IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 5831

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of:	**ANDREW STANYER**
Delivered On:	16 December 2015
Delivered At:	65 Kavanagh Street, Southbank 3006
Hearing Dates:	8 December 2015
Findings of:	CORONER JACQUI HAWKINS
Representation:	Mr Ron Gipp, counsel, on behalf of the Chief Commissioner of Police, instructed by the Victorian Government Solicitors' Office.
Counsel Assisting the Coroner	Ms Jodie Burns, Senior Legal Counsel.

I, JACQUI HAWKINS, Coroner having investigated the death of ANDREW STANYER
AND having held an inquest in relation to this death on 8 December 2015 at Melbourne
find that the identity of the deceased was ANDREW STANYER
born on 3 June 1977
and the death occurred on 16 November 2014
at 27 Augusta Way, Wallan, Victoria, 3756
from:
1(a) HANGING

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. Andrew Stanyer, aged 37, died as a result of hanging on 16 November 2014, at 27 Augusta Way, Wallan (the Home), the home he shared with his wife, Rachael Stanyer and their six children.
2. On the same day of Andrew's death, police officers attended the Home in response to a report of a family violence incident.

BACKGROUND CIRCUMSTANCES

3. Andrew was raised by his parents, Charles and Miriam Stanyer in the Fawkner and Epping areas with his brother Damien Stanyer.
4. Andrew completed his secondary education until Year 11, following which he commenced working in the family security door business.
5. In 1995 Andrew met Rachael, who at the time was completing Year 12 at Lalor Secondary College. In January 1996 Rachael moved in with Andrew and his family in Mill Park and they married in November 1996.
6. During their marriage Andrew and Rachael had five children the first being born in March 1997 and the last in March 2007. Rachael also had another son who was not Andrew's biological son, who was conceived while they had a period of separation. The evidence obtained during my investigation indicates that Andrew raised this child with Rachael as if he was his own child.
7. Andrew and Rachael moved house regularly and apart from one home purchased in 2000 in Roxburgh Park, their other residences were rental properties.
8. Andrew had a variety of jobs including Chubb security patrols, a security patrol franchise, truck driving, a truck business and other odd jobs.
9. Andrew and Rachael struggled financially throughout most of their marriage and this, coupled with other stressors, were the catalyst of numerous family violence incidents.

10. During the course of their marriage, Victoria Police's Law Enforcement Assistance Program (LEAP)[1] records reveal that police regularly attended family violence incidents which resulted in a number of intervention orders (IVOs) being issued including:

    a) 12 January 2002;
    b) 17 January 2002;
    c) 18 January 2004;
    d) 21 October 2005;
    e) 4 September 2009;
    f) 15 September 2009; and
    g) 1 August 2014.

11. These family violence incidents ranged in seriousness from verbal abuse to physical assaults. The evidence suggests that while IVOs were issued, Andrew and Rachael did not observe the conditions and generally reconciled shortly after. Rachael stated the main reasons for this were that she did not want Andrew charged criminally "*as he was the father to my children*" and "*if Andrew was locked up the kids wouldn't be able to see their dad on a daily basis.*" Rachael explained further that "*I also knew that the charges would affect Andrew's credibility and potentially his security licence which would impact on our income.*"[2]

12. Rachael stated that in 2004, Andrew completed an anger management course with Kevin Loftus in Roxburgh Park. Rachael stated:

> *I remember my mother spoke to Andrew about completing an anger management course and Andrew researched this by himself and arranged to start seeing Kevin. I think Andrew saw Kevin about twice a week and this course was very beneficial to Andrew.*[3]

13. Further:

> *I could see this anger management therapy really changed Andrew's persona. Previous incidents that would lead to domestic violence, simply became a conversation between us without arguments. The assistance that Andrew received from Kevin made a huge difference to our lives and decreased the incidence of family violence for many years.*[4]

14. While Andrew and Rachael's marriage was underscored with family violence there were also periods of harmony. Rachael particularly recalls the period between 2010 and 2013 where "*there were no arguments or violence and our relationship was perfect*".[5]

---

1 On 1 March 1993, Victoria Police implemented the Law Enforcement Assistance Program (LEAP) state-wide. The LEAP database is relational and stores particulars of all crimes bought to the notice of police as well as family incidents and missing persons. The database is accessible by police officers online and updated constantly, 24 hours a day.
2 Coronial brief, p14
3 Coronial brief, p15
4 Coronial brief, p15
5 Coronial brief, p17

15. The evidence obtained as a result of my investigation reveals several significant events that were impacting upon Andrew's quality of life, including:

a. That he had an extensive medical history that included:

- A heart attack on 12 April 2009 after which he had triple heart by-pass surgery. Andrew also had five stents inserted to prevent further heart attacks. As a result of these procedures Andrew had reduced capacity to obtain work due to impaired mobility of his upper body. In particular, after the heart surgery Andrew never regained full use of his arms and lost upper body strength.

- The possibility of prostate cancer, which was undiagnosed prior to Andrew's death because "*he didn't want to know*" the results.

- Mental health issues including depression for which he was diagnosed in 2008 and being treated for by his general practitioner at the Hillcrest Health Centre. Medical records indicate that Andrew's last prescription for Zoloft was on 11 August 2014.

b. Family conflict with Rachael.

c. A history of unresolved conflict with his parents and brother between 2010 and 2013 which resulted in Andrew not being included in significant family events such as his grandmother's 90th birthday in April 2013 and later her funeral in July 2013.

d. On 16 October 2014, the repossession of a truck due to outstanding Sherriff's Office debts. Andrew was significantly impacted by this event. Rachael's evidence is that Andrew was proud of his truck and he felt it was his only success in his life as he had managed to pay off the truck himself and it was the only thing in his life that he had achieved without any help from anyone else. She stated, "*This was probably the tipping point for Andrew as he had lost the truck and the truck was his everything*".[6]

e. Rachael's evidence is that at the time of his death Andrew was using cannabis to help him deal with stress. However, this was also the source of conflict between Andrew and Rachael.

16. Significantly, my investigation has revealed that Andrew had a history of suicide attempts. Rachael's evidence details two specific known suicide attempts:

a. In 2000, Andrew told Rachael that he attempted suicide in the garage of their house by using a chain to hang himself, but stopped because it hurt too much. This suicide attempt was in

---

[6] Coronial brief, p20

the context of mounting pressure from Andrew's family, particularly a family member to whom Andrew had lent $5,000 for a business venture and the family member had refused to pay the money back, despite several requests from Andrew. During this same period Andrew's four wheel drive vehicle was repossessed and sold at auction due to him being unable to meet repayments.

b. In 2009 Andrew took approximately 36 tablets believed to be endone, with alcohol. Rachael contacted the poisons line and was advised that Andrew would be fine, but drowsy for days afterwards. This suicide attempt was in the context of financial pressures, Andrew's sister-in-law dying from bowel cancer and Andrew's work pressures.

c. In addition Rachael stated that:

> *Sometimes Andrew would leave for work in the morning and say things like I'm going to run the truck into another truck, or a house, or a pole or something like that. I knew that Andrew was not in a good place on those days....*[7]

17. During mid-October 2014, around the same time the truck was repossessed, Andrew and Rachael began constantly arguing. These arguments ranged from issues of finances, their children, cars, general family conflict and everyday life events.

18. The arguments increased in intensity when Andrew suspected Rachael was having an extra-marital affair with one of his work colleagues, specifically his supervisor.

THE CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

19. On 16 November 2014, Andrew got up early and immediately began arguing with Rachael. The arguments ranged from issues relating to unpaid bills, cars, family issues, his grief of not being invited to his grandmothers 90th birthday party and general arguments about their relationship. Rachael's evidence is that "*the arguments just intensified from this point on and we argued about everything I can think of for the past 18 years we had been together*".[8]

20. Five of the couple's six children were present during these arguments and Shannon, the eldest child's evidence is that:

> *Dad brought a lot up from his past during the argument. He was saying how much he was hurting, and that he was hurting over so many things, like not being able to attend Nunna's 90th birthday party and being the 'black sheep of the family'. He also said things like he was a jack of all trades, but having nothing to show for it, and not being able to give us kids the life that we deserve, not having money and other things like this.*[9]

---

7 Coronial brief, p20
8 Coronial brief, p21
9 Coronial brief, p25

21. During the arguments Andrew also threw Rachael onto a bed, took her mobile telephone for the purpose of accessing her Facebook account, and pushed her backwards into a wall causing her arm to make a small hole in the plaster.
22. Andrew believed that a Facebook message was evidence that Rachael was having an affair with his work supervisor. Andrew also rang this person and accused him of having an affair with Rachael. Shannon's evidence is that she overhead her father speaking to someone she believed to be from his work and her father threatened to kill him.
23. Andrew later called his boss and told him that he believed his supervisor was having an affair with Rachael.
24. Due to the escalation in the argument, Rachael asked one of her children to call the police as she was in fear of Andrew.
25. Police officers Acting Sergeant Karen Arthurson and Constable Ty Ellis were performing divisional van duties when they received a "job" from ESTA at 12:25pm to attend 27 Augusta Way, Wallan. They arrived at the address at approximately 12.30pm. By the time they arrived Andrew was calm, quiet and not aggressive.
26. Acting Sergeant Arthurson initially spoke with Rachael to ascertain from her what had occurred and Constable Ellis spoke with Andrew separately. Rachael stated that she spoke to Acting Sergeant Arthurson for approximately 15-20 minutes during which time she was asked questions about what occurred. Rachael's evidence is that at no time was she asked questions about Andrew's mental state or whether he had previously attempted suicide. Acting Sergeant Arthurson's evidence is that Rachael advised her that a few months earlier she was drunk and sent silly text messages to Andrew's boss, which she thought she had deleted. Rachael also gave her a history of their relationship and stated that they were in financial difficulties, behind in their rent and could not afford to pay a vehicle registration that was due.
27. Rachael advised Acting Sergeant Arthurson that she and Andrew had been sleeping separately, that their relationship was over, as they had agreed to separate and Andrew was in the process of finding a house in Sunbury but did not have the finances to cover the cost of bond and rent. Rachael believed he was going to sell a car to fund this.
28. Acting Sergeant Arthurson also had a brief conversation with Andrew during which he admitted he "*knocked Rachael against the wall when he was trying to get out of the room*".
29. Acting Sergeant Arthurson asked Andrew who was the primary carer of the six children and he stated it was Rachael. Acting Sergeant Arthurson explained to Andrew that due to the fact that there had been physical pushing that they would need to investigate the incident and make an application for an IVO, which would contain a condition to exclude him from the Home.

30. According to Acting Sergeant Arthurson "*Andrew was crying and upset which I found to be normal behaviour for what he had just found out, believing his wife was having an affair*".[10]

31. Rachael's evidence is that the police officers told her that they would obtain an IVO by 4pm that afternoon and wanted to serve it before their shift finished. Rachael then left the Home with the five children, with the assistance of her brother and his wife.

32. The police officers remained at the Home for approximately 15 minutes and spoke with Andrew about a number of issues including that he had difficulty getting a job because he was a high health risk, due to his heart surgery. Andrew advised the police officers that he had been in his current job for approximately five months but stated it would be difficult going back finding out his wife was having an affair with someone at his workplace. Andrew also spoke about the child Rachael had conceived while they had a break in their relationship and stated that he loved this child just as much as his biological children. Andrew indicated to police his marriage with Rachael was over and he had been attempting to find alternate accommodation.

33. Acting Sergeant Arthurson's evidence is:

> *I conducted a risk assessment and as there was no other persons at the address I decided to allow Andrew the opportunity to remain at the house and pack what he needed whilst Rachael returned to the police station.*[11]

34. The police officers left the premises at about 12.58pm.

35. Constable Ellis' evidence is that:

> *there was nothing obvious that concerned me regarding his mental health...Andrew did not volunteer any information about his mental health to me. I did not specifically ask Andrew any questions about his mental health as I attributed his emotions to the argument he had with Rachael...I did not ask Andrew any questions regarding previous incidents of self-harm or suicidal ideations as he did not appear to be in this state of mind. Andrew was emotional but he was conversing with me, he was not aggressive or argumentative and he was fully compliant.*[12]

36. Acting Sergeant Arthurson's evidence is also that "*at no time did Andrew indicate or state that he intended to harm himself... at no time did Rachael mention anything in relation to Andrew threatening or showing any indication of suicide or self-harm*".[13]

37. At approximately 1.05pm Rachael received a text from Andrew which stated "*I love you ok bye babe I hope you find happiness*". Rachael's evidence is that she had received similar text messages from Andrew and did not think anything more of the message.

38. Rachael later went to the Wallan police station to make a statement in relation to the incident.

---

[10] Coronial brief, p35
[11] Coronial brief, p36.2
[12] Coronial brief, p41.5
[13] Coronial brief, p35

39. An application and an IVO complaint and warrant was made and subsequently issued by the after-hours Registrar of the Magistrates' Court at 3.14pm.

40. Due to Acting Sergeant Arthurson and Constable Ellis' being rostered to finish their shift at 4pm, at 3.45pm, they briefed Leading Senior Constable Ben Cornish and Constable Sikander Malhotra in relation to the matter with the expectation that they would execute the Warrant during their shift.

41. At approximately 7.12pm, Leading Senior Constable Cornish and Constable Malhotra (Wallan 304) attended the Home to serve the Warrant and there appeared to be no one home. They returned to the police station, called Rachael who advised them that if Andrew's car was present then he would be at the Home. Wallan 304 returned to the Home at 9.16pm and eventually forced entry to the house and located Andrew deceased in an upstairs linen cupboard. Andrew was located hanging from a rope secured around his neck and to a rafter in the roof and was deceased.

PURPOSE OF A CORONIAL INVESTIGATION

42. The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[14]

43. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention' role.[15] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These are effectively the vehicles by which the prevention role may be advanced.

44. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation.

---

[14] This is the effect of the authorities- see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[15] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act of the Coroners Act 1985 where this role was generally accepted as "implicit".

45. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

CORONIAL INVESTIGATION

Forensic medical investigation

46. On 17 November 2014, Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination on Andrew's body and concluded that the reasonable cause of death was 1a) HANGING.

47. Toxicology testing was conducted and found Sertraline, an anti-depressant, also known as Zoloft and Delta-9-tetrahydrocannabinol (cannabis). Dr Lee concluded that a rational interpretation of these results was difficult, in the absence of a complete post-mortem examination.

Victoria Police investigation

48. Upon discovering Andrew deceased, Victoria Police commenced an investigation to determine whether there were any criminal offences connected with the death. Police officers did not find any signs of any physical injuries to Andrew's body, damage to the property, or any sign that a physical altercation had taken place.

49. While there was no suicide note located, Victoria Police determined that the death was not consistent with homicide.

50. Consequently, Detective Senior Sergeant Timothy Tucker was nominated by the Chief Commissioner of Police to be the coroner's investigator[16] and he conducted a thorough investigation, at my direction, including the preparation of the coronial brief which included taking photographs of the scene, statements from witnesses, including the police witnesses and obtaining medical records.

Coroners Prevention Unit investigation

Suicides of male perpetrators of intimate partner violence

51. The Coroners Court of Victoria is assisted by the Coroners Prevention Unit (CPU). The CPU is a specialist service created for coroners to strengthen their prevention role and provide assistance on issues pertaining to public health and safety. The CPU is staffed by professional researchers; including a multi-disciplinary team of family violence case investigators.

52. At my request the CPU investigated the interaction between suicide and male perpetrators of intimate partner violence (IPV) and prepared a report (the CPU report). The CPU report uses the

[16] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions directly from a coroner and carries out the role subject to the direction of a coroner.

meaning of family violence as defined in section 5 of the *Family Violence Protection Act* 2008 (Vic) (FVP Act) and refers to behaviour by a person towards a family member of that person if that behaviour is physically, sexually, emotionally, psychologically or economically abusive, is threatening, coercive or if in any way controls or dominates the family member and causes the family member to feel fear for the safety or wellbeing of that family member or another person, or the behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of this behaviour.

53. Intimate or familial relationship is defined in section 8 of FVP Act and refers to a present or former relationship as a spouse, domestic partner, person who has shared an intimate personal relationship, relative, child who normally or regularly resides with the relevant person, or child of a person who has or had an intimate personal relationship with the relevant person.

54. The CPU report identified that there is a substantial amount of literature that explores the issue of risk factors for suicide and also literature exploring the risk factors for perpetration of family violence, but there was little, if any, literature that directly addresses the intersection between suicide and perpetrators of family violence. When they cross-referenced the two bodies of literature, the following risk factors were identified as common to both suicide and family violence perpetrators:

    a) Relationship or family breakdown;
    b) History of violence or abuse;
    c) Isolation;
    d) Financial concerns;
    e) Substance abuse;
    f) Mental illness;
    g) Response to the loss of control;
    h) Family violence as a precipitating factor in the suicides of victims and perpetrators;
    i) The presence of children emerged as a crucial factor in an individual's coping ability and suicide risk concerning family violence.

55. The CPU Report relied upon data derived from the Victorian Suicide Register (VSR)[17] which is a register maintained by the Coroners Court of Victoria that has all suicide data coded from 2009 to 2012. At the time of writing this finding the VSR now includes all suicides 'coded' up to the end of 2013. The purpose of the study was to identify the frequency of suicides among Victorian

[17] The figures identified in the CPU report are a conservative estimate, given the VSR is positively coded and other instances of family violence may have been missed if the coronial investigation did not identify any indicators of family violence.

males who were perpetrators of IPV. The study further sought to examine the profile of stressors and service contacts in this population.

Key findings

56. The key findings identified in the CPU report were as follows:
    a) There were 2,227 suicide deaths recorded by the Coroners Court of Victoria for the period 1 January 2009 to 31 December 2012.
    b) Of the 2,227, 1680 were males (75.5%).
    c) Of the 1680 males, in 567 (33.7%) suicides there was evidence of exposure to interpersonal violence, most frequently as perpetrators (24.7%).
    d) Of the 567 males, 368 (21.9% of all male suicides) were perpetrators of family violence.
    e) Of the 368 males who were perpetrators of family violence, 286 males (17% of all male suicides) were perpetrators of IPV.
    f) Of the 286 male perpetrators of IPV, 39.2% used violence against a former or current intimate partner within 6 weeks prior to the death.
57. These findings were noteworthy and suggested that due to a male family violence perpetrator's interaction with Victoria Police as the front-line organisation to family violence, it was appropriate to highlight this issue. Consequently, the CPU report was provided to Victoria Police to alert them to the issue and they were advised that I intended on conducting a limited inquest investigating this issue further with Victoria Police.

INQUEST

58. On 15 December 2014, I conducted a Directions Hearings in accordance with Practice Direction 4 of 2014 because Andrew's death appeared to be one that occurred in circumstances where police officers immediately preceding the death had been in contact with him and this required further investigation.
59. The circumstances of Andrew's death did not require a mandatory inquest. However, I exercised my discretion, pursuant to section 52(1) of the Coroners Act, to hold an inquest because I had identified matters of public health and safety that I considered required further investigation. Specifically, the purpose of this inquest was to highlight the suicide risk associated with perpetrators of family violence and investigate whether there were any prevention opportunities within Victoria Police.

60. I acknowledge that the Royal Commission into Family Violence[18] is currently investigating issues around family violence and I do not want to duplicate any work that it may be doing, however I do not consider that male perpetrator suicide is something it has examined.

Viva voce evidence at the inquest

61. A one-day inquest was held on 8 December 2015 and *viva voce* evidence was obtained from the following witnesses at the inquest:

    a) Dr Lyndal Bugeja, Manager, Coroners Prevention Unit;

    b) Ms Kavitha Selvakumar, Case Investigator, Coroners Prevention Unit; and

    c) Superintendent Mathew Ryan, Family Violence Command, Victoria Police.

Inquest issues

62. The purpose of the inquest was to highlight that the VSR data identified that male perpetrators of family violence appear to be at an increased risk of suicide. The inquest explored the following issues:

    a) Is there an increased risk of suicide to male perpetrators of family violence?

    b) What are the identified risk factors associated with IPV perpetrators and suicide?

    c) Were those risks present in Andrew's case?

    d) Is Victoria Police aware of the increased risk of suicide in male perpetrators of IPV?

    e) What are the prevention opportunities, if any?

Is there an increased risk of suicide to male perpetrators of family violence?

63. Dr Lyndal Bugeja and Kavitha Selvakumar gave concurrent evidence on their combined research into this area. Dr Bugeja outlined that there are 160 data fields that make up the VSR and that the whole Coroners Court of Victoria file including the coronial brief, medical records and findings are used to populate the VSR.

64. Dr Bugeja advised that there are approximately 550-600 suicides a year that are reported to the Coroners Court of Victoria. Ms Selvakumar explained that based on the current VSR data approximately 71.5 suicides of males are perpetrators of IPV per year. She further stated that these figures are conservative and based on information that was coded into the data base.

65. Further, that 68.6% of male perpetrators of IPV had contact with the police within 12 months of their deaths and 36.1% had contact with police within six weeks of their death. These results have

---

[18] Terms of Reference requires the Commissioners to, inter alia:

(a) Examine and evaluate strategies, frameworks, policies, programs and services across government and local government, media, business and community organisations and establish best practice, amongst other things, the prevention of family violence.

(b) Investigate the means of having systemic responses to family violence, particularly in the legal system and by police, corrections, child protection, legal and family violence support services, including reducing re-offending and changing violent and controlling behaviours

(c) Investigate how government agencies and community organisations can better integrate and coordinate their efforts;

(d) Provide recommendations on how best to evaluate and measure the success of strategies, frameworks, programs and services put in place to stop family violence.

assisted in building a profile of a male perpetrator of IPV and particularly their heightened risk of suicide.

What are the identified risk factors associated with male IPV perpetrators and suicide?

66. The CPU Report identified the following risk factors that were associated with male IPV perpetrators and suicide risk:

    a) Males aged between 25-44;
    b) Partner conflict;
    c) Family conflict;
    d) Family death;
    e) Breakdown in relationship;
    f) Financial stresses;
    g) Substance use/abuse;
    h) Legal system contacts, particularly police involvement;
    i) Mental illness; and
    j) Previous suicide attempts.

Were those risks present in Andrew's case?

67. When the identified risk factors were applied to the facts of Andrew's case, they were all present.

    a) **Male and aged between 25-44 -** Andrew was aged 37 years old at the time of his death.
    b) **Partner conflict** – Andrew was concerned that his wife was having an affair, which caused a physical confrontation on the day of his death, including pushing Rachael against the wall. There was also evidence that they had been recently fighting regularly, with issues ranging from unpaid bills, their children and their relationship.
    c) **Family conflict** – There is evidence that Andrew had experienced family conflict in the year before his death, including the fact that he was excluded from attending his grandmother's 90th birthday and her funeral.
    d) **Family death** – The evidence demonstrates that the death of Andrew's grandmother had a significant impact on him.
    e) **Breakdown in relationship** – Andrew and Rachael both agreed that their relationship was over, that they had been sleeping in separate rooms and were going to separate, however Andrew could not afford the bond or the first month's rent.
    f) **Financial stresses -** The evidence is that Andrew was suffering from financial stress, as he had recently had his truck re-possessed and was struggling to pay bills.
    g) **Substance use/abuse** - The evidence reveals that Andrew was regularly using cannabis and this is supported in the toxicology results.

h) **Legal system contacts, particularly police involvement** – There is evidence of regular police attendance at the Home, including on the day of his death and one month prior to his death in October 2014. There was also evidence of regular police attendance at the family home with approximately 8 intervention orders issued over a number of years.

i) **Mental illness** - In relation to mental illness, there is evidence that Andrew had been diagnosed with, and was being treated for depression, and the toxicology report confirms the presence of sertraline, an anti-depressant drug that was found in his post mortem blood samples. Also impacting on his mental health was his significant physical health conditions including his heart condition and possible diagnosis of prostate cancer.

j) **Previous suicide attempts** – Rachael's evidence is that Andrew had two previous suicide attempts in 2000 and 2009.

68. Even though the evidence demonstrates that the police officers who attended the Home on the day of Andrew's death engaged with him in conversation and attempted to understand his issues, not all of these issues were known by them because they did not specifically ask. The evidence is that the police officers did conduct a risk assessment, in the form of the L17[19], in response to the report of the family violence incident. However, the L17 is largely and appropriately based on protecting the affected family member and their children and to make the perpetrator accountable for his actions. It is not focused on assessing the perpetrator, who in my view is ultimately the source of the risk for the family violence incident.

Is Victoria Police aware of the increased risk of suicide in male perpetrators of IPV?

69. The evidence of Superintendent Matthew Ryan was that until the Coroners Court of Victoria provided the CPU Report to the Victoria Police they were unaware of the extent of this issue.

70. Superintendent Matthew Ryan's evidence was that the numbers were stark and significant and he agreed they were worthy of attention and that Victoria Police would take active steps to address this significant issue.

What are the prevention opportunities, if any?

71. Superintendent Ryan's evidence was that Victoria Police had identified three levels of responding to this issue including:

a) Partnering with other agencies to research this issue further;

b) Raise awareness across operational police officers; and

c) Have an increased awareness of this issue when developing and designing family violence training in the future.

---

[19] VP Form L17 – Victoria Police Risk Assessment and Risk Management Report.

72. Superintendent Ryan said that options a) and c) were long term options and dependent on the outcomes of the Royal Commission into Family Violence, but option b) could be addressed in the short term. Superintendent Ryan gave me an express undertaking that Victoria Police, in order to raise awareness of the risk of suicide to male perpetrators of IPV, would:

a) Publish an article in the *Police Gazette* which is released every second Monday and is distributed to all operational police officers;

b) Distribute an alert on the Victoria Police Family Violence intranet, so that operational police officers accessing the site for information about family violence and associated documents can be alerted to the issue.

c) Request the Family Violence Advisors and Team Leaders communicate and highlight the issue to their teams.

73. Superintendent Ryan's reasons for not wanting to amend the Code of Practice for the Investigation of Family Violence, the L17, the Ready Reckoner[20] or any of the Victoria Police Manual policy rules and guidelines was because they are based on the Common Risk Assessment Framework (CRAF).[21] Superintendent Ryan's firm and clear evidence was that changes to these documents should only occur after extensive consultation with relevant stakeholders (of which there are many) and having considered any recommendations that may come from the Royal Commission into Family Violence.

74. I accept Superintendent Ryan's evidence that the nature of police work is that police officers are trained to constantly risk assess every aspect of their policing role. I also accept Superintendent Ryan's evidence that Victoria Police's approach to responding to, and investigating, family violence is to protect the safety of the affected family member(s), including children and making the perpetrator accountable. Superintendent Ryan, in his evidence, accepted that in the family violence context, the person identified as the perpetrator of the family violence is the source of the risk for further family violence. Despite this evidence, Superintendent Ryan stated that it was not the purpose of the L17 to conduct a risk assessment of the perpetrator.

75. I acknowledge that the Victoria Police was not aware of the VSR data in relation to family violence perpetrator suicides until the Coroners Court of Victoria provided it to its legal representatives on 20 November 2015. Mindful of this, I appreciate Superintendent Ryan's

---

[20] The Ready Reckoner is a pocket sized risk assessment which was developed by the Family Violence Command of Victoria Police to assist operational members who attend family violence incidents.

[21] A key component underpinning the family violence system in Victoria is the Family Violence Risk Assessment and Risk Management Framework, commonly known as the Common Risk Assessment Framework or 'the CRAF'. The CRAF aims to help practitioners and professionals identify and respond appropriately to risk factors associated with family violence. The CRAF is limited in that it is aimed as assessing risks to a woman and not a child or the perpetrator.

evidence that raising this as an issue for police officers will require a cultural shift by Victoria Police.

76. Superintendent Ryan stated that Victoria Police is always seeking to improve its policing methods and as a result of the Coroners Court of Victoria raising awareness of this risk, Victoria Police will be more mindful of the issue when they attend a family violence incident, of which there are currently approximately 70,900 attendances a year.

COMMENTS

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

77. I acknowledge that the primary consideration for first responders, such as police officers, to a family violence incident is to ensure the safety of the affected family member and their children and to hold the perpetrator accountable.

78. Appropriately, the L17 is a risk assessment focused on the likelihood of family violence re-occurring. I also consider it necessary and appropriate that perpetrators of family violence be the subject of a risk assessment, including the risk of suicide. When conducting a risk assessment it is imperative that the source of the risk be assessed. In the family setting it is the perpetrator who is the source of the family violence. I consider that police officers, as first-responders, have a unique opportunity to assess the mental well-being of an alleged perpetrator. By turning their attention to risk assess the perpetrator they are potentially minimising the risk of harm to others, as well as harm to the perpetrator themselves.

79. I acknowledge that until the Coroners Court of Victoria recently highlighted the issue to Victoria Police, the risk of male perpetrators of IPV and suicide was not a known or considered issue. Now it is known, Victoria Police have identified short term and effective measures to manage this risk by communicating this knowledge to Victoria Police operational police officers.

80. I accept Acting Sergeant Arthurson and Constable Ellis' evidence that they conducted a risk assessment throughout the incident and that there was nothing in Andrew's presentation that made them concerned about his welfare or mental state.

81. Based on Superintendent Ryan's evidence, I do not propose to make any recommendations, however I expect that he will implement the following awareness measures to operational police as a matter of priority.

    a) Publish an article in the *Police Gazette*.

    b) Distribute an alert on the Victoria Police Family Violence intranet.

c) Request the Family Violence Advisors and Team Leaders communicate and highlight the issue to their teams.

82. Consequently, I commend Victoria Police's proactive response to this issue and appreciate that this particular issue does require a lot more evidence-based research.

83. I am grateful to the Coroners Prevention Unit for the assistance they provided to me in relation to this investigation.

FINDINGS

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

84. I find that Andrew Stanyer died on 16 November 2014 from 1a) HANGING. I further find that Andrew intended to end his life.

85. I find that there were a number of stressors impacting Andrew's life at the time of his death including; a breakdown in his relationship, financial hardship, a belief that his wife had been unfaithful with a work supervisor and that he would struggle to return to work with this issue being present, he had been diagnosed and treated for depression, Victoria Police had attended the Home in response to a report of family violence and as a result he would be named as the Respondent to an intervention order that contained a condition requiring him to leave the family home and he would therefore be separated from his children. I further find the combination of these factors contributed to his decision to end his life.

Pursuant to section 73(1) of the Coroners Act 2008, I order that this Finding be published on the internet.

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

- Rachael Stanyer
- Damien Stanyer
- Superintendent Matthew Ryan, Victoria Police
- The Victorian Government Solicitors' Office
- Royal Commission into Family Violence
- Senior Sergeant Tim Tucker, Coroner's Investigator

Signature:

JACQUI HAWKINS

CORONER

16 December 2015