners' past recommendations regarding how to manage suicide risk in people being investigated for alleged sexual offences. I also noted in that finding, and remain of the view, that police members are not the only persons who ought to be tasked with addressing the risk of suicide in this cohort.

84. Indeed, in the finding relating to Mr EK, I recommended that a health-lead approach be explored in order to mitigate the occurrence of suicides amongst this demographic. I recommended:

> *'That the Secretary of the Department of Justice and Community Safety, in tandem with the Secretary of the Department of Health, explore the development of a program in contact with relevant health experts, to support mental health and coping mechanisms with the view to reduce suicidality among Victorian persons who are under investigation for alleged sexual offences.'*

85. On 14 and 15 January this year, the Department of Health and the Department of Justice and Community Safety, respectively, responded to the recommendation.[18]

86. The Department of Health stated it had consulted with its counterparts at the Department of Justice and Community Safety and began consideration of the recommendation under the auspices of the *Victorian suicide prevention and response strategy 2024-34.* The

[18] The response of the Department of Health, dated 14 January 2025, is accessible via the Coroners' Court of Victoria website here: 2019 2791 Response to recommendations from DoH_EK.pdf. The response of the Department of Justice and Community Safety, dated 15 January 2025, is accessible via the Coroners' Court of Victoria website here: 2019 2791 Response to Recommendations from Department of Justice and Community Safety_EK.pdf.

corresponding *First implementation plan 2024-26* includes Initiative 1.7 to *'build an understanding of connections between family violence, sexual offending and suicide to identify key intervention points to support coordinated prevention and response efforts, including opportunities to strengthen referral pathways and service responses'.*

87. Both departments indicated an intention to cooperate in *'scoping'* Initiative 1.7 including *'whether it would be appropriate to incorporate the intent of the recommendation within* Initiative 1.7'.

88. Given this response, I have elected not to reiterate this recommendation in the present finding but will provide a copy of my finding to the Department of Health and Department of Justice and Community Safety to assist in navigating the specific issues associated with its future implementation, as appropriate.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr PNF, born [redacted] 1961;

    b) the death occurred on 22 December 2021 at [redacted] from *neck compression* secondary to *hanging*; and

    c) the death occurred in the circumstances described in paragraphs 12 to 21 above.

90. Having considered all the evidence, I find that Mr PNF intentionally took his own life. While there is evidence that he experienced a degree of mental ill health, there is no evidence that he was suicidal at any time prior to his engagement with Victoria Police members.

91. Accordingly, I find that Mr PNF's death occurred in the context of having recently learned he was under investigation by the Central Gippsland Sexual Offences and Child Abuse Investigation Team and that this influenced him to adopt the course of action he ultimately chose. Such is clear from the notes and Facebook correspondence he wrote prior to death.

92. I have considered the actions of the Central Gippsland Sexual Offences and Child Abuse Investigation Team's members who engaged with Mr PNF and his family on 21 December 2021. I find that their actions fell short of those required by the relevant Victoria Police Manual chapter, specifically that they did not provide the Information and Support Referral brochure to him as required.

93. I further find that, while it was not a mandatory requirement to document the 'thorough risk assessment' of a suspect's wellbeing required by the VPM, the absence of any contemporaneous record of Mr PNF's risks and how these were assessed leaves me unable to determine the basis of the SOCIT members' conclusion he was not "at risk." The evidence, however, shows a range of risk factors identified in the VPM to heighten suicide and self-harm including explicit concerns for reputation and the context of the interaction (a police interview following allegations of child sexual assault against a man with no previous contact with the criminal justice system) were present but that members perceived no overt signs of distress.

94. That said, the evidence also shows that Mr PNF's condition deteriorated after his release from police custody, and that the SOCIT members were not privy to this decline, nor could they have predicted it.

95. Having so found, the weight of the evidence does not permit me to conclude that the Victoria Police members' failure to adhere to the VPM was causative or contributory to Mr PNF's death. I draw no such conclusion. I also recognise that the investigation of such offences on the part of police is no easy task, and that appropriate organisational guidance is required to make clear the steps police members should be taking to address the heightened risk of suicide and/or self-harm of those they are investigating. In this regard, despite some shortcomings in their approach, it would not be fair to place the tragic outcome in this case on the shoulders of the police members investigating Mr PNF.

96. Indeed, it would be remiss not to acknowledge that Mr PNF's death forms part of a broader pattern of suicides amongst persons suspected of and/or investigated for child sexual abuse offences and note that is a matter which I have previously raised to the attention of the Victorian Department of Health and the Department of Justice and Community Safety.

97. I consider that, while Victoria Police plays a pivotal role in addressing suspect welfare considerations for suspected sexual offenders, and has been highly responsive to strengthening its approach to this issue over recent years, a health-led response (as evidenced in jurisdictions in the United States) is now required to complement existing Victoria Police approaches to managing suspect welfare and preventing suspects' suicides before the completion of the criminal law process, given the heavy burden such suicides can place on victims and their families (and indeed on investigating members) where the justice process is abruptly and permanently truncated before any outcome can be rendered.

98. I consider that enhanced prevention opportunities in this space to be in the best interests of victims, families, investigators and accused persons alike.

RECOMMENDATIONS

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

    d) That the **Chief Commissioner of Victoria Police** consider the implementation of a mandatory requirement that Victoria Police members record contemporaneous (or as close to) notes when they undertake risk assessments pertaining to the wellbeing of individuals suspected of child sexual offences.

    e) That the **Chief Commissioner of Victoria Police** consult with the **Office of the Chief Psychiatrist** with the view to consider the implementation of a protocol which explicitly advises suspects and/or their families, including their *'nominated support person'* (where applicable), of the increased risk of suicide and/or self-harm which affects persons investigated of certain offences and provides information on appropriate referral and escalation avenues to mitigate the same.

I convey my sincere condolences to Mr PNF's family for their loss and acknowledge the significant difficulties they face in the wake of questions that remain unanswered following his death.

ORDERS AND DIRECTIONS

Pursuant to section 73(1A) of the Act, I direct that a de-identified version of this finding be published on the Coroners Court of Victoria website.

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

Mrs MLE, Senior Next of Kin

Chief Commissioner Mike Bush CNZM, via Lander & Rogers

Central Gippsland Sexual Offences and Child Abuse Investigation Team

Department of Health

Department of Justice and Community Safety

Office of the Chief Psychiatrist

Senior Constable Aaron Bowen, Coronial Investigator

Signature:

Ingrid Giles

CORONER

Date: 04 December 2025

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.