IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2024 005252**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner Simon McGregor |
| Deceased: | HB |
| Date of birth: | 1972 |
| Date of death: | Between 30 August 2024 and 5 September 2024 |
| Cause of death: | 1a : NECK COMPRESSION<br>1b : HANGING |
| Place of death: | Tarneit, Victoria |
| Keywords: | Suicide; Family Violence |

## INTRODUCTION

1. On 5 September 2024, HB was 51 years old he was found deceased in an abandoned house in Tarneit. At the time of his death, HB lived in Tarneit, Victoria with his wife, HC and two children, HD and HE.

2. HB was born and raised in Colombia and moved to Australia to live with his mother. HB and HC knew of each other as familial acquaintances but became close when HB spent a year in Colombia living with HC in 2007. HB and HC got married in September 2008 and migrated to Australia. The couple initially lived in Sydney before moving to Melbourne and settling in Wyndham Vale. The couple's children, HD and HE were born in 2013 and 2015 respectively.

3. HB and HC experienced several periods of separation. The couple ultimately decided to separate permanently but still live together in October 2023. The couple remained living together with their children but were preparing to live separately in the lead up to the fatal incident.

## THE CORONIAL INVESTIGATION

4. HB'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.

5. 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.

6. 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.

7. Victoria Police assigned Senior Constable Darren Field to be the Coronial Investigator for the investigation of HB'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.

8. This finding draws on the totality of the coronial investigation into the death of HB 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.[1]

9. In considering the issues associated with this finding, I have been mindful of HB'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

10. On 29 August 2024, HD disclosed to HC that HB had sexually assaulted her on multiple occasions whilst HC was at work. HC confronted HB that same day and informed him that she would be taking further action in reporting the matter to Child Protection and that she no longer trusted him spending time alone with their two daughters.[2]

11. That same evening, HB slept in another room and left early for work the following day on 30 August 2024.[3] HB attended his workplace and completed his normal shift as a forklift operator until 2:00 pm. HB did not return home that evening.

12. During the time HB was at work, HC reported HD's disclosures to Child Protection and met with detectives from the Westgate Sexual Offences and Child Abuse Investigation Team (**SOCIT**) to provide a statement.[4] SOCIT detectives also interviewed both HD and HE and an arrest plan was formulated to attend HB's residence and place him under arrest. SOCIT detectives attended the residence in an unmarked vehicle at 3:38 pm but HB had not returned home.[5]

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[1] 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.

[2] *Coronial Brief*, Statement of HC.

[3] Ibid.

[4] *Coronial Brief*, Statement of Detective Sergeant Jessica Angland.

[5] Ibid.

13. SOCIT detectives later tried to call HB on his mobile phone without success. Between 30 August 2024 and 5 September 2024, police members made numerous enquiries to locate HB including:[6]

    a) Obtaining phone records for HB's mobile phone which showed that it was last active at 10:38 pm on 30 August 2024;

    b) CCTV footage and stills were obtained that captured HB on 30 August 2024, driving his car into the car park of Manor Lakes Shopping Centre at 3:15 pm and driving off at 3:40 pm;

    c) There were no financial transactions on his Commonwealth Bank account since 30 August 2024; and

    d) There were no sightings of HB's vehicle on Eastlink or Citylink highway cameras proximate to the fatal incident.

14. On 5 September 2024 at around 7:00 am, KJ, was riding a bicycle along Sayers Road in Tarneit when he came across 1170 Sayers Road, Tarneit, which he knew to be a long-term vacant property.[7] KJ observed a car to be parked on the property which was unusual in light of the long-term vacancy and he approached the property. KJ observed a male appearing to be standing on a step ladder in the front of the house and he entered the premises and found HB's body hanging without any signs of life. KJ left the premises and returned home to contact triple zero for assistance.[8]

15. On the same day at around 7:40 am, local police members attended the property located at 1170 Sayers Road, Tarneit.[9] Attending police members located HB's body hanging from an exposed roof beam and noted no signs of life. Ambulance paramedics arrived on scene at 8:02 am and pronounced HB deceased onsite.[10]

**Identity of the deceased**

16. On 18 September 2024, HB, born in 1972, was identified via DNA comparison.

[6] Ibid.
[7] *Coronial Brief*, Statement of KJ.
[8] Ibid.
[9] *Coronial Brief*, Statement of Constable Quang Lam.
[10] Ibid.

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

**Medical cause of death**

18. Forensic Pathologist Dr Vianney Rajakarunanaike from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 6 September 2024 and provided a written report of his findings dated 16 October 2024.

19. The post-mortem examination revealed evidence of an up-slanting parchment-like ligature abrasion. Post-mortem CT scans revealed no hyoid, thyroid or cervical spine fractures/dislocations.

20. Toxicological analysis of post-mortem blood samples did not identify the presence of any alcohol or other common drugs or poisons.

21. Dr Rajakarunanaike provided an opinion that the medical cause of death was 1(a) NECK COMPRESSION, 1(b) HANGING and I accept her opinion.

## FINDINGS AND CONCLUSION

22. 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.[11] Adverse findings or comments against individuals, 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 caused or contributed to the death under investigation.

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

    a) the identity of the deceased was HB, born in 1972;

    b) the death occurred on sometime between 30 August 2024 and 5 September 2024 in Tarneit, Victoria, from 1(a) NECK COMPRESSION, 1(b) HANGING; and

    c) the death occurred in the circumstances described above.

[11] *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…'.

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

25. The consequences of child sexual assault can affect the victim's family, friends and community. Research has shown that non-offending parents can experience a wide range of negative emotional responses to their child's victimisation.[12] In particular, parents have been known to report feelings of anger, sadness and guilt; become overprotective and isolated from their children, partners, family, friends and community.[13] In the tragic circumstances of this case, I commend HC for her bravery and immediate actions in taking proactive steps to protect her children.

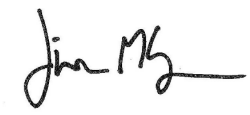
I convey my sincere condolences to HB's family.

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

HC, Senior Next of Kin

Senior Constable Darren Field, Coronial Investigator

Signature:






Coroner Simon McGregor

Date: 09 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.

[12] Fuller G, Non-offending parents as secondary victims of child sexual assault. *Trends & issues in crime and criminal justice* no. 500 (2016). Canberra: Australian Institute of Criminology. Available online at: https://doi.org/10.52922/ti158270

[13] Ibid.