IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 003251

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Caitlin O'Brien
Date of birth:	31 March 1988
Date of death:	25 June 2019
Cause of death:	1(a) Compression of the neck
Place of death:	8/487 Kooyong Road, Gardenvale, Victoria, 3185
Keywords:	Intimate partner homicide; family violence; mental health

INTRODUCTION

1. On 25 June 2019, Caitlin O'Brien was 31 years old when she was fatally strangled by her then partner, Mr Shea Sturt. At the time of her death, Ms O'Brien lived in Gardenvale with Mr Sturt. Ms O'Brien is survived by her older sister and parents.

2. Ms O'Brien was born in Carlton and completed a nursing degree at Monash University before commencing employment as a nurse at Caulfield Hospital for approximately 8 years before moving onto the Alfred Hospital.

3. Ms O'Brien and Mr Sturt met at TAFE in Frankston and commenced a relationship shortly afterwards.

THE CORONIAL INVESTIGATION

4. Ms O'Brien'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 an officer to be the Coroner's Investigator for the investigation of Ms O'Brien's death. The Coroner's 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 Caitlin O'Brien 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]

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

Circumstances in which the death occurred

9. In the weeks leading up to the offence, Mr Sturt was smoking highly potent cannabis daily. On 23 June 2019, Ms O'Brien had concerns about his deteriorating mental state and observed Mr Sturt having delusions that he was Jesus and that the neighbours worshipped Satan and sacrificed people.[2]

10. Ms O'Brien contacted emergency services, and police and paramedics attended the couple's residence. Mr Sturt was aggressive towards the police members, stating '*don't touch me, you are all rapists'*.[3] Mr Sturt was taken to the Alfred Hospital psychiatric unit for treatment. Mr Sturt was released the same night and returned home.

11. On the morning of 25 June 2019, Mr Sturt and Ms O'Brien had an altercation starting in the loungeroom. Ms O'Brien ran into the bathroom, grabbed a pair of scissors and went to the bedroom where Mr Sturt had relocated with the scissors. Mr Sturt overpowered Ms O'Brien and took the scissors from her. Mr Sturt then struck Ms O'Brien several times causing minor abrasions and bruising to various parts of her body, principally to her upper body.[4]

12. Mr Sturt then pushed Ms O'Brien onto the bed and put a pillow over her face and used all his body weight to hold it there for approximately two minutes.[5] When he removed the pillow, Ms O'Brien was not moving. Wanting to ensure that she was dead, Mr Sturt went into the lounge room and grabbed a pair of tracksuit pants. He then tied them tightly around Ms O'Brien's neck.[6]

13. Mr Sturt left the apartment and spoke to some Protective Service Officers near Flinders Street Station, asking them to arrest him.[7] Eventually Mr Sturt was arrested and charged with Ms

---

[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 Tina O'Brien dated 23 July 2019, 105
[3] *Coronial Brief*, Statement of police member dated 27 July 2019, 154
[4] *Coronial Brief*, Exhibit 72 – Record of interview, 483-485
[5] Ibid
[6] Ibid
[7] *Coronial Brief*, Statement of PSO dated 25 June 2019, 163-164

O'Brien's murder. Ms O'Brien's body was later discovered deceased by Ambulance paramedics at approximately 9.28pm on the evening of 25 June 2019.[8]

14. On 10 June 2020, in the Supreme Court of Victoria, Mr Sturt was convicted of the murder of Ms O'Brien and sentenced to 22 years' imprisonment with a non-parole period of 16 years.[9]

Identity of the deceased

15. On 27 June 2019, Caitlin O'Brien, born 31 March 1988, was identified by a comparison of dental records.

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

Medical cause of death

17. Forensic Pathologist Dr Noel Woodford from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 26 June 2019 and provided a written report of his findings dated 23 October 2019.

18. The post-mortem examination revealed the following:

    a) Sparse petechiae was present around the eyes and on the conjunctivae. There was a fracture of the right thyroid cornu associated with the haemorrhage; and

    b) There was no evidence of natural disease that would have contributed to the death.

19. Toxicological analysis of post-mortem samples identified the presence of cannabis and duloxetine. Neither was found in concentration levels that would affect the cause of death.

20. Dr Woodford provided an opinion that the medical cause of death was 1 (a) Compression of the neck.

21. I accept Dr Woodford's opinion.

[8] *Coronial Brief,* Statement of Ambulance paramedic dated 3 July 2019, 151
[9] *R v Sturt* [2020] VSC 317

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

22. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by an intimate partner is particularly shocking, given that all persons have a right to safety, respect and trust in their most intimate relationships.

23. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr Sturt and Ms O'Brien was one that fell within the definition of '*de facto partner'*[10] under that Act. Moreover, Mr Sturt's actions in fatally assaulting Ms O'Brien constitutes '*family violence'*.[11]

24. In light of this death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[12] examine the circumstances of Ms O'Brien death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[13]

Family violence history between Ms O'Brien and Mr Sturt

25. Evidence reviewed indicates Mr Sturt perpetrated family violence against Ms O'Brien throughout their relationship, however system intervention is minimal. Family violence intervention orders were issued with Ms O'Brien as the protected person and Mr Sturt as the respondent:

a) For 12 months from November 2008 (police application with limited conditions)[14]

b) For 2 years from April 2010 (police application with limited conditions).[15]

26. Criminal charges for recklessly causing injury were placed in relation to the 2010 family violence incident, however charges were dismissed on 6 September 2011 after it was determined Mr Sturt had complied with an undertaking.[16] Documented police involvement from this point forward was limited to mental health intervention for Mr Sturt.

---

[10] Family Violence Protection Act 2008, section 9
[11] Family Violence Protection Act 2008, section 8(1)(a)
[12] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[13] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community
[14] Coronial brief, Exhibit 63.
[15] Coronial brief, Exhibit 64.
[16] Coronial brief, Exhibit 65, 409-411.

27. Risk factors (noting risk assessment frameworks changed from CRAF in 2007,[17] to MARAM in 2018[18]) identified from reviewing the evidence include:

a) Multiple incidents of strangulation by Mr Sturt (dating back to 2007),[19] escalating in the 12 months prior to the fatal incident[20]
b) Mr Sturt's persistent unemployment throughout his adult life[21]
c) Mr Sturt's ongoing drug use[22]
d) Mr Sturt's mental health diagnosis[23]
e) Ms O'Brien's imminent plans to leave the relationship, proximate to the fatal incident[24]
f) Coercive control by Mr Sturt[25]
g) Isolation of the couple increasing from 2016[26]
h) Ms O'Brien's assessment of risk, including expressing fear Mr Sturt would kill her within 24 hours of him doing so[27]
i) Mr Sturt's previous threats to harm Ms O'Brien[28]
j) Mr Sturt's previous threats to kill Ms O'Brien[29]
k) Mr Sturt's previous threats to suicide[30]
l) Mr Sturt's previous sexual assault of Ms O'Brien[31]
m) Previous intervention orders against Mr Sturt[32]
n) Mr Sturt's previous physical harm to Ms O'Brien[33]
o) Mr Sturt's emotional abuse of Ms O'Brien[34]
p) Mr Sturt's property damage[35]
q) Financial abuse by Mr Sturt[36]
r) Mr Sturt's threats to kill/harm pets.[37]

---

[17] Monash University, Review of the Family Violence Risk Assessment and Risk Management Framework (CRAF) 2016, 29; Department of Health and Human Services, Family Violence Risk Assessment and Risk Management Framework and Practice Guides 1-3 (2012), 2nd Edition.

[18] Family Violence Protection (Information Sharing and Risk Management) Regulations 2018 (Vic), Schedule 3; Family Safety Victoria, Family Violence Multi-Agency Risk Assessment and Management Framework (2018).

[19] Coronial brief, Statement of Statement of M Parsons, 109; Statement of A Walters, 117; Coronial brief, Statement of K Shi 121-122. Coronial brief, Exhibit 58, 399. Coronial brief, Exhibit 25, 388. Dr Frank Imeneo Medical Records (Sturt), 6.

[20] Alfred Health Medical Records (Sturt) 118, 119, 396.

[21] Alfred Health Medical Records (Sturt) 396.

[22] Alfred Health Medical Records (Sturt) 396.

[23] Alfred Health Medical Records (Letter from Saraf Sudeep to Dr Imeneo) 130.

[24] Coronial brief, Statement of S Sturtevant, 146-147.

[25] Coronial brief, Statement of K Shi 121-122. Coronial brief, Exhibit 25.

[26] Coronial brief, Statement of M Parsons, 110.

[27] Coronial brief, Statement of E Furness, 124-126.

[28] Coronial brief, Statement of K Shi, 122; Coronial brief, Statement of E Furness, 124-126. Coronial brief, Statement of K Shi 121-122. Coronial brief, Exhibit 25.

[29] Coronial brief, Statement of K Shi 121-122. Coronial brief, Exhibit 25.

[30] Coronial brief, Statement of K Shi 121-122, Coronial brief, Statement of M Parsons, 110.

[31] Coronial brief, Statement of M Parsons, 110; Coronial brief, Exhibit 70; Coronial brief, Statement of K Shi, 122; Exhibit 25, 388. Alfred Health Medical Records (O'Brien) 12; Coronial brief, Statement of K Shi 121-122.

[32] Alfred Health Medical Records (Sturt) 396.

[33] Coronial brief, Statement of Statement of M Parsons, 109; Statement of A Walters, 117. Coronial brief, Statement of F Ellesley, 230-231; Exhibit 57, 396-397. Coronial brief, Exhibit 58, 399. Coronial brief, Statement of K Shi 121-122.

[34] Coronial brief, Statement of M Parsons, 110.

[35] Coronial brief, Statement of F Ellesley, 230-231; Exhibit 57, 396-397. Coronial brief, Exhibit 58, 399.

[36] Coronial brief, Statement of M Parsons, 110. Coronial brief, Exhibit 25; Coronial brief, Statement of T O'Brien, 105.

[37] Alfred Health Medical Records (Sturt) 119.

COMMENTS

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

28. A Coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice. The power to comment and recommend is a vital part of giving effect to one the statutory purposes of the Act.

29. While I have made comments below that appear appropriate to me as they arise from the coronial investigation into Ms O'Brien's death, the available evidence does not support a finding that there is any causal connection between the circumstances highlighted in the comments and Ms O'Brien's death. Rather the comments below identify prevention opportunities with services that had proximate contact with Ms O'Brien and those involved in her death which may have had a significant impact on the circumstances leading to Ms O'Brien's death and the supports available to her.

Alfred Health treatment provided to Ms O'Brien

30. In October 2018, notes from a social work appointment at Alfred Health are the first and only indication of a family violence risk assessment being completed with Ms O'Brien and notes appropriately the history of strangulation as precursor for homicide.[38] It is noted that Ms O'Brien took phone numbers for Salvation Army and Safe Steps and agreed to make contact the following week however there is no evidence to indicate she followed through. It is unclear the extent (if any) of safety planning that was completed or followed up specifically for her supports.

31. In November 2018, a psychiatry note records the main issue impacting Ms O'Brien's mental health as domestic violence, that she is at risk of physical harm, and medication will only have a limited impact as a result.[39] At this time Ms O'Brien was offered phone numbers for family violence support services, and to have coordinated support with Mr Sturt, both of which she declined.[40]

32. In January 2019, a letter from psychiatrist Dr Sudeep Saraf indicated Ms O'Brien experiencing '*interpersonal problems'* and instability in her relationship, refers to '*specific stressors'* but

[38] Alfred Health Medical Records (Sturt) 118, 119, 396.
[39] Alfred Health Medical Records (O'Brien #1) 22.
[40] Alfred Health Medical Records (O'Brien #1) 23.

makes no note of family violence, risk assessment, nor safety planning.[41] Part of the plan noted from this consultation was for Ms O'Brien to meet with Mr Sturt's mental health clinician to develop a mental health safety plan for Mr Sturt. It is concerning that the implication of this plan insinuates that Ms O'Brien's management of Mr Sturt's mental health would afford her safety from Mr Stuart's use of family violence and suggests a broader understanding of family violence would have deemed this strategy inappropriate.

33. On 29 January 2019, Ms O'Brien was admitted for psychiatric assessment and suicidal ideation after a friend called 000 following her social media posts. The assessment noted sexual abuse by her partner, and noted Ms O'Brien was offered helplines which she again declined.

34. The available evidence suggests that the health treatment for Ms O'Brien was limited in its capacity to assist beyond providing contact details for specialist family violence services, however practitioners skilled in family violence may have taken the opportunity to develop a safety plan, further explore the level of risk with her, and her disinclination to engage with family violence services.

Alfred Health treatment provided to Mr Sturt

35. Instances of relevant medical treatment and disclosures by Mr Sturt in the lead up to the fatal incident between 2018 and 2019 are summarised below in themes, with only the medical treatment directly proximate to the fatal incident outlined in detail.

36. The available evidence indicates that within the 12 months prior to the fatal incident, Alfred Health had a documented and significant history about Mr Sturt including physical/sexual violence, threats to kill himself or his partner, and a lack of responsibility for his violent behaviour, which he consistently minimized.

37. Records from September 2018 noted a history of family violence perpetrated by Mr Sturt including sexual, emotional and physical violence.[42]

38. Records from October 2018 note Ms O'Brien had reported that Mr Sturt raped her on being discharged after a similar presentation to hospital,[43] and that Mr Sturt had recently threatened

[41] Alfred Health Medical Records (O'Brien #1) 15.
[42] Alfred Health Medical Records (Sturt) 100.
[43] Alfred Health Medical Records (Sturt) 81.

to kill another sexual partner he met online.[44] Visits by Ms O'Brien to Mr Sturt during this hospital admission were monitored due to his history of violence.[45]

39. Threats to kill were noted in both September[46] and October 2018,[47] including specifically a suicide pact '*not reciprocated'* by Ms O'Brien.[48] Mr Sturt detailed he wanted to kill Ms O'Brien then himself but would prefer they enter into a suicide pact.[49] Further detail indicates Ms O'Brien reported that Mr Sturt had told her he wanted to kill her and then suicide via an Endone overdose (which he no longer had access to as Ms O'Brien had confiscated).[50]

40. In September 2018, it was noted by clinicians that Mr Sturt tells staff what he thinks they want to hear so he is discharged.[51]

41. In October 2018, records indicate Mr Sturt admitted perpetrating violence but not for 3-4 years,[52] then minimizing the incident of strangulation by suggesting he did it gently.[53] Mr Sturt later denied any intention to act on his the '*suicide pact'* outlined above,[54] then denied having these thoughts at all.[55] Records from Alfred Health also note Mr Sturt demonstrates a prominent external locus of control with Mr Sturt's aggression "*triggered*" by his girlfriend or friends online.[56] It was further noted by the Emergency Psychiatry Service that Mr Sturt showed a lack of remorse or acceptance of responsibility for his repeated violence, providing an '*unconvincing'* account of paranoia and fear, manifesting only in aggression towards his partner.[57]

[44] Alfred Health Medical Records (Sturt) 81.
[45] Alfred Health Medical Records (Sturt) 76.
[46] Alfred Health Medical Records (Sturt) 174.
[47] Alfred Health Medical Records (Sturt) 80.
[48] Alfred Health Medical Records (Sturt) 370.
[49] Alfred Health Medical Records (Sturt) 80.
[50] Alfred Health Medical Records (Sturt) 79.
[51] Alfred Health Medical Records (Sturt) 91, 170, 176.
[52] Alfred Health Medical Records (Sturt) 43.
[53] Alfred Health Medical Records (Sturt) 44.
[54] Ibid.
[55] Ibid.
[56] Alfred Health Medical Records (Sturt) 80.
[57] Alfred Health Medical Records (Sturt) 81.

42. Records between November 2018 and March 2019 evidence a documented history of physical/sexual/emotional abuse against Ms O'Brien.[58] They also note increased risk to himself and others when Mr Sturt uses substances.[59]

43. In a psychological report the same month, it was noted that that Mr Sturt may benefit from Men's Behaviour Change through Star Health or Relationships Australia and forensic assessment to manage risk to partner and others.[60] In November 2018 Mr Sturt indicated a willingness to engage with other men around his violence[61] (however Mr Sturt never contacted Men's Referral Service despite being provided with their details).[62]

44. On 23 June 2019 emergency services were contacted,[63] and on attendance, Mr Sturt accused both the Victoria Police members and Ms O'Brien of being rapists,[64] before agreeing to be conveyed to the Alfred Hospital by ambulance.[65]

45. The time between Mr Sturt being transported to hospital and receiving a psychiatry assessment was approximately 3.5 hours. The Emergency Psychiatry Assessment of Mr Sturt at that time was that he presented as calm, warm, co-operative, articulate, with good insight.[66] While it was noted that he had been diagnosed with Borderline Personality Disorder, Narcissistic Personality Disorder and had a history of family violence,[67] family violence risk assessment appears to be limited to asking about homicidal ideation, and the fact that Ms O'Brien had not disclosed recent threats of harm. It is unclear how Ms O'Brien was contacted to inform this assessment. There is evidence that Ms O'Brien posted on social media during this time that she was scared for her life, and that he had asked '*how she could do this'* and '*he was going to get her back'*.[68] The themes and pattern of violence noted in the sections above from prior Alfred Health records do not appear to have been reflected in the assessment.

---

[58] Alfred Health Medical Records (Sturt) 75.

[59] Alfred Health Medical Records (Sturt) 74, 304.

[60] Alfred Health Medical Records (Sturt) 109.

[61] Alfred Health Medical Records (Sturt) 118.

[62] Alfred Health Medical Records (Sturt) 118.

[63] Coronial brief, Statement of T O'Brien, 105.

[64] *R v Sturt [2020] VSC 317*, 1; Coronial brief, Statement of P Devienne, 156.

[65] Coronial brief Statement of E Avery, 149; Statement of D Berhang, 151; Statement of P Booth, 153-154; Statement of P Devienne, 155-157.

[66] Alfred Health Medical Records (Sturt) 69.

[67] Alfred Health Medical Records (Sturt) 170-171.

[68] Coronial Brief, Statement of E Furness 124, 126

46. On 24 June 2019, records indicate a call to Ms O'Brien from Alfred Health where Ms O'Brien advised she was already aware Mr Sturt had been discharged as he had texted her to advise of his discharge and that she would '*pay'* for contacting police.[69] Advice provided to Ms O'Brien was contact emergency services if needed.[70] The fatal incident occurred on 25 June 2019.

Adequacy of mental health treatment provided

47. I recognise that the public health system was under resourced at the of the fatal incident to manage family violence in the context of mental health and family violence risk (MARAM) obligations. I also recognise that potentially compounding the situation was that Mr Sturt appears to have woven a strong narrative that deflected blame onto Ms O'Brien in his final hospital assessment,[71] which is consistent with his history of minimising his violence.

48. The evidence suggests that the health treatment for Ms O'Brien was limited in its capacity to assist beyond providing contact details for specialist family violence services, however practitioners skilled in family violence may have taken the opportunity to develop a safety plan, further explore the level of risk with her, and her disinclination to engage with family violence services.

49. The available evidence also suggests that practitioners trained in family violence, with streamlined access in a high-pressure environment with key risks or red flags associated with Mr Sturt, may have been better equipped to identify problematic narratives and address the risk posed to Ms O'Brien prior to Mr Sturt's discharge on 24 June 2019.

50. This may have included completing a family violence risk assessment and working with Ms O'Brien on a safety plan, given the extensive history and themes outlined above. Whilst this may or may not have impacted the ultimate outcome, Ms O'Brien may have been encouraged to seek assistance or been provided additional supports in the lead up to the fatal incident.

51. Since the fatal incident, Alfred Health has implemented significant reforms and education to clinicians. Alfred Health was prescribed in Phase 2 of the Victorian Family Violence Multi-Agency Risk Assessment and Management (**MARAM**) roll out on 19 April 2021. As part of

[69] Alfred Health Medical Records (Sturt) 279.

[70] Ibid.

[71] Examples of victim blaming include they were drinking and *she* was smoking THC, they were eating dessert that *he* made, the relationship was strained and *she was* unfaithful so they explored polyamory, there had been no recent significant conflict but *she* has family stress, that he is shocked by *her* concerns for his mental health, and he would like to gain full time work to move on but *he likes* being a house husband.

the rollout, Alfred Health established a Family Violence Program. The Family Violence Program leads the whole of Alfred Health service's approach and response to preventing, recognising and responding to family violence experienced by patients, families and staff.

52. Since the implementation of the Family Violence Program, the following initiatives have been developed:

    a) An updated Family Violence Policy and several associated guidelines which are aligned with the MARAM Framework.

    b) Formal processes established to facilitate information sharing with other Information Sharing Entities including development of the Alfred Health Child and Family Violence Sharing Scheme Guideline.

    c) Family violence training across all staff in the organisation and mandatory *Manager's Training in Workplace Support (Staff Family Violence)* for all Alfred Health managers. This contains content on how managers can best support staff who are experiencing family violence.

    d) Mandatory training for all clinicians who are required to undertake family violence risk assessments including but not limited to Social Workers, Case Managers, Mental Health Clinicians, Community Health Nurses and Psychologists.

Victoria Police service contact with Mr Sturt and Ms O'Brien

53. Mr Sturt was subject to multiple transfers by police under s351 of the Mental Health Act 2014 (Vic)[72] which are summarised below.

54. In September 2018, Victoria Police records indicate Mr Sturt's statements of intentional self-harm and homicidal ideation.[73] There is no indication of further proactive enquiries given the family violence history, and transportation from the same address as previous family violence incidents.

55. In October 2018, medical records indicate Mr Sturt told paramedics and police he wanted to kill Ms O'Brien and himself,[74] while being transported after waking Ms O'Brien by strangling

[72] The *Mental Health Act 2014 (Vic)* has since been replaced with the new *Mental Health and Wellbeing Act 2022 (Vic)*. This new act took effect from 1 September 2023.
[73] Coronial brief additional materials, LEAP Records, 7.
[74] Alfred Health Medical Records (Sturt) 80.

her and biting her face.[75] Medical records indicate that police advised they would not be charging Mr Sturt due to Ms O'Brien's wishes.[76] No family violence report was made in relation to this incident, and while police initially waited at the hospital to encourage Ms O'Brien to make a statement,[77] they ultimately left a card at the hospital for Ms O'Brien to contact them.[78] There is no evidence of an application for a Family Violence Safety Notice (**FVSN**) or any other action.

56. The final mental health transfer in June 2019 provides no indication that any explicit disclosures of family violence were made to Victoria Police or paramedics when they attended Ms O'Brien's residence to transport Mr Sturt to the Alfred Hospital for a mental health assessment. There is also no indication they made active enquiries given the family violence history.

57. Whilst there were no specific family violence incidents recorded in police records for Ms O'Brien and Mr Sturt in the 12 months leading up to the fatal incident, there were possible opportunities in relation to attendances by police members for mental health concerns relating to Mr Sturt noted above.

58. The available evidence suggests that police members attending the incidents in September 2018, October 2018 and June 2019, could have explored and identified risk of family violence, given the nature of the transfers, nature of the risks reported at the time of attendance and history of family violence available to Victoria Police between the parties at the same home address. None of these incidents recorded any family violence concerns and were recorded as mental health incidents.

59. Victoria Police have a responsibility to respond and act on all reports of family violence regardless of the context of disclosure.[79] Given the history of family violence, the nature of Mr Sturt's verbal and physical acts observed by, or reported to police around the mental health transfers, it may have been appropriate to make further enquiries as to the risk to Ms O'Brien in relation to family violence from Mr Sturt.

60. The current *Victoria Police Manual – Family Violence* (11 April 2022) policy notes that when a patient is currently being transported for a mental health assessment and the patient has a

[75] Alfred Health Medical Records (Sturt) 79.
[76] Ibid.
[77] Ibid.
[78] Alfred Health Medical Records (Sturt) 82, 182.
[79] Victoria Police Code of Practice for the Investigation of Family Violence, 3rd edition Version 3, section 2.3.

known history of family violence and/or circumstances that indicate risk to a family member, police members must comply with the following:

a. The presence of family violence should be considered at all incidents attended by police, even where family violence was not the initiating report (and should be considered specifically in mental health incidents and during welfare checks);[80]

b. Before attending the scene, members must conduct LEAP checks on the premises and persons involved to determine if there is a history of family violence including any intervention orders in place, check warning flags and any presence or access to firearms or weapons;

c. Make appropriate referrals for all parties involved in a family violence incident through the Family Violence Portal in line with the Mental Health Protocol;[81] and

d. Consider and take criminal and/or civil enforcement action as the circumstances require based on the affected family member's circumstances and needs, risk assessment and investigation to break the cycle of violence.

61. The current *Victoria Police Mental Health Protocol* stipulates that:

a) When arranging a mental health examination, police are prompted to provide relevant information to the examining practitioner regardless of whether the examination is in the community or at a hospital, including information about safety and risks (like threats, family violence and firearms), intervention orders, family court proceedings and family circumstances.[82]

b) if an apprehended person threatens to hurt anyone, police and/or mental health clinicians are required to conduct a risk assessment. The Protocol directs police and mental health clinicians to be aware of increased risk where family violence is evident or intervention orders exist, and to consider whether, the conditions of any existing intervention order should be reviewed. If no intervention order exists, members are directed to consider whether an order should be obtained. Further, guidance is provided to members to submit

[80] Victoria Police Manual – Family Violence (11 April 2022).
[81] The Mental Health Protocol is a practical guide to assist police and clinicians when responding to mental health crises.
[82] Section 2.1.7 of the Victoria Police Mental Health Protocol.

a written request to the hospital emergency department mental health service provider if advance notice is required of a patient's discharge from hospital due to safety concerns.[83]

c) The Protocol also requires police after apprehension to provide information relating to safety and risks (including family violence) during handover to clinical staff.[84]

d) The Protocol provides guidance for police regarding information sharing to reduce and prevent a serious and immediate threat, including the disclosure of information about threats, family violence and the existence of intervention orders, firearms, current family law proceedings or a history of violence.[85]

62. The new *Mental Health and Wellbeing Act 2022* (Vic) (**MHW Act**) took effect on 1 September 2023 and in preparation for the commencement of the new MHW Act, Victoria Police have reviewed and updated its policies and procedures in relation to its responses to mental health incidents. The Mental Health Protocol will also be updated in 2023 in response to the commencement of the MHW Act.

63. On 1 September 2023, the existing '*VPMG Apprehending persons under the Mental Health Act'* will be replaced by the *VPM Care and Control* under the MHW Act (**VPM Care and Control**). The *VPM Care and Control* will:

a) include information relating to family violence and circumstances that indicate risk to a family members;

b) provide information for police members and protective services officers (**PSOs**) on responding to threats made by people taken into care and control, including the need to be aware of the increased risk where family violence is evident, or intervention orders exist;

c) direct police members to review the conditions of any existing intervention order if a threat has been made by a person taken into care and control. If no intervention order exists, members are directed to consider obtaining an order; and

d) refer police members to the *VPM Family Violence* as a related document, for further information and direction on responding to family violence.

[83] Ibid, section 2.1.8
[84] Ibid, Section 3.4.4
[85] Ibid, Section 5.4

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Caitlin O'Brien, born 31 March 1988;

    b) the death occurred on 25 June 2019 at 8/487 Kooyong Road, Gardenvale, Victoria, 3185, from compression of the neck; and

    c) the death occurred in the circumstances described above.

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

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

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

Mr and Mrs O'Brien, Senior Next of Kin

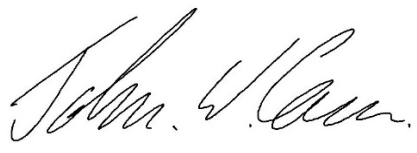
Rachel Quinn, Senior Solicitor, Victorian Government Solicitor's Office

Devereaux De Silva, Manager of Patient and Family Services, Alfred Health

Detective Sergeant Caitlin Jones, Coroner's Investigator

Dr Neil Coventry, Chief Psychiatrist, Office of the Chief Psychiatrist

Signature:



Judge John Cain
STATE CORONER
Date: 20 November 2023

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.