IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 001300

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

Inquest into the Death of: Frederick Joseph WILLIAMSON

Delivered On:	4 August 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Dates:	24 August, 7 and 13 December 2010, 13 June, 3, 4, 5, 7 September, 16 October and 13 December, 2012 3 to 7, 10 to 14 and 17 June, 2013 Final submissions received between 11 October and 20 December 2013
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Ms Mary Anne HARTLEY SC, Ms Sarah THOMAS and Ms Viola NADJ of Counsel, instructed by Corrs Chambers Westgarth, appeared on behalf of the family. Dr Sharon Keeling of Counsel, instructed by Minter Ellison, appeared on behalf of Austin Health. Mr Paul J LAWRIE of Counsel, instructed by the Victorian Government Solicitor, appeared on behalf of the Chief Commissioner of Police. Mr Ben H IHLE of Counsel, instructed by Lander & Rogers, appeared on behalf of D/S/C James COOPER, D/L/S/C Tracey MICHEL, L/S/C Sean HENDERSON, S/C Claire McMORRON and Mr Chris YATES.
Counsel Assisting the Coroner:	Ms Sarah L HINCHEY of Counsel, instructed by Ms Sarah GEBERT, Principal Solicitor, from the Court's In-House Solicitor Service.

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of FREDERICK JOSEPH WILLIAMSON, known as FREDDY

and having held an inquest in relation to this death at Melbourne on 24 August, 7 and 13 December 2010; 13 June, 3, 4, 5, 7 September, 16 October and 13 December 2012; 3 to 7, 10 to 14 and 17 June 2013 with final submissions received between 11 October and 20 December 2013

find that the identity of the deceased was FREDERICK JOSEPH WILLIAMSON known as FREDDY, born on 9 April 1955, aged 52

and that the death occurred on 30 March 2008

at the Secure Extended Care Unit of Austin Health, Burgundy Street, Heidelberg Victoria 3084

from:

I (a) CONSISTENT WITH PLASTIC BAG ASPHYXIA

in the following circumstances:

INTRODUCTION [1]

1. Mr Williamson was a 52-year-old man who had resided in the Secure Extended Unit of Austin Health (SECU) since 16 December 1987. To his family, Mr Williamson was known as Freddy, and in deference to their wishes, he will be referred to as such throughout this finding. Freddy had a longstanding history of mental illness with a diagnosis of schizophrenia first made when he was about 18 years of age. His illness was particularly debilitating and resistant to treatment, including clozapine.[2]

2. Freddy was the third of five children and a much loved member of the Williamson family. They remained supportive and devoted to Freddy throughout his life. Most Saturdays and Sundays, Freddy's parents, Mrs Roma and Mr Fred Williamson, would take him on outings out of the hospital, often to the beach, and often accompanied by his sister Ms Karen Madzell. They also strove to include him in family functions and celebrations whenever possible.[3]

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[1] This is a brief personal history and background.

[2] Statement of Dr Peter Bosanac dated 10 July 2008, Exhibit B and statement of Dr Julian Davis dated 1 August 2008, Exhibit C.

[3] Statement of Mrs Roma Williamson dated 20 July 2008, Exhibit A.

3. On the afternoon of Sunday 30 March 2008, Freddy's parents arrived as usual to take Freddy on an outing, as they had on the previous day. When SECU staff could not find Freddy in his room or in any of the common areas, they started searching other patients' rooms. After unlocking the door to the room 21 and opening the door to the bathroom, Registered Psychiatric Nurse (RPN) Peter Flynn found Freddy lying on the floor. He had a plastic bag over his head, appeared not to be breathing and was bleeding. RPN Flynn raised the alarm and a number of other Austin Health staff came to render assistance. Despite some 35 minutes of resuscitative efforts, Freddy could not be revived and was pronounced deceased at about 2.40pm.

4. Police were called to the scene and uniformed members from the Heidelberg Police Station attended, arriving shortly before 3.00pm. After initial enquiries and appraisal of the scene, they called for and received assistance from the Crime Investigation Unit. The shift supervisor also attended.

5. The adequacy of the police investigation will be discussed below.[4] Suffice for present purposes to say that the hypothesis formulated by the police was that Freddy was alone in the bathroom, that he placed a plastic bin liner from the bathroom rubbish bin over his head, twisted it closed under his chin and then lost consciousness. As a result, he fell forward sustaining an injury around the left eye when it came into contact with a solid metal toilet roll holder protruding from the bathroom wall adjacent to the toilet.[5]

A REPORTABLE DEATH

6. The police reported Freddy's death to the Coroner. Apart from a jurisdictional nexus with the State of Victoria, certain deaths are required to be reported to the Coroner. They are, generally, deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury. However, some deaths are reportable irrespective of the nature of the death, based simply on the legal status of the person immediately before their death.

7. Section 4 of the ***Coroners Act 2008*** contains an exhaustive definition of a *reportable death* that includes the death of a person who immediately before death was a patient within the meaning of the ***Mental Health Act 1986***, as Freddy was, and indeed had been for most of his adult life.

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[4] See paragraphs 59 and following.

[5] See also Counsel's brief 'opening' of the circumstances on 13 June 2012 at transcript pages 1-4.

8. In this way, the Coroners Act recognises that people in the control, care or custody of the State, in any of its iterations, are vulnerable, and affords them the protection of the independent scrutiny of a coronial investigation of their deaths.

9. Another protection is the statutory requirement for mandatory inquests. While there is a discretionary power to hold an inquest in relation to any death a coroner is investigating,[6] this was a mandatory or statutorily prescribed inquest as Freddy was, immediately before death, a person placed in custody or care.[7]

THE PURPOSE OF A CORONIAL INVESTIGATION

10. The purpose of a coronial investigation of a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[8] 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.[9]

11. The broader purpose of any coronial investigation 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.[10]

12. Coroners may also report to the Attorney-General in relation to a death they have investigated, comment on any matter connected with the death, including matters of public health or safety and the administration of justice, and make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the

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[6] Section 52(1) of the *Coroners Act 2008* provides that a coroner may hold an inquest into any death that the coroner is investigating. Unless otherwise stipulated, all references to legislation that follow are to the provisions of this Act

[7] Section 52(2) and the definition of "person placed in custody or care" in section 3, in particular paragraph (i) - "a patient in an approved mental health service within the meaning of the ***Mental Health Act 1986***". This was never at issue but is attested to by both Drs Bosanac and Davis – Exhibits B and C respectively.

[8] Section 67(1).

[9] This is the cumulative effect of a number of 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).

[10] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, in contradistinction with the *Coroners Act 1985* where the prevention role was generally accepted as implicit.

administration of justice.[11] These are, in effect, the vehicles by which coroners can advance the prevention role.[12]

13. It is important to stress that Coroners are not empowered to determine the guilt of any person, or the extent of any civil liability arising from a death.[13]

INVESTIGATION – SOURCES OF EVIDENCE

14. This finding is based on the totality of the material the product of the coronial investigation of Freddy's death. The investigation was not straightforward; its chequered history reflected in the number of directions hearings and the spread of hearing dates between August 2010, the conclusion of the evidence on 17 June 2013 and the receipt of final written submissions on 20 December 2013.

15. The original investigation was undertaken by one of the attending uniformed members, Constable Claire McMorron from Heidelberg Police, who also compiled the first coronial brief. Following the Directions Hearing on 13 December 2010, and acceding to an application on the family's behalf, I referred the investigation of Freddy's death to the Homicide Squad of Victoria Police for a formal review of the investigation and brief. In due course, Detective Sergeant Sol Solomon undertook a review and provided a memorandum dated 17 May 2011, concluding that there were deficiencies in the original investigation and identifying several avenues for further investigation.[14]

16. In response to D/Sgt Solomon's review, and as a result of the internal processes of Victoria Police, additional investigation was undertaken by Detective Senior Constable James Cooper and Detective Senior Constable Tracey Michel from Heidelberg Crime Investigation Unit (CIU), the original detectives who attended the scene. They provided a number of additional statements, and a reply to D/Sgt Solomon's review in the form of an eleven page memorandum dated 17 February 2012 (the second investigation).[15]

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[11] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[12] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[13] Section 69(1). A Coroner must not include in a finding or comment any statement that a person is, or may be, guilty of an offence. However, if a Coroner believes an indictable offence may have been committed in connection with a death, they must refer the matter to the Director of Public Prosecutions. Sections 49(1) and 69(2).

[14] At pages 100-117 of the final form of the inquest brief, tendered through D/Sgt Solomon as Exhibit MMM.

[15] At pages 100-106 of the final form of the inquest brief, tendered as Exhibit JJJ.

17. All of the above were incorporated into the final inquest brief.[16] The other main source of evidence was the statements, reports and testimony of those witnesses who testified at inquest, and any documents tendered through them. Finally, I have taken into account the written submissions of Counsel, which were comprehensive and reasoned, and helpfully clarified the ultimate positions of the respective parties.[17]

18. All of this material, together with the inquest transcript, will remain on the coronial file, and is accessible in accordance with the Act.[18] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and the interests of narrative clarity.

FINDINGS AS TO UNCONTENTIOUS MATTERS

19. In relation to Freddy's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity, the date, time and place of his death were never at issue. I find, as a matter of formality, that Frederick Joseph Williamson, known as Freddy, born on 9 April 1955, died between 1.00pm and 2.30pm on 30 March 2008 at the Secure Extended Care Unit of Austin Health, Burgundy Street, Heidelberg Victoria 3084.

THE MEDICAL CAUSE OF DEATH

20. On 2 April 2008, Professor Stephen Cordner, Director of the Victorian Institute of Forensic Medicine (VIFM) and a senior forensic pathologist, reviewed the circumstances as reported by the police to the coroner, performed an autopsy on Freddy's body and provided a detailed written report of his findings.[19] Based on his knowledge of the circumstances of Freddy's death at the time and his findings at autopsy, Professor Cordner formulated Freddy's cause of death as *consistent with plastic bag asphyxia.*[20]

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[16] The final inquest brief was compiled by Ms Sarah Gebert from the Court's In-House Solicitor Service, and comprised the original brief, the Solomon review, the product of the second investigation, emails between police members and other materials. Exhibit A13 was the balance of the inquest brief, after tender of the statements/reports of those witnesses who testified at the inquest and separate tender of a number of items.

[17] I note that solicitors for the family and for the members provided a document headed "Joint Acknowledgement/Agreed Facts as between Family and the Members" dated 19 December 2013, appended to the final submissions of Counsel for the Members, which will be discussed in some detail below.

[18] From 1 November 2009, the date on which the Act commenced operation, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[19] Professor Cordner's formal qualifications and experience are outlined in the preamble to his report, Exhibit QQQ.

[20] Professor Cordner explained his use of the qualifier "consistent with" at transcript page 1188. See also Dr Gaya's original report, Exhibit WWW where he helpfully explains the mechanism of death in the following terms – *"If placed*

21. Professor Cordner found no obvious natural disease or traumatic injuries at autopsy capable of causing or contributing to death. Nor did he consider that the drugs identified by post-mortem toxicological analysis caused or contributed to death.[21]

22. The plastic bag was not available for examination by Professor Cordner who stressed, in his autopsy report, that his opinion about the cause of death relied on the circumstances as reported by police. Absent a view in situ, photographs of the plastic bag in situ or preservation of the plastic bag for inspection by the forensic pathologist as a minimum, evaluation of the death from the pathologist's point of view is completely dependent upon the information provided at the time. In Professor Cordner's words *"This is because the presence of a plastic bag secured over the head is capable of causing death, but it leaves no signs to allow an examiner to say either that it was present during life or that it did actually cause death."*[22]

23. Although he not incorporated in his formulation of the cause of death, Professor Cordner identified a number of fresh traumatic facial injuries that he considered complicating features of the investigation – *"There is bruising to the right side of the face, bruising to the left side of the face together with three lacerations to the outer left orbit, bruising to the root of the nose with a broken nose, and bruising to the back of the head."*[23] As these injuries were particularly significant to the investigation of the circumstances in which Freddy died, they are discussed in some detail below.

24. I find that the medical cause of Freddy's death is appropriately formulated as *consistent with plastic bag asphyxia.*

FOCUS OF THE CORONIAL INVESTIGATION

25. The coronial investigation of Freddy's death was focused on the circumstances in which death occurred, in particular whether he caused his own death, either deliberately or accidentally, or

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over the face or head, the soft plastic may become electrically charged, is readily inhaled into the mouth and nose, where it clings tightly, resists removal, and rapidly produces asphyxia.

[21] Analysis detected the benzodiazepine sedative/hypnotic drug Diazepam at ~0.1mg/L and its metabolite Nordiazepam, as well as the antipsychotic drug Quetiapine at ~0.4mg/L and the antidepressant Nefazodone. This is *consistent with* but not entirely explicable by the last documented administration of Freddy's regular medications (Quetiapine, Diazepam, the antipsychotic Aripiprazole, and antihypertensive Atenolol) at 0800hrs on 30 March 2008. Also transcript page 1210.

[22] Page 6/7 of the autopsy report, Exhibit QQQ.

[23] Page 6/7 of the autopsy report, Exhibit QQQ. These injuries were described as "fresh" as opposed to the minor injury to the left collarbone sustained on 24 March 2008 when Freddy was attacked by another patient and which was *clearly an older injury* and *played no part in his death*. See also transcript page 1192 where Professor Cordner's testifies that the nature and extent of these injuries, might have caused a concussion, but could not account for Freddy's death, and transcript pages 1210-11 where he testifies that *'consistent with plastic bag asphyxia is as high as he would put it due to the degree of uncertainty around the circumstances' [paraphrased].*

whether a third party was involved. A related but separate issue was the adequacy of the police investigation of Freddy's death, particularly their initial response and appraisal of the scene. The Williamson family also raised concerns about the clinical management and care provided to Freddy by Austin Health, in particular the failure to increase observations of Freddy in response to his attack by another patient on 24 March 2008.

THE ADEQUACY OF CLINICAL MANAGEMENT AND CARE

26. The Williamson family did not raise concerns about Freddy's overall clinical management and care, and there is nothing in the evidence to support a finding that there was any material want of clinical management and care by the staff of Austin Health.

27. Freddy's established diagnosis was Treatment Refractory Schizophrenia with catatonic features. He was a long term resident of the SECU and its predecessor.[24] Even in the context of the minimally restrictive care paradigm that prevails, Freddy required inpatient admission to provide containment and care, as his illness was unable to be controlled by conventional medications or therapies, including electroconvulsive therapy. His schizophrenia made him disorganised in thought and behaviour and unable to care for himself in the community. He was vulnerable to exploitation by others and his bizarre actions placed him at risk of assault or denigration. During episodic exacerbation of his illness, Freddy could be aggressive to others or place himself at risk of assault from others.[25]

28. In his statement, Dr Davis characterised SECU as a rehabilitation and long term treatment facility designed to be as welcoming and homelike as possible, and not designed for the management of acutely disturbed or at risk patients.[26] At inquest, in response to a question about the desirability of patients being able to lock themselves in their room, Dr Davis testified that that the SECU is meant to be a home and not a prison, a therapeutic environment that is

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[24] Bunjil House, previously at the Repatriation campus of Austin Health, and before that Mont Park.

[25] Exhibit C. Also, Exhibit B where Dr Bosanac gives a convenient description of Freddy's illness and behaviours – *"persecutory ideation, auditory hallucination, long standing mutism and limited interaction with others, a blunted affect, social withdrawal, impaired self-care, wandering and intermittent aggression towards others, including staff (reportedly often in the setting of delusions and hallucinations). His mental state at SECU was generally characterised by being withdrawn and mute (except when requiring things, for example pen and paper or cigarettes, and reportedly often asking female staff members for sex), and appearing to respond to internal stimuli."*

[26] Exhibit C – *"Such patients are transferred to acute facilities that also have the capacity to observe people in a contained environment free of any devices, furnishings, or architectural features that could be utilised in self-harming behaviours."*

able to sustain a person socially, emotionally and positively in terms of social interaction with as little deprivation of liberty as possible.[27]

29. On 24 March 2008, about one week before his death, Freddy and another patient were assaulted by patient AK with a shard of glass from a broken picture frame. Freddy received a superficial wound above the right clavicle that was dressed but did not require stitches. He was initially agitated but appeared to settle over the next 24 hours with the administration of a small dose of diazepam and a reduced stimulus environment.[28] Patient AK was more seriously injured during the incident, and the assault of Freddy appeared random in that he was nearby waiting in line for his medications. As a result of the incident, patient AK was kept under observations with one on one nursing care around the clock.[29] This was a sensible response on the part of Austin Health to minimise the risk of another incident.

30. On 25 March 2008, there was another incident when Freddy drew on another patient FH's art work and the other patient hit him. Given the nature of the SECU, there is nothing in the evidence to suggest that Freddy was at any ongoing risk from this or any other patient, and/or required closer supervision, or that more frequent observation of Freddy would have prevented his death.

31. As to the broader concern that the SECU was unusually unsettled in the months preceding Freddy's death due to the presence of a number of patients with personality disorders and/or intellectual disabilities and increased incidents involving violence, the evidence indicates that Austin Health had little choice but to accept these patients under the current public mental health system. This concern was raised by Counsel for the Williamson family, and while a number of clinical staff commented on the heightened atmosphere and even the difficulties associated with trying to accommodate patients with such different acuities and needs, it is beyond my scope to seek to determine if such a situation existed, and it is inappropriate to

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[27] Transcript pages 88-89. He went on to say that *"...when a lot of these units were designed they talked about the dignity of risk and that you can't eliminate all the risks and so people should have a certain amount of dignity and they should be able to have independence...We never had any indication before that there...would be a problem with people locking themselves in a toilet...clearly after this event you can make a case for removing them. But in so doing you're removing a little bit of the ambience that makes their life pleasant. They have good things in their rooms, they have treasures... and if everything is open their sovereignty over those, their independence is reduced to some extent. So yes perhaps we should have all the doors without any locks, but...if you want to provide a decent sort of lifestyle you're compromising that by doing that."*

[28] Exhibit B & C.

[29] Exhibit K and transcript page 36.

criticise Austin Health for accommodating patients they were obliged to accept as part of the public health system.[30]

SELF-HARM, MISADVENTURE OR HOMICIDE?

32. The primary focus of the coronial investigation and inquest into Freddy's death was on whether he caused his own death, either deliberately or accidentally, or whether a third party was involved, and if so whether that person could be identified or the field of potential assailants narrowed. For all its inadequacies, the investigation of Freddy's death ultimately yielded a significant body of evidence that elucidated this fundamental issue.

Professor Cordner's Evidence

33. The genesis of the idea that Freddy's death could not be easily characterised as having occurred in circumstances of self-harm or suicide, were the four areas of traumatic injury identified by Professor Cordner on external examination and at autopsy.[31]

34. During the course of the investigation and inquest, and largely in response to new or nuanced information put to him, Professor Cordner provided a number of supplementary opinions about these injuries and the broader circumstances in which Freddy died.[32] There is an understandable vacillation in Professor Cordner's opinions over time, as he attempts to incorporate new information about the circumstances of Freddy's death, and he is well aware of this.[33] He also testified at inquest and was cross-examined at length,[34] and in their submissions, all Counsel relied to a greater and lesser extent on his evidence.

35. While advocating for pathologists having access to information as to circumstances in order to contextualise their input to a death investigation, Professor Cordner's evidence as a whole needs

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[30] Transcript pages 33-34, 64, 106-107.

[31] See paragraph 20 above and Exhibit QQQ.

[32] A letter dated 6 July 2011 addressed to Senior Constable Kelly Ramsey from the Police Coronial Support Unit, Exhibit RRR (pages 98-99 of the inquest brief); An undated Supplementary Report prepared in response to a letter from Ms Sarah Gebert dated 5 July 2012, Exhibit SSS (pages 228-233 of the inquest brief); A second Supplementary Report dated 20 May 2013, Exhibit TTT (pages 1276-1277 to be read in conjunction with the file note from Corrs dated 25 February 2013). Transcript pages 1160-1179.

[33] See the concluding paragraph of Exhibit TTT – *"I am sorry if it seems that I am changing with the wind. As I mentioned in the comments in the autopsy report "The evaluation of this death from the point of view of the pathologist is completely dependent upon the information provided at the time of the autopsy". As this information changes or is added to, the evaluation may change."*

[34] Transcript pages 1160 and following.

to be read in light of his acknowledgement that the making of findings as to circumstances, is properly within the coroner's province.[35]

36. Ultimately, Professor Cordner's expert evidence was that there were four distinct areas of injury to Freddy's head, namely the left pre-orbital region, the bridge or root of the nose, the right side of the face and the back of the head or occipital region. These injuries were the result of blunt force trauma, consistent either with the particular body part hitting an unyielding surface or an unyielding object hitting the body part.[36]

37. The constellation of injuries was such that it was unlikely, in Professor Cordner's opinion, that they were caused by one simple fall or even one complex fall, and were probably caused by at least two falls. Alternatively, if the injuries were not sustained in a fall, at least two impacts. On purely pathological grounds, he could not exclude the possibility that any one or all of these injuries resulted from an assault. [37]

38. Professor Cordner advised that self-inflicted blunt impact injuries are very rare, but may be more likely in a person with severe psychotic illness. In evidence, he explained that the pain of inflicting such injuries is a self-limiting factor. Another variable is the strength of the voices telling the person to do something or the strength of their hallucinations.[38] As to this, he deferred to the treating clinicians as regards the nature of Freddy's illness, and what he was likely to do in a given situation.[39]

39. After testifying, Professor Cordner was provided with the toilet roll holder from Room 21 of the SECU, as a potential object in the bathroom implicated in the injuries. He compared the dimensions of the toilet roll holder to the dimensions of Freddy's face captured on post-mortem CT scanning performed on admission to the mortuary.

40. In his opinion, the injury to the right side of the face had features that were not consistent with impact with the toilet roll, and while the injury to the left peri-orbital region could possibly be accounted for by contact with the right side of the toilet roll holder, he would have expected an abrasion in association with the lacerations. Having compared the dimensions of the toilet roll holder with the dimensions of Freddy's head and facial features, Professor Cordner concluded

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[35] Transcript page 1199.

[36] Transcript page 1188-1189.

[37] Reiterated in his various reports and also at transcript pages 1190-1191.

[38] Exhibit RRR and transcript page 1184.

[39] Transcript pages 1184-1186.

that the toilet roll holder did not represent an explanation for more than one of the injuries occurring together at the same time and otherwise stood by his evidence at inquest.[40]

Dr Gaya's Evidence

41. Clinical Forensic Physician Dr Doorendranath Sanjeev Gaya from VIFM provided an initial report and two written reports by way of glosses that were based on additional information as to circumstances that was provided to him, and also testified at inquest. Like Professor Cordner, Dr Gaya conceded that contextual information frames or colours opinions and may change as additional information becomes available.[41]

42. Dr Gaya agreed with Professor Cordner's evidence as to the nature and extent of the injuries to Freddy's head. That is, he agreed that the injuries resulted from blunt force trauma, noted that they were on different planes and areas of the skull, and expressed the view that it was *unfathomable* that one fall/impact or even two falls/impacts could produce such a constellation of injuries.

43. He also agreed that blunt force trauma to the head or face is a very rare mechanism of self-harm, due to the associated severe pain and that when it does occur, it is usually in the setting of a severe psychiatric disturbance.[42] He too deferred to the opinions of treating clinicians as to the likelihood that Freddy's injuries were self-inflicted in the setting of his psychotic illness,[43] and concluded that a non-accidental cause could not be excluded, based on the nature and extent of the injuries.[44] It is this appraisal of injuries that is within his field of expertise proper.

44. On the assumption that the plastic bag was not torn, Dr Gaya's accepted that the extent of blood at the scene was such that, irrespective of whether or not Freddy's injuries were self-inflicted or the result of an assault, the plastic bag could not have been covering his head at the time they were sustained.[45] Moreover, even without a clear sequence of injuries, it was difficult to

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[40] See discussion at transcript pages 1208 and following. Exhibit A11 was a two page report entitled 'Third Supplementary Report in the Case of Frederick Williamson (Deceased)' dated 13 June 2013.

[41] The original report was an eight page document dated 5 August 2010, Exhibit WWW (pages 65-72 of the inquest brief). Second report dated 28 August 2012 is Exhibit XXX (pages 234-235 of the inquest brief) and the third dated 30 May 2013 is Exhibit YYY (pages 1316-1317 of the inquest brief). Transcript page 1234.

[42] Exhibit XXX and transcript pages 1231, 1241.

[43] Transcript pages 1231-1232.

[44] Apart from the reports mentioned in the preceding footnote, see transcript pages 1229 and following, especially 1232.

[45] Transcript page 1233.

identify a likely time in the sequence of injuries, when the plastic bag might have been donned by Freddy.[46]

Psychiatric Evidence

45. It is highly significant, that despite such a long history of inpatient care, self-harm or suicidal ideation or act, were not a feature of Freddy's illness.[47] While it is trite to say that some people take their own lives on a first attempt,[48] and without signalling to those around them that they might do so, Freddy's was a restricted institutionalised life, closely monitored and observed in a clinical setting and well documented.

46. The evidence of Dr Davis at inquest is particularly instructive on the question of whether or not Freddy died as a result of deliberate self-harm. According to his statement Freddy *had never engaged in any self harm during his 34 year history of Schizophrenia, rather any harmful behaviours were directed to others.*[49] While he allowed of the possibility that Freddy may have been responding to command hallucinations, at inquest he qualified this by testifying that this was *only a remote possibility, that he was responding to some form of command hallucination as he had many years earlier.* In such circumstances, Dr Davis expected that there would be associated changes in behaviour and likely repeated escalating behaviour, unlikely to be lost on clinical staff. [50] As regards the suggestion that Freddy died as a result of a deliberate act of self-harm, Dr Davis testified that he *thought it is absolutely so unlikely as to be beyond reasonable doubt.*[51]

47. Apart from nothing to suggest a tendency to self-harm in a longitudinal assessment of Freddy's illness, clinical staff noted no unusual behaviour *for him,* in the period immediately preceding his death.[52] Significantly, Mrs Williamson did not notice anything unusual or concerning about her son's behaviour when she and Mr Williamson took him on their regular outing the day

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[46] Exhibit WWW paragraphs 12-13. Also transcript page 1195 where Professor Cordner concedes that if there was blood in the bag, Freddy must have been bleeding while it was over his head, but otherwise has nothing to say about when the bag may have been placed there.

[47] Statement of Dr Peter Bosanac dated 10 July 2008, Exhibit B (pages 5-8 of the inquest brief) and transcript page 39. Statement of Dr Julian Davis dated 1 August 2008, Exhibit C (pages 9-10 of the inquest brief) and transcript pages 59 and following.

[48] Professor Cordner made this observation in the course of his evidence at transcript page 1207.

[49] Exhibit C.

[50] Transcript page 59 and following and page 97.

[51] Transcript page 59-60.

[52] Exhibits B, C.

before his death. Given her ongoing supportive relationship with her son, Dr Davis took great comfort from this evidence.[53]

48. The nature of Freddy's illness was also significant in another respect. In particular, his tendency to wander into other patients' room uninvited, and his ritualised repetitive and bizarre behaviours which were known to frustrate other patients, making him a target for negative attention. Thus, the behavioural manifestations of his illness potentially provided both a motive for someone to attack him, and interference with his ritual behaviours might lead Freddy to resistive or even aggressive behaviour that might lead to an assault by another.[54]

Access, opportunity and potential assailants

49. Even a cursory perusal of the inquest transcript will substantiate the extent to which access to Room 21, and the nature of the locking mechanism on the door were the subject of extensive scrutiny. While it may not have been apparent at the outset, it is certainly now clear that the door could be "snib-locked" by anyone leaving the room, so that it could then only be opened by someone on the inside, or by clinical staff with a key from the outside. If Freddy entered Room 21 without locking the door behind him, anyone else could have entered after him and/or anyone in the room before he entered could have locked the door and left, giving the superficial impression that Freddy was alone in the room/bathroom when he sustained his injuries.

50. As at 30 March 2008, Freddy was nursed on Standard or Level 1 observations pursuant to which clinical staff were required to sight patients at specified times during the day, and hourly overnight. During the day shift, which is of relevance to Freddy's death, these times were during handover from the outgoing night shift to day shift staff, at breakfast, lunch, dinner and during handover from the outgoing day shift to the incoming night shift staff.[55]

51. Freddy was last sighted by RPN Anita Noyan at 12.25pm in the dining room area,[56] and by RPN James Walby at about 1.00pm in the courtyard attached to the SECU where he was repeatedly pressing the igniter button of the safety light mounted on the outside courtyard wall.[57] As RPN

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[53] Transcript page 109.

[54] In final submissions dated 8 October 2013, Dr Keeling succinctly summarises the state of the evidence at page 27.

[55] Dr Lakshmana's evidence at transcript page 123-126. Also Dr Bosanac's evidence at transcript page 37 and Dr Davis' at transcript page 56.

[56] Statement of RPN Anita Noyen dated 27 July 2008, pages 31-32 of the inquest brief, Exhibit A13.

[57] Statement of RPN James Walby dated 29 July 2008, Exhibit K and transcript page 218.

Flynn found Freddy in the bathroom at about 2.30pm, these sightings leave a window of opportunity of about one and a half hours.

52. Although the evidence does not support a finding that Freddy was known to be at risk from any particular patient, there were a number of patients in the SECU at the time had a propensity for violence. Dr Davis[58] identified patients who fell within this category. In light of the suppression order I made to protect the identities of SECU patients, I will not repeat his evidence here.

53. It should be noted however that Freddy's assailant of 24 March 2008 was still being "specialled" on 30 March 2008[59] as a consequence of the attack, and can be excluded as a potential assailant. The patient residing in room 21, was elderly and frail and can also be excluded with some confidence. Of course, the group of potential assailants, is not restricted to those with a known propensity for violence, and includes anyone with access to the SECU between about 1.00pm and 2.30pm that day.

Blood at the scene

54. The failure to arrange a proper forensic scene assessment was an irremediable failure of the original police investigation. Nevertheless, scene photos and other material was provided to Mr Maxwell Kevin Jones, Forensic Officer from the Victoria Police Forensic Services Centre, and he provided an expert opinion about what could be reasonable inferred from the blood stains as depicted in the scene photos, and what could not.[60]

55. In summary, Mr Jones was of the view that while the bloodstains as depicted could be accounted for by the actions of Freddy alone under particular circumstances, it is not possible to exclude the presence of another person from the scene on the basis of the bloodstains. Mr Jones identified bloodstain evidence that indicated that Freddy may have remained low to the floor for some time, possibly seated or kneeling while bleeding, before either falling against the wall adjacent to the toilet roll holder, or expirating blood from the nose or mouth onto the same wall and the floor below. If the plastic bag was over Freddy's head at the time, it would have had to

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[58] Transcript pages 106-107. Note JH should be excluded as she had been transferred out of SECU on 28 March 2008.

[59] He had one-on-one nursing around the clock. RPN James Walby was specialling AK during the day shift and he was relieved by RPN Peter Flynn over lunch. Exhibits K & L and N respectively.

[60] Mr Jones' 13 page statement dated 22 December 2011, Exhibit NNN (pages 151-165 of the inquest brief). See also Exhibit OOO, bundle of documents produced by him.

be perforated to a significant extent or arranged in such a way that the blood could escape and result in the pattern of bloodstains, and this explanation belies asphyxia.[61]

56. At inquest, Mr Jones testified that even with the poor quality of the photos, the lack of blood staining on Freddy's hands makes it most improbable that any of the blood deposits came from his hands.[62] Moreover, the lack of blood staining on the upper surfaces of Freddy's shoes indicates that he was kneeling or lying on the floor while the blood was being projected onto bathroom surfaces and thereby shielding his shoes as well as the floor.[63] Mr Jones was also of the opinion that the rivulets of blood running down the wall to the left of the toilet roll holder and pooling on the floor, are likely to have come from a source at or below the height of the toilet roll holder, lending more weight to the idea that Freddy was seated or kneeling (rather than lying) on the floor when those bloodstains were made.[64]

CONCLUSION

57. It is settled law that the <u>standard of proof for coronial findings</u> of fact is the civil standard of proof, on the balance of probabilities, with the Briginshaw gloss or explication.[65] Applying that standard, to the evidence before me, <u>I find that the weight of evidence supports a finding that Freddy's injuries were not self-inflicted and that he died in circumstances of an assault by a person whose identity I am unable to ascertain.</u>

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[61] I have paraphrased to an extent Mr Jones' conclusion at page 11/13, Exhibit NNN.

[62] Transcript pages 1073-1074.

[63] Transcript page 1079. Mr Jones referred to this process as "satelliting", testifying that the existence of an area devoid of blood spatter in an area that otherwise had a continuous bloodstain pattern also indicated that Freddy was shielding the floor.

[64] Transcript pages 1087-1088. Mr Jones testified that optimally, crime scene investigators should have been called to the scene, that the quality of photographs taken by specialists from FSC would have enabled better analysis of bloodstains and examination of the plastic bag/bin liner would have been critical to the investigation – transcript pages 1071-2, 1075-1078 and 1094.

[65] *<u>Briginshaw</u> v <u>Briginshaw</u> (1938) 60 C.L.R. 336 - "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."* This is the passage from the judgement of Dixon, J that is often quoted in this context. Note also the following from his judgement – *"The truth is that, when the law requires proof of any act, the tribunal must feel an actual persuasion of its occurrence or existence before it can be found. It cannot be found as a result of a mere mechanical comparison of probabilities independently of any belief in its reality.* Note also the dicta of Rich, J – *"The nature of the allegation requires as a matter of common sense and wordly wisdom the careful weighing of testimony, the close examination of facts proved as a basis of inference and a comfortable satisfaction that the tribunal has reached a correct and just conclusion."*

58. As I have formed the belief that an indictable offence may have been committed in connection with Freddy's death, a literal reading of section 49[66] requires referral of this matter to the Director of Public Prosecutions. Although recognising that, in the absence of an identified assailant, referral to the DPP may be futile, I feel obliged to make the referral.[67]

ADEQUACY OF THE POLICE INVESTIGATION

59. As mentioned above, D/Sgt Solomon review the police investigation and provided a memorandum dated 17 May 2011 identifying deficiencies and several avenues for further investigation. The Solomon review, his evidence at inquest, to a lesser extent the evidence of Mr Jones, and the "Joint Acknowledgements / Agreed Facts as between the Family and the Members"[68] obviate the need for a detailed repetition of the inadequacies of the police investigation.

60. However, as the inquest was held in public and this finding is to be published, the public interest requires at least a summary, in the interests of accountability and transparency. While I have considered the evidence in its totality in light of the final submissions of all Counsel in this regard, I have relied heavily on the submission of Ms Hinchey, Counsel Assisting me, as accurately reflecting the state of the evidence.

D/Sgt Solomon's evidence

61. It is important to say that neither D/Sgt Solomon's review, nor his evidence at inquest were challenged. The main failures he identified and key comments he made in D/Sgt Solomon's review[69] were as follows:

    a. D/Sgt Solomon was unable to accept that the attending members were entitled to conclude, with certainty, that the death of Freddy was a probable suicide, given the information available to them on their initial attendance;

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[66] Section 49(1) provides that *"The principal registrar must notify the Director of Public Prosecutions if the coroner investigating the death or fire believes an indictable offence may have been committed in connection with the death or fire."* The established practice in this jurisdiction, with rare exceptions, is to do so at the conclusion of the inquest, after delivery of a finding.

[67] I note that Section 57 certificates protect the testimony of each of the members represented by Mr Ihles (Cooper, Michel, Henderson, McMorron and Yates). The effect of the certificates is that evidence given by them cannot be used against them in any proceeding in a court or before any person or body authorised by a Victorian law, or by consent of parties, to hear, receive and examine evidence, other than in criminal proceedings in respect of the falsity of the evidence (perjury).

[68] These were Appendix A to the submissions of Mr Ihle and for convenience, will be Appendix A to this finding.

[69] Exhibit MMM.

b. a prudent approach would have been for the scene to have been properly secured and treated as a potential crime scene;

c. the attending crime investigators should have exercised far more leadership and taken control of the scene rather than handing it over to untrained uniform members and should have had far more input into the investigation which followed;

d. the callout of forensic crime scene specialists when the deceased was still *in situ,* may well have yielded valuable information that could explain and number of the anomalies that are now evident;

e. Freddy and his devoted family deserved far better service than they received;

f. quality control processes concerning the management and completion of the investigation failed on all levels;

g. D/Sgt Solomon recommended that the investigation be re-assigned to the original crime scene investigators and that they complete a proper and thorough investigation into Freddy's death, addressing the failures identified.

62. At inquest, D/Sgt Solomon expanded on his review. He stressed that the scene was not an ordinary or routine death scene, but one that was extremely unusual, disturbing and complicated.[70] It was absolutely not possible to conclude with any certainty that Freddy's death was non-suspicious. Further investigation was definitely required because of the number and distribution of Freddy's injuries,[71] the quantity and distribution of blood within the bathroom given the presence of the plastic bag[72] and the possibility that items within the bathroom may have been disturbed.[73] These features of the scene combined with the information that there had been recent unrest within the SECU, that Freddy had been subjected to two recent assaults, and that he had been found in the bathroom of another patient, all pointed to the need for further investigation.[74]Forming a theory about events and then gathering evidence to support that theory was the exact opposite of what is required of an investigator, that is, search for the truth by keeping an open mind, and exploring all possibilities before settling on a theory. This is

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[70] Transcript pages 1543, 1549 and 1565.

[71] Transcript pages 1543, 1549 and 1565.

[72] Transcript pages 1541-1542.

[73] Transcript page 1542. This was a reference to the toilet brush and its holder that were lying on their side and may have been knocked over in a struggle/disturbance.

[74] Transcript page 1542.

fundamental and is taught on day one in detective training.[75] In D/Sgt Solomon's view, the "key failing" in the investigation by Detectives Cooper and Michel was that there was insufficient investigation in the first place, to allow them to reach the conclusion that the death was non-suspicious.[76]

63. As regards the suggestion that Detectives Cooper and Michel appeared to have founded their assessment of the scene on information to the effect that the room was locked, Freddy was alone and the lock could only be engaged from the inside, D/Sgt Solomon's evidence was as follows:

"Q. Do you have a comment to make about the legitimacy of that approach...that the detectives took on the day?

A. I can't see how establishing the locking mechanism of the door would have then enabled the person to come to a conclusion that it was non-suspicious with all of the other evidence and aspects of the crime such as the blood, the multiple injuries the plastic bag...

Q. They just accepted that the door had been locked, therefore Mr Williamson had been alone?

A. If they were hanging their hat on that one aspect about the locking they needed to be pretty sure what the facts were.

Q. But [at] the very least, you would've tested to see how the door [locking mechanism worked]...?

A. Yes";[77]

64. 68. Moreover, on this point, D/Sgt Solomon said that when he spoke to the attending members in the course of his review, at no stage was the fact that the room was locked raised with him as having been a key issue, and that if it had he would have made a note. He reiterated that no matter what police were told, it was their obligation to investigate the door locking mechanism for themselves.[78]

65. Apart from the failure to recognise the potential that Freddy's death was suspicious, and the consequential failures to establish a crime scene and to request the attendance of forensic specialist ser, D/Sgt Solomon described the failure to secure and examine the plastic bag found

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[75] Transcript page 1576.

[76] Transcript page 1543.

[77] Transcript pages 1560-1570.

[78] Transcript pages Transcript pages 1618-1621.

over Freddy's head as a "catastrophic failure" for the efficacy of the investigation.[79] As disclosed by his discussions with various members, the state of the evidence as regards the plastic bag is wholly inadequate. Was it torn, how much blood did it contain, had it been secured in some way, was their a cloth inside, had it been used as a gag?[80]

66. At the very least, inquiries should have been made with patient AP in whose room Freddy was found, and patients AK and FH who had been in conflict with Freddy recently. It would have been prudent to speak to all the patients and staff in the SECU at the material time.[81]

67. During the course of his evidence, D/Sgt Solomon gave a sense of what a proper investigation of Freddy's death might have looked like, had the attending police recognised that the scene was suspicious. The attendance of crime scene examiners, members of the Homicide Squad and other specialist services would have literally locked down the scene for hours.[82] If the death had been treated as suspicious, Freddy's body would have been escorted to VIFM, a member of the Homicide Squad would have been present at the autopsy[83] and would have been advised of the autopsy findings immediately.[84] That information would then have been fed back to the investigators at the scene. Investigations into a theory such as whether the toilet roll holder was responsible for the injuries sustained by Mr Williamson in a single fall, would have been undertaken by specialist services, who would be equipped to take measurements of the item in question and compare those with measurements of Freddy's face;[85]

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[79] Transcript page 1656.

[80] Transcript pages 1555-1561. L/S/C McMorron did not see the slit she refers to in her statement. It was mentioned to her by her partner S/C Henderson on the day. S/C Henderson said he did not see the slit, doesn't known what happened to the bag, recalled seeing a cloth inside the bag and believes it was from the bathroom. He also did not know that Freddy was in the room of another patient and did not make inquiries as he was not the primary investigator. D/S/C Cooper did not inspect the plastic bag and did not see a slit in the bag. This is broadly consistent with their evidence at inquest.

[81] Transcript 1550. D/Sgt Solomon recognised the difficulties posed by the psychiatric setting but recounted his experience of a death at Thomas Embling Hospital where such an investigation was able to be managed with cooperation from the staff and sensitive handling.

[82] Transcript pages 1544,1546-1547.

[83] Note that in accordance with current practice, the autopsy would have taken place as soon as possible, generally within 24 hours of receipt of the body, and not as occurred some three days later.

[84] The relevant sections of the Victoria Police Manual (VPM-PR and VPM-G) are outlined in Mr Lawrie's submissions on behalf of the Chief Commissioner – pages 4-5.

[85] Transcript page 1546, see also Professor Cordner's findings having undertaken precisely such an exercise outlined in paragraphs 41 and 42 above.

68. D/Sgt Solomon was unable to explain the failure of police to recognise the need to establish a crime scene, and to proceed accordingly.[86] He made the following important points about the conduct of the various police members:

a. What the detective members faced with was straight out of their detective training school or their field investigators course.[87]

b. It was not merely a matter of the attending members failing to recognise that this was a potential crime scene, since the existence of a crime scene log (albeit an inadequate one) indicated that someone thought of this possibility.[88]

c. Given this fact, there had been a comprehensive failure to follow all Victoria Police Manual requirements about what to do <u>if a crime scene is suspected</u>.[89]

d. He would be *absolutely shattered* if he was to find out that a certain view had been taken by police because the death occurred in a psychiatric setting and that this had an effect on the way police dealt with matters *I would be absolutely mortified ...I don't know what the attitude was.*[90]

e. It was inappropriate for a junior police member like Const McMorron then was, to be left to prepare the coronial brief. A/g Sgt Yates ought to have had input into that decision. If the decision to allocate the case to Const McMorron because she was the driver on the first job, as was the suggested local practice, *it was not only inappropriate, but absolutely outrageous, totally inappropriate for a matter of this gravity where you are talking about a man's death.*[91]

f. While Const McMorron had had some input from A/g Sgt Dixon into what matters ought be included in the coronial brief, her response to that advice was totally *inadequate.* The original brief should never have Heidelberg Police Station in that state.[92]

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[86] Transcript page 1565.

[87] Transcript page 1567.

[88] Transcript page 1578. Emphasis added. The requirements are premised on members recognising the need for establishment of a crime scene.

[89] Transcript page 1578.

[90] Transcript page 1566.

[91] Transcript page 1585. Paraphrased to some extent.

[92] Transcript pages 1588-1593.

g. At the conclusion of the second investigation/review conducted by Detectives Cooper and Michel, although all further inquiries that could be expected had been completed, the failure to conduct those inquiries at an earlier time resulted in the loss of valuable evidence.

h. D/Sgt Solomon accepted Ms Hinchey's assertion that in short *"Q?... we have a chain from beginning to end... of engagements with the task that have proved to be inadequate and well below the standard that you would expect from each and every person who was responsible for the actions involved? A Sadly, yes.*[93]

CONCLUSION

69. Subjecting the available evidence to the applicable standard of proof, I find that the weight of the evidence supports a finding that the investigation was inadequate, indeed that the errors made by the police who attended the scene were largely irremediable. In arriving at the conclusion that there were no suspicious circumstances, the police ignored what should have been apparent and failed to secure the scene and ensure a thorough forensic investigation. They lost the opportunity to ascertain the whereabouts and the state of all those within the SECU at the material time. Exculpatory as well as incriminatory evidence was lost.

70. I have referred to the 'police' generically but it is appropriate to exclude Senior Constable Thompson and Constable Nutbean from any criticism due to their limited role as first responders who secured the scene initially before handing over to S/C Henderson and Const McMorron (as they were at the time). Otherwise, I find that D/Sgt Solomon's criticisms of the conduct of S/C Henderon, Const McMorron, A/g Sgt Yates (as he then was) and D/S/C James Cooper and D/L/S/C/ Tracey Michel are well-founded, and I adopt them.

71. The authorities establish that adverse coronial findings or comments should not be made lightly, and should only be made against a professional person in their professional capacity where there is a comfortable level that their negligence, unprofessional conduct or departure from the standards of their profession has been established as contributing to the death.[94] Of course, there is no possible causal connection between the failures of these five police members and Freddy's death. Nevertheless, as a consequence of a death investigation that was seriously flawed in a manner that cannot now be remedied, I am unable to find all the relevant

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[93] Transcript page 1617.

[94] *Anderson v Blashki [1993]2V.R.89, per Gobbo, J; Secretary to the Department of Health and Community Services and Ors v Gurvich (1995)2V.R.69, per Southwell, J; Chief Commissioner of Police v Hallenstein [1996]2V.R. 1.*

circumstances in which Freddy's death occurred, namely who was involved in his death and why his life was taken.

72. The evidence does not enable me to determine why this investigation went so terribly awry. It is difficult to imagine that police members attending a similar scene in a public access bathroom or toilet, or even in a domestic setting, would so readily discount the possibility of suspicious circumstances. It is equally difficult to imagine if called out to, say, a theft at business premises, that they would have failed to ascertain by *investigation* how the door locked and/or established who had keys, and accounted for them. I do not suggest anything deliberate or even conscious on the part of the police members who attended the scene, but absent another explanation for their failure to recognise a potentially suspicious scene, leaves open the possibility that the setting in which Freddy died may have played a role.[95]

COMMENTS

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

1. Although there is no basis for adverse finding or comment regarding the clinical management and care provided to Freddy by Austin Health, it is appropriate to acknowledge that Austin Health has implemented a number of changes in the SECU since Freddy's death. These include the use of paper bin liners in place of plastic ones, patients have a daily risk assessment and a critical incident review is undertaken following a significant adverse event, medical staffing levels have increased, and a designated clinician/case manager is allocated to oversee longitudinal management and care of each patient.

2. At the risk of internal inconsistency, despite my conclusions about the inadequacy of the police investigation, I do not propose to address any recommendations to the Chief Commissioner of Police. It is apparent from D/Sgt Solomon's evidence which I accept in its entirety, that this was not a situation where Victoria Police systems and training were found wanting, but one where the individual Members' competence fell below the standard required of them.

3. The Williamson family's determination to see justice done for Freddy in pressing for further investigation of his death has again highlighted that the integrity of the coronial system relies

[95] See transcript page 1566 where this is raised with D/Sgt Solomon.

heavily on the police as its primary investigators, whether or not concomitant criminal proceedings are envisaged. I reiterate comments made earlier this year,[96] that is that –

"While some evidence is not time critical or time sensitive, and can be obtained in the days, weeks or even months following a death without compromising the integrity of the investigation, scene examination is not. Where indicated, scene examination requires scene containment, timely action and specialist services. In an ideal world with limitless resources, a case could be made for treating all apparent suicides as homicides, until homicide can be reasonably excluded. As matters stand, the coronial system relies on assessments made by the police officers who are dispatched to the scene, applying their training and experience to make an appraisal of the scene. It is only where they perceive suspicious circumstances or the potential for suspicious circumstances, that additional police resources are requested, be it from Forensic Services, one of the Crime Investigation Units or the Homicide Squad.

4. During the inquest, Counsel for the Family and Counsel for the Members indicated that they were making efforts to arrive at a joint acknowledgement or agreement of facts. The Joint Acknowledgement/Agreed Facts as between the Family and the Members referred to above is indeed a helpful document containing appropriate concessions by the Members regarding their joint and several failings and accurately reflects the Members' evidence. In the coronial jurisdiction, therapeutic interventions and appropriate professional reflection are encouraged, and all the parties involved are commended for their efforts in this regard.

[96] Finding in relation to the death of Sibel YILMAZ (2009 4452) delivered on 12 February 2014. I should note that, although the family in this matter raised concerns about suspicious circumstances, I found no evidence to support such a finding.

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

The Williamson Family

Ms Pauline Chapman, Austin Health

The Chief Commissioner of Police

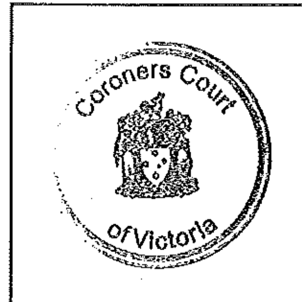
Detective Sergeant Sol Solomon

Dr Mark Oakley Browne, Chief Psychiatrist

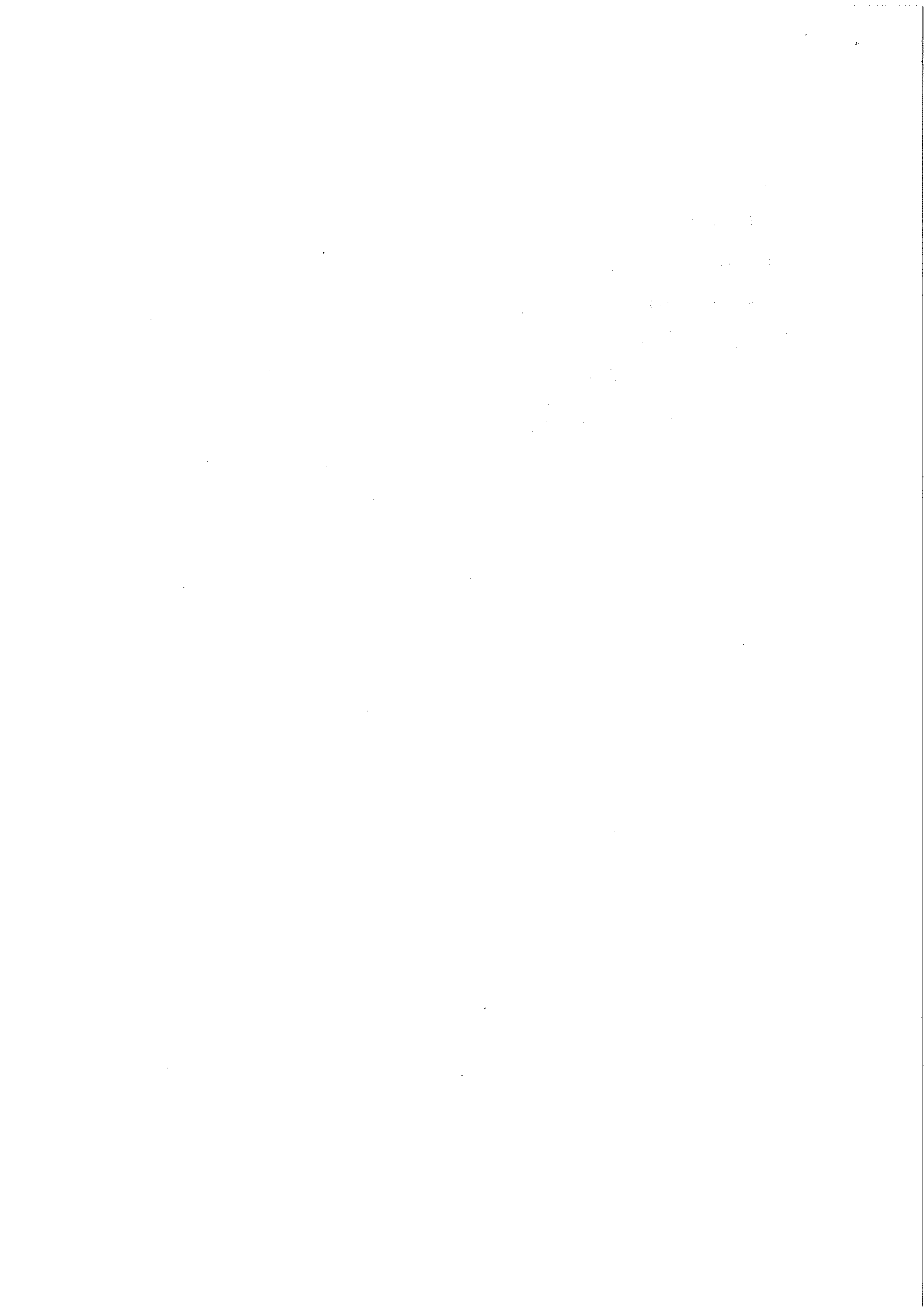
Each of the Members c/o Lander & Rogers

The Director of Public Prosecutions (Victoria).

Signed:



PARESA ANTONIADIS SPANOS
Coroner
Date: 4 August 2014



APPENDIX A

In the Coroners' Court of Victoria
at Melbourne

No. 1300 of 2006

In the matters of:

An inquest touching upon the death of Frederick Williamson

Joint Acknowledgments / Agreed Facts as between Family and the Members

- Each of the police members failed to adequately check and/or conduct investigation as to a significant matter of which they were advised (i.e. locking mechanism of door). Their untested belief misinformed their interpretation of the scene and thus the direction of their investigation.

- There were shortcomings by each member individually, as well as collective shortcomings.

- The deficiencies in the investigation deprived court of relevant evidence and have deprived the family of a proper explanation of what happened to their loved one.

- The scene in which Mr Williamson was found was much more complicated than appreciated by the members at the time of their attendance. It warranted much more thorough investigation and consideration.

- The death occurred in apparently unusual circumstances and should not have been deemed as non-suspicious so readily.

- The incident was originally considered to be suspicious and treated as a crime scene. A police officer was assigned to guard the scene and CIU officers were called in accordance with police protocols. However, upon arrival of the CIU the police view of the scene changed and the incident was determined to be not suspicious. This view was misconceived. It should have

remained to be considered a crime scene and the Victoria Police protocols relating to crime scenes should have been applied, but were not.

- Greater consideration should have been given to the calling for assistance from specialist services including Crime Scene officers and Homicide Squad.

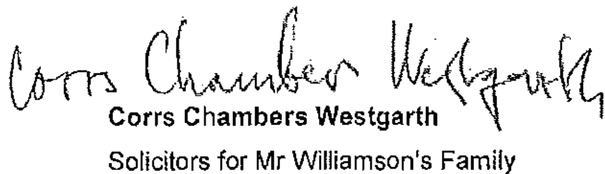
- Evidence that was not preserved or seized may have deprived this court of an ability to come to precise findings regarding the mechanism of death. This has added to the anxiety and distress of the Williamson family.

- Notes/records of the scene by some of the members were not as thorough as they ought to have been.

- CIU (Michel and Cooper) did not take sufficient leadership of investigations at the scene (regarding photos and determining who was on the ward at the time of death).

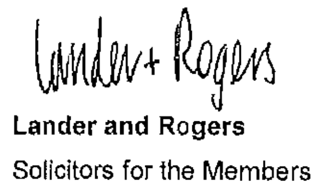
- CIU (Michel and Cooper) neglected to contact the family when they were sent the matter for reinvestigation – It is accepted that they should have.

DATED: 19 December 2013



Corrs Chambers Westgarth

Solicitors for Mr Williamson's Family



Lander and Rogers

Solicitors for the Members