IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 297/09

# FINDING INTO DEATH WITH INQUEST

*Form 37 Rule 60(1)*
*Section 67 of the* ***Coroners Act 2008***

## Inquest into the Death of ALEKSANDRA BIRUTE VOLKAS

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| Delivered On: | 4 April, 2012 |
| Delivered At: | Coroners Court of Victoria<br>Level 11, 222 Exhibition Street<br>Melbourne 3000 |
| Hearing Dates: | 11 January, 2011<br>28 to 30 September, 2011 |
| Findings of: | PETER WHITE, Coroner |
| Representation: | Counsel for the members, Mrs E Gardner of Counsel on the instructions of Russell Kennedy<br><br>Counsel for the Commissioner of Police, Mr R Gipp on the instructions of the VGSO. |

Police Coronial Support Unit:
Counsel Assisting the Coroner, Leading Senior Constable T Christiano, and Ms Debra Siemensma of Counsel on the instructions of Meridian Lawyers, from the 28th of September 2011.

I, PETER WHITE, Coroner having investigated the death of ALEKSANDRA VOLKAS

AND having held an inquest in relation to this death on 11 January, 2011 and 28 to 30 September, 2011 at Melbourne

find that the identity of the deceased was ALEKSANDRA BIRUTE VOLKAS

born on 5 May, 1923

and the death occurred on 19 January 2009

at Bogong Avenue, Glen Waverley, Victoria 3150

from:

1a. CORONARY ARTERY DISEASE AND HEAT EXPOSURE[1]

**in the following circumstances:**

**Background**

1. Aleksandra Volkas was an 85 year old woman who was admitted to respite care at Grace Manor, Glen Waverley, on the 6th of January 2009.[2]

2. Prior to that time she lived alone at an address in Brazilia Avenue, Glen Waverley, but was finding it increasingly difficult to cope following her return home after bowel surgery.[3] On the 5th of December 2008, Mrs Volkas experienced chest pain and was hospitalised for five days. Following her release she used a four-wheel walking frame, intermittently at home.

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1 Dr Michael Burke, a Senior Forensic Pathologist gave evidence that his post mortem examination conducted on the 23rd of January 2009, revealed significant coronary artery atherosclerosis. In his report he stated that this is a common cause of sudden death. He further stated that,
*"In the absence of an immediate post mortem temperature recording one is unable to determine with certainty the extent to which hyperthermia contributed to death. It would appear reasonable to suggest that such environmental temperature may aggravate. underlying heart condition and thus contribute to the cardiac event which led to death."*
In testimony he further testified that in high temperatures there would be a greater stress on her heart.
*"people who have underlying heart disease have decreased physiological reserve. If one is fit and well you can tolerate a greater insult, if you like. If you have underlying disease processes, one of them being heart disease, you may not be able to tolerate an insult at significant temperature as would a younger and fitter person."*
See Exhibit 9 at page 8 and transcript at page 347.
Mrs Volkas GP, Dr Tang later agreed with Dr Burke's opinion concerning the contribution of coronary disease although he was not able to say whether heat exposure had been a trigger.
Dr Burke was unable to establish the time of death. It follows that I am unable to determine whether any acts or omissions by employees of Grace Manor or Victoria Police, caused or contributed to Mrs Volkas' death.

2 Grace Manor was a Supported Residential Service, which was registered and regulated by the State of Victoria, under the *Health Services Act 1988*. It was in 2009, a low care mixed gender Supported Residential Service, situated at 2B Grace Street, Glen Waverley.
At the time under investigation the Health Services Act was administered by the Department of Human Services. These responsibilities passed to the newly formed Department of Health on the 12th of August 2009.
Grace Manor was deemed a low care facility. At the time under consideration, it housed up to 40 residents. At any time it was manned by two to three personal care attendants who had access to a registered nurse manager, should the need arise. The facility (formerly operated by Premier Assisted Living Pty Ltd), went into liquidation during 2010. See the evidence of premises manager, Susan Griffin, from transcript page 68.

3 Mrs Volkas had a number of diagnosed illnesses which included diverticular disease, hypertension, chronic renal failure and hyponatrenia. See Exhibit 10(a), the Eastern Hospital Discharge Form and Notes of Dr Tang. She also suffered from rectal cancer and wore a colostomy bag. See the statement of Ms Griffin at Exhibit 6 page 2.

3. It is also relevant that she wore spectacles and was hard of hearing.

4. It was in these circumstances that arrangements were made by her son, Raymond Volkas, for her admission to Grace Manor.

5. An admission process was undertaken by the premise's manager, Susan Griffin,[4] and Mrs Volkas' GP, Dr John Tang. Ms Griffin testified that prior to admission a residents' GP would attend on her and discuss the patients presentation and prepare a drug chart. At the relevant time both were of the view that she was a suitable candidate for low level care. It was not customary and Grace Manor did not receive any medical records relating to Mrs Volkas' medical history.

6. I note here that Mr Volkas informed Mrs Griffin prior to her admission (and at the time of her admission) that his mother was frail and prone to falling over.[5]

7. Ms Griffin prepared, or began to prepare, a care plan in respect of Mrs Volkas.[6] According to Ms Griffin the plan was an interim plan only and was not completed on her admission of Mrs Volkas, because it was usual to prepare same over a 30 day period.

8. It is relevant that the plan recorded that she wore glasses and was hard of hearing. I also note that the plan recorded answers of both 'Yes' and 'No', to observations concerning her orientation to time and place, and her ability to recall, (short term memory). The interim plan also recorded 'no' to the matter of whether she had balance when walking.

9. It is also relevant that Ms Griffin neglected to complete the falls risk assessment. She was unable to say whether this occurred because the risk wouldn't be assessed unless Mrs Volkas had a total of three falls, or because she thought Mrs Volkas had her own physiotherapist coming in to see her.

10. Ms Griffin was also unable to offer a cogent reason as to why such matters were permitted to influence the decision of whether a falls risk analysis should be undertaken, in any particular case.[7]

11. In her further evidence as to her admission practice, Ms Griffin confirmed that Mrs Volkas' admission papers suggested that she was not a 'wanderer' and that she could not be admitted if she was a wanderer because Grace Manor was a low care facility which, 'did not take wanderers'.

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4 Ms Griffin was not a registered nurse but testified that she had experience in aged care before coming to Grace Manor. She had also worked as a carer at Grace Manor for 18 months prior to becoming the manager in (approximately) 2009. She further testified that she was not required to undertake any specialist training in relation to assessing residents for low care facilities, or any training or to otherwise obtain Govt approval before she took up the position as manager. See transcript at pages 144 to 145.

5 See transcript at page 91.

6 See exhibit 4.

7 See transcript page 103-104.

12. At the time of her admission, it was agreed by Ms Griffin and Raymond Volkas that Mrs Volkas would stay for a period of one month, during which her suitability for a more lengthy stay would be assessed.[8]

13. These arrangements were not well received by Mrs Volkas and, over the duration of her residence, she didn't settle as her son had hoped.

14. It is relevant to note that during this period she constantly kept her bag packed and sat by the window overlooking the drive and that she often explained that she was waiting for her son to come and pick her up.[9]

15. Staff at the home evidently met this behaviour by seeking to distract Mrs Volkas from her stated intent (to leave). Ms Griffin further testified that she hoped that in time Mrs Volkas would modify her behaviour.

16. It is also relevant that staff made written notes in respect of residents and that Ms Griffin referred to a communication book containing notes about residents, although this book was not produced.

17. There was however a Premier Assisted Living Issues Input Sheet in respect of each resident that could be referred to during the shift handover. Mrs Volkas' Input Sheet records several incidents commencing from the 7th of January 2009 in which Mrs Volkas was confused and packing as if to go home. On the 13th of January, the notes also record that Mrs Volkas offered a staff member some money to ring police. It is noted that on the 15th of January Mrs Volkas was up for most of the night packing and going through her belongings and was confused, and on the 16th of January (the notes record) a confrontation between Mrs Volkas and another resident.[10]

18. Ms Griffin was aware of this behaviour.

19. It is also the case that following her admission Mr Volkas had regular discussions with Ms Griffin about his concerns in regard to her deteriorating condition.

20. According to Mr Volkas he was informed by Ms Griffin that confusion was a common reaction to an elderly person being placed in a new environment and that it should settle down within 2 weeks to a month. He was uncertain whether his mother's confusion was temporary or permanent and after discussions with Ms Griffin he came to assume that hers was just a common reaction to adjusting to a new environment.[11]

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8 See residential agreement at Exhibit 6D.

9 On one such occasion it is known that she called a taxi and on another, that she offered staff money to call police and, 'tell them where she was.' See evidence of Ms Griffin at transcript page 106.

10 See Exhibit 4a.

11 See transcript at pages 13 and 15.

21. I note here that notwithstanding the evidence of her ongoing confusion and Mr Volkas' increasing concern, there were no additional strategies employed by Ms Griffin[12] or others, to discourage or otherwise prevent her departure.

> *"Well its pretty normal behaviour for someone coming into the facility that doesn't want to, yeah".*[13]

22. Specifically neither Ms Griffin nor Ms Jeffrey, a PCA involved with the care Mrs Volkas, called a team meeting to discuss the issue and no changes were made to her (largely incomplete) interim care plan. Further, there was no attempt either directly or through her son to seek the assistance of an aged person mental health professional, as referred to in the Interim Care Plan and no attempt was made to confer with her GP or any other medical professional.

23. I further note that this inaction occurred despite Ms Griffin's assurance that if it was felt the residence could no longer meet needs, that an ACAS assessment would be made in consultation with the residents' family.[14]

24. Grace Manor had a key pad entry/exit system but only for after hour's security purposes. It is also the case that the premises was an open facility during daylight hours and that it was normal practice for residents (including Mrs Volkas) to be permitted to come and go as they pleased. There were no particular directions given to staff or residents concerning coming and going and the evidence further establishes that it would have been relatively easy for Mrs Volkas to leave the premises without staff becoming aware of that matter.[15]

**The 19th of January 2009**

Mrs Volkas' departure from Grace Manor

25. Monday the 19th of January was an extremely hot day in Melbourne.

26. As before, during the course of the morning Mrs Volkas told staff that she wished to return home. Again, no-one specifically responded to this request.

27. It is now known that during the course of the early afternoon Mrs Volkas acted on her earlier stated wish and left the premises. The weather conditions during the afternoon are known to have reached a maximum temperature of 36.4.[16]

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12 Although Ms Griffin was becoming concerned that Mrs Volkas may be suffering from dementia,
13 See transcript at page 106.
14 See Exhibit 6Aat page 5.
15 Ms Griffin testified that the facility was not suitable for persons who 'wandered'.
16 The period between the 12th and the 26th of January 2009, was a time of very difficult weather conditions in Victoria, which culminated in the Black Saturday bushfire disaster.

28. There has been no direct evidence which establishes precisely when Mrs Volkas left the premises. According to staff she was believed to have attended lunch, as her absence between 12.30pm and 1.30pm was not noted and would have been had she been absent during this time.[17]

29. It is also the case that her absence was not revealed until 3.00pm when a friend came to visit her and she could not be found. At this time, Ms Griffin was immediately informed.

30. I note here that it is unclear whether, at the time of her departure, Mrs Volkas was inadvertently assisted to leave, or opened the door herself, or whether instead the front door itself was left propped open to better allow for the entry of a cool breeze.

31. It is also the case that no particular limits were placed upon the movement of residents in and out of the home, on the 19th, this notwithstanding earlier published warnings from the then Premier Mr John Brumby and the Dept of Human Services Aged Care Division, for responsible persons to take measures to protect the elderly in what had become extremely difficult weather conditions.[18]

The response by Grace Manor

32. As at the 19th of January, Ms Griffin had some knowledge of Mrs Volkas' medical history. She was also aware of the impact extreme heat could have on the residents of Grace Manor generally, as set out in the Department's advice on this matter.

33. On learning from staff of Mrs Volkas' disappearance, Ms Griffin consulted with a retired police officer, Mr George Cooney, who happened to be visiting a family member at the facility.[19]

34. Acting on his advice, she then launched a search of the facility, without result. Thereafter, she drove around the surrounding area for approximately 20 minutes searching nearby railway stations, taxi ranks and shopping centres for Mrs Volkas, again without result.

35. While this was taking place, Mr Cooney conducted a search of the immediately adjacent Bogong Park, which he detailed in his statement.[20]

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17 See transcript 134 to 135. See also discussion page 9 below and at Exhibit 6, page 1

18 There was widespread publicity given to the need to take special care of the elderly during this heatwave period.

19 Ms Griffin believed that Mrs Volkas may have been last seen (at the residence) at 2.15 pm. She agreed in testimony that she may have been seen at the residence after this time. See transcript at pages 134-5.

20 See Exhibit 2 at page 1. *"I had a walk around the garden area of the facility before (I) entered the Bogong Reserve from Grace Avenue and walked along the path looking into the light scrub areas and open grass lands including the easement that runs back to Carramar Street. From the path I had a clear view up the grassed slope to the play ground area where two school boys were sitting talking.*
*I left the path and walked around the small lake, looking into the reeds, bushes and the water. I came back on the path and walked along in front of the houses in Riley Court.*
*From there I walked back into the path and looked around the area consisting of light scrub and grass as I walked toward the Scout and Guide Halls on the east side of the park looking towards Bogong Avenue.*
*I walked around both halls looking for the elderly female. Bythis time the two school boys I had seen at the play ground had left the area.*
*I then walked through the park toward the North Boundary and onto Bogong Avenue. I then turned left into Florence Avenue and along Montclaire Avenue where I turned left and walked to Carramar Street, turned right and walked to Carramar Street, turned right and walked along to Grace Avenue and back towards the facility."*

36. Later, at approximately 4.45 pm following his earlier search through Bogong Reserve and surrounding streets, Mr Cooney drove around the area and checked public car parks near the Glen Waverley Railway Station and the shopping centre in Montclair Avenue continuing to keep a lookout for Mrs Volkas.[21] Ms Griffin herself also undertook a drive around the area, seeking to locate Mrs Volkas.

Police management of the search for Mrs Volkas

37. At approximately 3.30pm Ms Griffin had contacted the Glen Waverley station and advised of Mrs Volkas disappearance.[22] The patrol Sergeant supervising the area was Sergeant Gary Hughes who had been transferred into the area only a few days before the 19th of January. Previously he had served most of his 35 year Victoria police career in country Victoria, with 21 years as a Sergeant. He confirmed in evidence that he had completed the Sergeant's course, which included training about the management of subordinates.

38. There were two divisional vans in the area on the 19th of January, one of which, 4GW303, was dispatched as a result of a radio communication from the police radio channel. At 3.35 pm Senior Constable Annesley and his patrol partner, Constable Pepperall (manning 4GW303), attended Grace Manor and spoke with Ms Griffin.

39. S/C Annesley was informed that, Mrs Volkas was a resident who had previously indicated a wish to leave the facility and return home, that staff had searched the facility without result and that retired officer Mr Cooney had conducted a search of the garden area and Bogong Reserve without result.[23] It seems likely that her frail mental state was also discussed,[24] and that Ms Griffin expressed concern at the time about her physical frailty and the heat.[25]

40. The attending police then left to commence their own search.

41. Ms Griffin did not have a photograph to assist police with that inquiry but at 3.45 pm D24 advised Glen Waverley 303 of a description of Mrs Volkas.

> *"Dark slacks, red jacket, very small frame, very frail, dementia and other health problems, took her handbag, walking frame left behind, not sure how far she would be moving."* [26]

42. After speaking with Ms Griffin the officers drove to the Glen Waverley RSL, located a few blocks away.

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21 Ibid Page 2.
22 See Exhibit 7(f), the police record of relevant radio communications.
23 It seems unlikely that Const Annesley spoke directly to Mr Cooney. See transcript page 31.
24 See Sergeant Hughes note of this matter in Exhibit7a.
25 See transcript at page 141
26 See exhibit 7f.

43. They checked the RSL and the Glen Waverley railway station which was located opposite to the RSL. Thereafter, they walked along a strip of shops near to the station and spoke with security officers at The Glen Shopping Centre.

44. Immediately afterwards they went to check to see if she was at her home in Brazilia Drive, Glen Waverley, this without success.

45. Finally, they drove along the major arterials in the immediate area over a period of approximately 15 minutes, before they returned to Glen Waverley police station arriving there at 5.15pm.

46. Ms Griffin did not believe that they contacted her again that afternoon either to obtain further details or to ask any questions.[27]

47. In his supplementary statement, dated the 7th of September 2011 Senior Constable Annesley stated that he returned to the station at that time (5.15pm)[28] because he decided that reports needed to be compiled.[29] At the station they completed their reports and broadcast a

'keep a look out for',

in accord with Sergeant Hughes' earlier instructions. They then rang details of their inquiry through to D24 and details were logged onto LEAP.

48. The Missing Persons Report required the attending members to report the incident to a supervisor who was required to sign the risk assessment portion of the document.

49. In this instance and without authority, Senior Constable Annesley signed the report as supervisor by using Sergeant Hughes' number 20575 - his explanation for so doing being that his section sergeant from Glen Waverley (Sergeant Hughes) was not in the station.

50. The above search process, including the member's attendance at the station to compile reports and broadcast the 'keep a look out for', took place between 3.35 and 5.43pm.[30] They then cleared the work at 5.43 pm after compiling the reports.

51. I note here that Senior Constables Annesley and Pepperall did not notify Sergeant Hughes of their decision to cease at 5.43pm.

52. It is also relevant that at the time Senior Constable Annesley knew that Mrs Volkas had not been found and from the earlier D24 communication, that she had some health problems and issues with her mobility. Both members were also aware of the extreme temperature and, I find, must have had some

27 Ibid.
28 See exhibit 7e.
29 Ibid.
30 See exhibit 7e.

understanding of the threat these conditions posed to Mrs Volkas, should it be the case that she was still alive and remained outdoors.

Further actions taken by Senior Constable Annesley to assist Mrs Volkas

53. Senior Constable Annesley gave equivocal and at times contradictory evidence about whether he had sought other assistance in his search for Mrs Volkas.[31] From that evidence, I find that I do not know whether he did or did not seek outside assistance to assist with the search for Mrs Volkas. The fact that there were no file notes suggesting that such an approach was made tends to indicate that he did not.

The time of Mrs Volkas departure

54. According to S/Constable Annesley, he was advised by Ms Griffin at their initial meeting that Mrs Volkas had been missing for two hours. I note here that there was in fact no evidence as to when Mrs Volkas had actually left the premises.[32] This follows from the fact that neither Senior Constables Annesley or Pepperall undertook investigations designed to establish whether anyone else had seen her in the premises after 2.15pm.

55. The result is that at this point the evidence only establishes that she left the facility at some time between when she was last seen after lunch and when she was first discovered to be missing, i.e. between 2.15pm and 3.00pm.

56. At around 4.30 pm the Divisional Patrol Supervisor was requested to telephone Senior Constables Annesley and Pepperall regarding the missing persons report concerning Mrs Volkas.[33]

57. Sergeant Hughes testified and it was not in dispute that during his telephone conversation with Senior Constable Annesley, he had been told that Mrs Volkas had been missing since 2 pm. (Thereafter no one undertook further investigations as to whether other staff had seen her in the residence after 2pm).

58. The conversation between Senior Constable Annesley and Sergeant Hughes took place at 45 seconds past 5.00pm. The duration of that call was 110 seconds and there was no evidence of further conversations between them before Senior Constable Annesley cleared the case at 5.43 pm.

59. I find that Sergeant Hughes was informed about a departure at 2.00pm, but note here that the information so given was incorrect.

60. From this evidence it is apparent that the principal investigator, Senior Constable Annesley failed to recognize the importance of checking out this matter.

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31 See transcript of my attempts to question the witness on this issue at pages 27-32.

32 Ms Griffin had been told that she had last been seen at 2.15pm, but I note that that information did not establish how long after that time it was when she left the premises.

33 Sergeant Hughes was performing the duties of Division Patrol Supervisor, with the call sign 251.

**Supervision of the search for Mrs Volkas, by Sergeant Hughes**

61. In his supplementary statement,[34] Senior Constable Annesley said that during this (one) telephone conversation with Sergeant Hughes he told him about the 'details of the incident'.

62. Sergeant Hughes made brief notes of his call to Senior Const Annesley, which he amplified in his evidence.[35]

63. His testimony was that he told (Glen Waverley 303) to conduct a search of the area and arrange for the broadcast of a 'keep a look out for', KALOF, so that information could be broadcast over the whole metropolitan area.[36]

64. Consistent with this instruction,[37] the KALOF was broadcast by D24 to all police radio channels.

65. Sergeant Hughes could not recall whether he was informed that Mrs Volkas 'had dementia', but may have been, given that this was recorded in his notes.[38]

66. I observe however that whatever was discussed over the phone could only have been at a very superficial level, as it appears from his own testimony that Sergeant Hughes was not at the time of the call, made aware that Senior Constables Annesley and Pepperall had already commenced their search, and for all intents had actually completed same.

67. Senior Constable Annessley and Constable Pepperall returned to the station at 5.15pm. They cleared the matter at 5.43pm.

68. At 5.50 pm, D24 notified Sergeant Hughes of a factory fire in Mount Waverley. Sergeant Hughes arrived at the scene at 6.10pm and liased with attending police officers and the local fire warden. He later cleared the scene and then attended the Mount Waverley police station to compile reports in relation to the fire. He further testified that there were 100 factory workers who could have been trapped or killed in the fire.[39]

69. At 7.51pm Sergeant Hughes was notified by D24 that a female body had been located in Bogong Reserve and that it was believed to be Mrs Volkas.[40]

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34 See Supplementary Statement 7 September 2011 which is attached to the Exhibits List at MFI 2
35 See transcript at page 199.
36 See transcript at page 203.
37 See Exhibit 7f.
38 See Exhibit 7a.
39 See transcript at page 188 and 233.
40 See Exhibit 7(b)

The discovery of the body of Mrs Volkas

70. Between 7.10 and 7.30pm on the 19th of January, Mrs Volkas' body was discovered by a pedestrian, Mr Brian Scammell, walking his dog.[41] The body was found a few metres off the track in a secluded area located between trees.[42]

Cause of Death

71. An autopsy undertaken by Senior Pathologist, Dr Michael Burke, found that Mrs Volkas had suffered from a significant underlying natural disease in the form of coronary artery atherosclerosis and lipoid pneumonia.[43] His further opinion was that the extreme environmental temperature she encountered after leaving Grace Manor aggravated her underlying condition and contributed to the cardiac event which caused her death. [44]

The evidence of Inspector Guilmartin [45]

72. At the time of the incident under investigation and until the present, he is Officer-in-Charge of the Victorian Water Police and the Search and Rescue Squads.

73. The evidence of Inspector Guilmartin may be summarized as follows.

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41 Mr Scammell stated that it was his dog which drew his attention to the presence of Mrs Volkas' body.

42 Dr John Tang noted in his statement that upon his attention being drawn to Mrs Volkas' remains, he thought it was 'a little girl, lying on the ground playing dead.'

43 Dr John Tang testified that he had not previously been aware of her underlying heart condition.

44 See Autopsy Report at Exhibit 9 and discussion at footnote 1 above.

45 Procedural Fairness

On the afternoon of the first day of hearing (11/1/11), the inquest was adjourned on the application of the Coroners Assistant, to allow for the appointment of a privately instructed Counsel Assisting.

I also later caused a letter to be sent to Sergeant Hughes dated 10/6/11, notifying of my intention to further investigate certain aspects of the police search for Mrs Volkas including the failure to search Bogong Park, a copy of which I have now attached to the Exhibits list-see MFI 1.

Thereafter, I was advised that the police officers concerned in the search together with the Chief Commissioner of Police, would seek leave to (separately) appear, following my resumption of the inquest.

Appropriate arrangements were then made to allow for the inquest to reconvene and I was further informed that the Chief Commissioner would be seeking leave to call expert evidence from the head of Vic Police Search and Rescue, Inspector Guilmartin. His statement dated 23rd of September, 2011, Exhibit 8, was also circulated.

On resumption (28/9/11), I was assisted by Ms Simensma of Counsel, with Ms Gardiner of Counsel representing Sergeant Hughes and Senior Constable Annesley, and Mr Gipps of Counsel representing the Chief Commissioner for Police.

I further note here that it has been suggested in the submission of Senior Constable Annesley, that he has been denied procedural fairness because, as I understand Counsel's submission, Senior Constable Annesley has not been given an opportunity to answer the criticisms made by Inspector Guilmartin (joined by the Commissioner), concerning the Senior Constables failure to conduct a search for Mrs Volkas in a manner which included his undertaking a walk through and search of the adjacent Bogong Park.

In this regard it is relevant that on the morning of the resumption of the inquest (28/9/11), I informed all interested parties, in the presence of Counsel and Senior Constable Annesley, of their rights to seek leave to call additional evidence. (See transcript page 66/67). It is also relevant that this matter was raised directly with Counsel for the Senior Constable when Counsel unsuccessfully sought to submit a third statement from her client (transcript page 172), and earlier when the ordering of witnesses was discussed at transcript page 66. It was again raised (by inference) with Counsel at transcript page 411, when it was pointed out that Counsel had not challenged the criticisms made of her client during her cross-examination of Inspector Guilmartin, and that he could be recalled for that purpose, if such an application was made.

Having reviewed all of the evidence I am satisfied that procedural fairness has been accorded to all interested persons during this investigation.

74. His opinion was that a responsible supervisor was required to supervise by maintaining communications and by sufficiently informing himself as to what had occurred and as to any lack of progress being made.[46]

75. His further view was that the responsible person was required to undertake an ongoing risk assessment as required by Victoria Police Manual 108.12 at 4.1.2[47] and to give adequate consideration to, and or to seek advice as to, whether additional support such as the State Emergency Service, Search and Rescue, the Dog Squad or the Victoria Police Air Wing, should be engaged to assist.

76. Inspector Guilmartins further view was that Senior Constable Annesley, and his colleague should *at some stage*, have undertaken an on foot search of Bogong Reserve themselves, and not relied upon Ms Griffin's advice that it had earlier been searched by retired Inspector of Police, Cooney.[48]

77. His further opinion was that the advice provided to Sergeant Hughes by Senior Constable Annesley was inadequate and that he, Senior Constable Annesley, had failed to obtain an accurate understanding of the available evidence as to when Mrs Volkas had disappeared and as to what exactly had been done by Mr Cooney, or of his capacity so to act.[49]

78. Inspector Guilmartin stated that the prime issue was to consider the level of urgency in terms of the risk to Mrs Volkas. She was properly assessed as high risk and an urgent case.[50]

79. His further testimony was that this level of urgency should have informed the priority given to the use of resources and to the searching of different locations.

80. Inspector Guilmartin further considered that the members should also have consulted with the different specialist units, before winding down their search and returning to the station.

COMMENTS AND FINDING:

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. I consider that the procedures adopted by Grace Manor employees for admitting Mrs Volkas were unsatisfactory and that the ongoing care provided to Mrs Volkas failed to address what was her apparently deteriorating mental state and poor physical condition.

2. I further find that Grace Manor staff failed to properly respond to appropriate State Government warnings in regard to the extremely difficult weather conditions which prevailed on the day in question and that, as a result, inadequate protection against that threat was provided to Mrs Volkas.

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46 See transcript from page 335 to 338.
47 See exhibit 8B.
48 See transcript page 311-14.
49 I accept the validity of these observations. By inference I understand (and accept the opinion), that Sergeant Hughes should have taken it upon himself, to ask questions of Senior Constable Annesley and where necessary direct him to further investigate, until the answers to these questions were known.
50 See transcript page 320-21 and page 5 of exhibit 3A.

3. In regard to the response of Victoria Police to her departure from Grace Manor, I note that the comments and criticisms made by Inspector Guilmartin were not put in dispute, Sergeant Hughes being of the view that he was entitled to delegate his supervisory duties to Senior Constable Annesley, an experienced local police officer, because that was the way he had been taught to conduct such searches when he served in regions outside the metropolitan area.[51]

4. I also note that in evidence Sergeant Hughes confirmed that his actions were guided by the contents of the Victoria Police Manual.[52]

5. Paragraph 4.1.2 of the Missing Person VPM[53] applied to Sergeant Hughes and he agreed that it required the supervisor to, among other things,

- Ensure the level of risk is continuously considered and the appropriate investigative response is undertaken; and

- Ensure that appropriate notifications to other areas have been made.

6. On his own admission, I am satisfied that he effectively sought to delegate these responsibilities, and I find that his actions in so doing, did not properly serve the public interest.

7. The facts were that this was an elderly, ill and mentally and physically fragile woman, at large in extreme conditions.

8. Moreover, these events occurred with the front line response officers returning to their station without, themselves, having searched the most obvious path for her departure and, while the whereabouts of this, (if still alive), 'high risk' and increasingly vulnerable elderly woman, remained unknown.

9. Further, having determined that she was not at the relatively safe locations (previously searched by the two officers), there was immediately an even greater reason for Senior Constable Annesley to elevate his search to include Bogong Park and/or to seek further advice.

10. It is also relevant that Senior Constable Annesley did not mention or discuss Bogong Reserve during his telephone conversation with Sergeant Hughes and that Sergeant Hughes did not ask what, if any, search the members had done.[54]

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51 In regard to Senior Constable Annesley's position, I note that he did not seek to refute Inspector Guilmartin's observations. See the discussion at footnote 45 and most particularly, the penultimate line of that reference. See also my discussion with Sergeant Hughes on the subject of delegation of duties etc, at transcript page 307.

52 See transcript page 166.

53 See exhibit 8B.

54 See transcript at page 274-76. In answer to questions raised by the Commissioner, Sergeant Hughes broadly stated that he left it to Senior Constable Annesley to make the relevant inquiries.

11. I also note here that reference to a Melways would have informed Senior Constable Annesley that much of the park could have been searched, this even while the members remained in their vehicle.

12. In this regard I find that Senior Constable Annesley's ongoing reliance on what was his hearsay based knowledge of what Mr Cooney had done and the quality of his (Mr Cooney's) search, became increasingly unsafe as time passed.

13. Accordingly, I find that he should have reviewed his approach and sought advice from Sergeant Hughes and others, before returning to the station. At a minimum he should also have gone back to Bogong Park to conduct a motor vehicle based (and an on foot) search, as circumstances in the park indicated.

14. Having regard to these matters I find that the decision-making demonstrated by the actions of Senior Constable Annesley was unsatisfactory[55] and further that Sergeant Hughes failed to conduct his supervisory duties in accord with the direction provided by the VPM.[56]

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

1. Having regard to the evidence of Inspector Guilmartin, in particular, as well as Sergeant Hughes, I recommend that Victoria Police through the Police Training College, reinstitute the teaching of a training course segment to allow for the (re)training of all Victoria Police sergeants in regard to the procedures to be adopted when searching for missing persons.

Such training should put particular emphasis on, but not be limited to, the procedures to be followed by officers tasked to search and supervise the search for persons missing in extreme and threatening environmental conditions.

2. I further recommend that the Missing Person Risk Assessment form currently in use by Victoria Police be amended to include a mandatory direction that members contact the Search and Rescue Squad, in all cases of 'high risk' missing persons, which cases remain unresolved after a period of time to be determined by the Commissioner.[57]

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55 Senior Constable Annesley's action in counter-signing off the missing persons risk assessment report, under the number of Sergeant Hughes, is evidence of what, in my view, is at best, a policy defeating and otherwise inappropriate practice. See exhibit 3A at page 5.

56 Given Mrs Volkas' underlying heart disease and our inability to establish the time of death, the evidence does not establish that her death occurred only after police were notified of her disappearance, or that Mrs Volkas remained in the park during the whole period her whereabouts remained unknown, (and therefore the possibility that the acts or omissions of Victoria Police contributed to her death). See further discussion of this aspect at footnote 1 above.

57 See Exhibit 3Aat page 5.

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

The family of Aleksandra Volkas
The Chief Commissioner of Victoria Police
Sergeant Gary Hughes
Senior Constable Dale Annesley
Ms Susan Griffin
The Chief Executive, Victoria Police Training College
The Administrator, Premier Assisted Living Pty Ltd
The Manager Coroners Court Prevention Unit, Attention Mr David Hogan

I ALSO direct that a copy of this finding be provided to the following for their information only:

Counsel Assisting the Coroner, Ms T Christiano, and Ms Debra Siemensma of Counsel on the instructions of Meridian Lawyers, from the 28th of September 2011

Counsel for the members, Mrs E Gardner of Counsel on the instructions of Russell Kennedy

Counsel for the Commissioner of Police, Mr R Gipp of Counsel on the instructions of the VGSO

Signature:


PETER WHITE
CORONER

Date: 4th April, 2012