IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 003567

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Robert Ali Chehade
Date of birth:	18 October 1971
Date of death:	26 June 2024
Cause of death:	1a : COMPRESSION OF THE NECK 1b : HANGING
Place of death:	42 Thomas Street Laverton Victoria 3028
Keywords:	Suicide; Family violence; Community Correction Orders

INTRODUCTION

1. On 26 June 2024, Robert Ali Chehade was 52 years old when he was found deceased in his home. At the time of his death, Robert lived in a share house at 42 Thomas Street Laverton Victoria 3028.

2. Robert was raised by his parents as one of five siblings and lived across multiple Victorian suburbs including Essendon, Ascot Vale, Brunswick and Heidelberg. Robert worked in various roles across his life including doing mechanical work, carpentry and general labouring jobs.

3. Robert got married in 2005 and due to ongoing substance dependence issues, the couple separated after four years. Robert had a substantial criminal history and spent significant periods of time in prison.[1]

4. Robert's treating General Practitioner confirmed that Robert had a complex history of trauma and substance dependence.[2] Robert received treatment with opioid replacement therapy and had monthly long-acting injectable buprenorphine. Robert also attended Austin Neurology for epilepsy treatment. Robert was diagnosed with post traumatic disorder after psychiatric review in 2022 and was prescribed quetiapine and diazepam.[3]

THE CORONIAL INVESTIGATION

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

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of

[1] *Coronial Brief*, Exhibit 10 – Robert Chehade criminal history extract.
[2] *Coronial Brief*, Statement of Dr Denise Chao.
[3] Ibid.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned Senior Constable Edward Middleditch to be the Coronial Investigator for the investigation of Robert's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Robert Ali Chehade 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.[4]

10. In considering the issues associated with this finding, I have been mindful of Robert's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

11. In the six months prior to his death, Robert formed a relationship with Kiara Morrow and on 25 June 2024, a family violence incident occurred in Werribee at around 7:30 pm in the evening.[5] Police members attended this incident and arrested Robert. Robert was transported to Werribee police station and served with a Family Violence Safety Notice with conditions preventing him from contact with Kiara.[6]

12. At around 11:40 pm, Robert was charged with assault in relation to the earlier incident and released on bail. Robert was escorted by an associate back home to his residence and was last seen alive at 1:30 am on 26 June 2024.[7]

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[4] 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.

[5] *Coronial Brief*, Statement of Kiara Morrow.

[6] *Coronial Brief*, Statement of Sergeant Nathan Gardiner.

[7] *Coronial Brief*, Statement of Scott Hansen.

13. At around 1:50 am on 26 June 2024, one of Robert's house mates, Mr Scott Hansen, went to check in on him as he couldn't hear him pacing in his room, which he often did late at night.[8] Mr Hansen found Robert unresponsive and hanging from a chain and rope that was suspended from one of the metal roof trusses. Mr Hansen cut Robert down and contacted emergency services for assistance.[9] Ambulance paramedics arrived on scene at 2:05 am and were unable to revive Robert, he was pronounced deceased onsite.[10]

Identity of the deceased

14. On 26 June 2024, Robert Ali Chehade, born 18 October 1971, was visually identified by their partner, Kiara Morrow.

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

Medical cause of death

16. Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 26 June 2024 and provided a written report of his findings dated 20 August 2024.

17. The post-mortem examination revealed evidence of an abraded injury to the deceased's neck. The abraded injury extends around the deceased's neck on the left side and for 10 cm on the right side. There was evidence of a second parallel abrasion which extends transversely across the anterior neck with a faint indentation along the left jawline. The external examination was otherwise unremarkable.

18. Toxicological analysis of post-mortem blood samples identified the presence of Buprenorphine (~2 ng/mL), Norbuprenorphine (~2 ng/mL), Methylamphetamine (~0.2 mg/L), Nordiazepam (~0.03 mg/L) and Metoclopramide (~0.01 mg/L).

19. Dr Burke provided an opinion that the medical cause of death was 1(a) COMPRESSION OF THE NECK, 1(b) HANGING and I accept his opinion.

[8] Ibid.
[9] Ibid.
[10] *Coronial Brief*, Statement of Ambulance paramedic Laura Perree.

FURTHER INVESTIGATIONS – CORRECTIONS VICTORIA AND FAMILY VIOLENCE

20. To gain a fuller picture of Robert's proximate contact with various support services in the lead up to the fatal incident, I directed that further information be obtained from Victoria Police, the Orange Door, Family Safety Victoria and the Department of Justice and Community Safety (**DJCS**).

21. As a result of receiving records from DJCS, I was made aware that on 22 June 2023, Robert was sentenced to a 12 month Community Corrections Order (**CCO**) that was managed by Sunshine Community Correctional Services (**Sunshine CCS**).[11] The conditions of the CCO included supervision, mental health treatment and rehabilitation, drug treatment and rehabilitation and programs to reduce re-offending. Robert was also sentenced on 23 January 2024 to a 12-month CCO requiring the completion of 75 hours of unpaid community work.

22. Following Robert's death, a Manager's Review was undertaken by Sunshine CCS and a copy of the report was provided to the Court. I note the following relevant observations from the Manager's Review:[12]

Mental health treatment

23. On 21 March 2024, Robert was requested to attend with his General Practitioner (GP) for the purposes of obtaining a mental health treatment plan. He was also referred to Banyule Community Hub. Robert saw his GP who managed prescriptions for Robert and noted that Robert had reported anxiety, depression and Post-Traumatic Stress Disorder. Robert's GP supported making a mental health care plan for Robert, but Robert said he had a psychologist being arranged through Sunshine CCS and his last contact for mental health was through services provided by Caraniche in 2023.[13]

24. The available evidence confirms that Robert stopped seeing a mental health clinician from CoHealth around 16 November 2023 and since that time was never reconnected with any mental health support services until the fatal incident.[14]

[11] *Coronial Brief*, Exhibit 10 – Robert Chehade criminal history extract.
[12] *Coronial Brief*, Response letter from DJCS to Court dated 8 October 2025 and the CCS Manager's Review dated 6 September 2024.
[13] Ibid.
[14] *Coronial Brief*, Holstep Health (Banyule Medical Centre) records.

Drug treatment and rehabilitation

25. Robert was assessed by the Australian Community Support Organisation (**ACSO**) on 9 August 2023 for drug dependence and was found suitable for treatment. Robert had a prior treatment with an Alcohol and Drug counsellor at Caraniche Sunshine but was exited from that program on 15 February 2024.[15] There was no evidence of any follow up in his supervision sessions with his CCS case manager regarding his compliance with the condition to receive drug treatment and rehabilitation. Furthermore, Robert was directed to complete a drug test on 5 June 2024 and failed to attend this.[16]

Other programs and supervision

26. Whilst Robert was initially assessed as 'high risk of reoffending, very high risk in alcohol/drug problems and antisocial patterns', Robert's supervision with his CCS case manager did not focus on risk management, harm minimization, his mental health status or offence specific needs. The Manager's Review noted that, "*Points of potential risk escalation were not identified or followed up during the operational period of the order. With limited conversations occurring with supervisory staff*."[17]

27. The Department of Justice and Community Safety has a significant role in ensuring that offenders who are subject to CCOs have the opportunity to maintain and improve their social and economic support networks in a community setting, are accountable for their actions and undergo any court-ordered rehabilitation, while they make amends for their offences. By providing case management services to offenders subject to CCOs, there is a responsibility to ensure that risks to the community and safety of the offender's family members/intimate partner are minimised.

28. The available evidence suggests that Robert's CCS case manager had minimal contact with his treatment providers to monitor progress against conditions and further explore this during supervision. This was a missed opportunity for Sunshine CCS to ensure that Robert had appropriate ongoing supports for his substance dependence issues, mental health and wellbeing in the lead up to the fatal incident. I however find that while Sunshine CCS's lack of follow-up is suboptimal, , Robert's own conduct in misrepresenting or obfuscating his

[15] *Coronial Brief*, Response letter from DJCS to Court dated 8 October 2025 and the CCS Manager's Review dated 6 September 2024
[16] Ibid.
[17] Ibid.

engagement with those services means these shortcomings did not have sufficient causal impact to represent a direct prevention opportunity.

FINDINGS AND CONCLUSION

29. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[18] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Robert Ali Chehade, born 18 October 1971;

    b) the death occurred on 26 June 2024 at 42 Thomas Street, Laverton, Victoria, 3028, from 1(a) COMPRESSION OF THE NECK, 1(b) HANGING; and

    c) the death occurred in the circumstances described above.

31. Having considered all of the circumstances, I am satisfied that Robert intentionally took his own life.

I convey my sincere condolences to Robert's family for their loss.

[18] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: '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 issues 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…'.

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

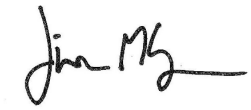
I direct that a copy of this finding be provided to the following:

Gloria Chehade, Senior Next of Kin

Ashlee Briffa, Department of Justice and Community Safety – Community Operations & Parole

Senior Constable Edward Middleditch, Coronial Investigator

Signature:





Coroner Simon McGregor

Date: 05 November 2026

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.