IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 0354

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	**BRETT MCDONNELL**
Date of birth:	27 JULY 1982
Date of death:	21-22 JANUARY 2018
Cause of death:	HANGING
Place of death:	301/201 BUCKLEY STREET, ESSENDON VICTORIA 3040

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HIS HONOUR:

BACKGROUND

1. Brett Jeffrey McDonnell was 36 years old when he died from hanging between 21-22 January 2018. Precisely when Mr McDonnell died is not known and cannot be ascertained. Immediately prior to his death, Mr McDonnell lived alone at Unit 301/201 Buckley Street, Essendon.

2. At the time of his death, Mr McDonnell was subject to a twelve-month Community Corrections Order (**CCO**). He was also scheduled to appear at the Magistrates' Court at Broadmeadows on 1 & 2 February 2018, in relation to various criminal charges.

3. Mr McDonnell was a carpenter by trade and, at the time of his death, worked as a construction leading hand.

4. Mr McDonnell was the oldest of three siblings; he had a younger brother and sister who were twins. Mr McDonnell's parents divorced when he was eight years old. His mother, Nola McDonnell provided a statement to police in which she stated that Mr McDonnell was very close to his maternal grandfather who became his *'surrogate dad"*. Following his grandfather's death, Mr McDonnell became aggressive and violent and eventually went to live with his paternal grandparents.

5. After completing Year 11 at Essendon Keilor College, Mr McDonnell completed a carpentry apprenticeship and when he was 17-18 returned to live at home. Mrs McDonnell stated that Mr McDonnell then became a bit of a *"drifter, coming and going"*, at times living at home, at times with his father and then he moved to Queensland where he lived for five years, working in construction jobs. Mr McDonnell also participated with a group of male performers and sustained an injury to his neck (a fracture to C7[1]) during a practice session. Mrs McDonnell stated that, as a result of the injury, Mr McDonnell was unable to work, pay his rent or car payments and was more-or-less homeless for six months.

6. Around this time, Mr McDonnell commenced a relationship and moved to Perth with his partner where they lived for twelve months. When the relationship ended in December 2013, Mr McDonnell moved back to Melbourne. His mother attributed Mr McDonnell's subsequent depression to the relationship breakdown and said that:

[1] The seventh cervical vertebra located in the neck.

"It took him a good 2 years to get over her. To my knowledge, he didn't go and speak to anyone about his mental health".

7. Mr McDonnell continued to move around, living for periods with his father, his mother and at his late grandmother's house. One short romantic relationship ended badly, apparently resulting in a family violence intervention order (**IVO**) (see paragraph 29 below) after which Mr McDonnell moved back to live with his mother for two years.

8. In July 2017, Mr McDonnell commenced a relationship with AB. AB provided a statement to the Coronial Investigator in which she described the relationship with Mr McDonnell as getting off to a promising start. In September 2017, Mr Mc Donnell moved into an apartment on his own in Essendon and shortly afterward AB moved in with him. Frequent arguments ensured and after about four weeks AB moved out although she maintained the relationship with Mr McDonnell.

9. AB stated Mr McDonnell commenced attending a Men's Behavioural Change Program in Richmond on a weekly basis for twelve weeks[2]. She did not provide any details regarding when the course started. She stated that:

"Before the course, Brett didn't realise that he was yelling at me and calling me names but when he started the course, he became more mindful of what he was saying to me and we started arguing less".

10. AB said she was aware that Mr McDonnell suffered from depression which, he told her, commenced following his neck injury. She was also aware that he had previously had an addiction to methamphetamine, which, he told her, he had overcome.

11. AB stated that, in December 2017, Mr McDonnell was served with "*paperwork related to an intervention order*" She stated that the complainant was a former girlfriend who, she understood:

"...had made up the whole story to get the intervention order. Brett was really stressed about it because he was going to have to pay a solicitor $5,000 to fight it in court.".

12. In her statement to police Mr McDonnell's mother said that around Christmas 2017:

"Brett seemed OK. I spent Christmas Day with him and he seemed great".

[2] Attendance at this Program was a condition of Mr McDonnell's CCO and was completed by 15 December 2017.

13. Mrs McDonnell stated that, on 19 January 2018, Mr McDonnell called her to discuss legal issues he was having and that he was upset about the costs involved.

Medical history

14. On 17 August 2015, Mr McDonnell attended Dr Mehraz Chowdury a general practitioner at Coolaroo Clinic, requesting a prescription for Pristiq.[3] He told Dr Chowdury that he *"normally gets it from his GP in Caroline Springs but has not seen him for a while"*. Dr Chowdhury appears to have accepted what he was told and provided Mr McDonnell with a prescription (Pristiq 100mg) as requested.

15. On 10 December 2015, Mr McDonnell attended a consultation with Dr Muy Lim at Coolaroo Clinic. Dr Lim's notes for the consultation incidentally record that Mr McDonnell was using anabolic steroids.

16. On 3 February 2016, Mr McDonnell attended a consultation with Dr Andrew Ramsay at Coolaroo Clinic complaining of problems with sleep, appetite, concentration, fatigue, restlessness and feeling edgy related to *"family issues"*. Dr Ramsay completed a Mental Health Care Plan, referred Mr McDonnell to a psychologist and provided him with a prescription for Pristiq. There is no evidence that Mr McDonnell ever acted on the referral to a psychologist at that or any other time.

17. On 21 June 2016, Mr McDonnell attended a consultation with Dr Muy Lim at Coolaroo Clinic and told Dr Lim that he was keen to wean off Pristiq as he did not feel that he needed it but felt agitated when taking a reduced dose (which he achieved by halving the 100mg strength tablets). Dr Lim provided Mr McDonnell with a prescription for Pristiq 50mg and discussed the need to slowly wean himself from the medication.

18. On 25 July 2016, Mr McDonnell had further discussions about the problem of side effects associated with withdrawal from Pristiq with Dr Anna Middleton at Coolaroo Clinic. She advised him that it was fine to keep taking Pristiq for the time being if everything was going well.

19. On 26 December 2016, Mr McDonnell attended Dr Al-Taheb at Coolaroo Clinic to request a repeat prescription for Pristiq. Dr Al-Taheb recorded that Mr McDonnell was doing well and that his condition was stable. Dr Al-Taheb provided a prescription for Pristiq 100mg.

[3] Antidepressant medication

There is nothing recorded about the consultation that day to indicate Mr McDonnell's previously stated desire to wean from Pristiq nor any discussion about the earlier prescription for a lower dose.

20. At a consultation with Dr Nataliya Lischenko at Coolaroo Clinic on 20 May 2017, Mr McDonnell asked for advice about ceasing Pristiq and told Dr Lischenko he was not interested in attending a psychologist for the time being. Dr Lischenko advised him to wean himself slowly from Pristiq however, a repeat prescription was apparently not requested nor required at this consultation and it is not known what strength Pristiq Mr McDonnell was taking during this time. On 5 June 2016 however, Dr Lishchenko provided a prescription for the lower dose, 50mg.

21. During June and July 2017, Mr McDonnell attended consultations with Dr Lischenko for, inter alia, injection of dermal fillers into naso-labial folds on his face, and an infection arising from that procedure. Contrary to Dr Lischenko's advice, Mr McDonnell believed that more filler was required. Following Mr McDonnell's final consultation at the Coolaroo Clinic on 26 July 2017, Dr Lischenko recorded in her notes of the consultation that Mr McDonnell was very unhappy and *"almost lost his temper"*. She recommended he seek review by another cosmetic physician, and recorded the possibility of Body Dysmorphic Disorder[4], "*? Obsession, ?Anger/Frustration*". There is no record of discussions about Pristiq during that consultation, however the prescription provided by Dr Lischenko on 5 June 2016 included 5 repeats which should have been sufficient until December 2017. Mr McDonnell did not return to the Coolaroo Clinic.

22. On 6 December 2017 and 12 & 17 January 2018, Mr McDonnell attended consultations at SIA Medical Centre in Essendon. Dr Vishakentegowda provided a statement to the CI on behalf of the SIA Medical Centre. He stated that on 6 December 2017 Mr McDonnell attended a consultation to request repeat prescriptions of Voltaren and Pristiq (50mg). He stated that Mr McDonnell gave a history of taking Pristiq since 2016. Neither of the doctors attended by Mr McDonnell at SIA Medical Centre conducted any psychological assessments of Mr McDonnell. Both appear to have taken the history given of depression and treatment at face value.

[4] A mental condition involving an obsessive focus on a perceived flaw in appearance.

23. On 12 January 2018, Mr McDonnell complained of anxiety related insomnia and was given a prescription for temazepam. On 17 January 2018 he complained of a painful right wrist of three days' duration. He was not seen again at SIA Medical Centre.

Forensic history

24. Mr McDonnell's forensic history commenced in 2001at the age of 19. He was charged in relation to a set of *"knuckle dusters"* and an iron bar located in his car. Mr McDonnell undertook a diversion program.

25. In 2008, Mr McDonnell was arrested following a fight at a nightclub resulting in serious injuries to an unknown number of other patrons. He was charged with possession of ecstasy and intentionally causing injury. Mr McDonnell did not attend court and a warrant was issued for his arrest. The warrant was executed on 26 August 2016 and was listed for hearing in 2018 – the gap between the execution of the warrant and hearing date was due to Mr McDonnell move to Queensland.

26. Also in 2008, Mr McDonnell was charged in relation to an assault on a fellow worker at a construction site, resulting in injury to the other worker. Mr McDonnell was charged with intentionally causing injury and the matter was resolved by payment of a fine.

27. Between 2010 and 2012, Mr McDonnell, then living in Queensland, was convicted of *"assaults occasioning bodily harm whilst in company*". He was sentenced to 12 months imprisonment suspended for 18 months. He was subsequently charged with 2 separate counts of breaching bail conditions, however convictions were not recorded in relation to the breaches; Mr McDonnell was fined.

28. In November 2015, Mr McDonnell instigated a road rage incident which resulted in a collision with another vehicle. When Mr McDonnell and the other driver pulled over to exchange details, Mr McDonnell punched the other driver several times in the face resulting in an eye injury. As a result, Mr McDonnell was charged with intentionally causing injury and criminal damage. He was convicted of criminal damage and sentenced to 7 days imprisonment. The assault charge was withdrawn.

29. On 10 January 2017 and in breach of an IVO Mr McDonnell attended at a former girlfriend's home, twice during the night.

He was charged with a breaching the intervention order and sentenced to 7 days imprisonment. On 27 January 2017, Mr McDonnell again breached the IVO by sending the same former girlfriend a text message.

30. On 25 September 2017 Mr McDonnell attended a hearing in the Magistrates Court of Victoria in relation to the above and various criminal offences including recklessly causing injury, criminal damage and persistent contravention of an IVO. He was convicted and sentenced to seven days imprisonment and a twelve-month CCO to commence immediately upon release. He appealed the verdict to the County Court of Victoria and was granted bail.

31. On 29 November 2017, Mr McDonnell abandoned his appeal and was taken into custody. He served seven days imprisonment at the Melbourne Assessment Prison (**MAP**) between 29 November and 5 December 2017. On his release on 5 December 2017, he commenced the 12-month CCO, reporting to Broadmeadows Community Correctional Services (**CCS**). He was also required to undergo the Men's Behaviour Change Program.

JARO and Corrections Victoria (CV) Involvement

32. When Mr McDonnell was taken into custody on 29 November 2017, a Mental Health Professional Prisoner Summary was undertaken. On his release on 5 December 2017, Mr McDonnell attended an "*induction appointment*" at Broadmeadows CCS. On this occasion he was noted to be stressed and "*overwhelmed*". He advised CCS that he was taking medication for depression. Mr McDonnell attended subsequent appointments with his case manager at CCS on 12, 20 and 28 December 2017 and 11 January 2018

33. On 19 December 2017, Mr McDonnell's risk of re-offending was assessed. He was identified as presenting at medium risk for re-offending and scored high risk levels for family/marital, companions and pro-criminal attitude/orientation. The assessment also indicated that his strengths were in maintaining employment and avoiding alcohol and drugs, *"whilst noting his depression and engagement in denial/minimisation responses"*.

34. JARO subsequently conceded that because Mr McDonnell was assessed as being at medium risk of re-offending he should have been allocated an Advanced Case Manager but he wasn't.

35. A 'Corrections Victoria Suicide and Self-Harm Risk Screening Checklist Suite' was also completed by the case manager on 19 December 2017 and the:

"overall screening test results showed a negative result for the three tests screened, indicating that Mr McDonnell was unlikely to have a depressive illness or serious mental illness and expressed no suicidal ideation tendencies"

36. The Broadmeadows CCS "Suicide & Self-harm Risk Screening Suite" was clearly inaccurate; Mr McDonnell had already advised CCS of his pre-existing depression and ongoing treatment with antidepressant medication.

37. I note that around the time/s Mr McDonnell was being assessed by CCS and/or attending meetings with his case manager, he was also being seen by GPs at SIA Medical Centre seeking prescriptions for Pristiq (6 December 2017) and complaining of insomnia (12 January 2018)

THE CORONIAL INVESTIGATION

Coroners Act 2008

38. Mr Mc Donnell's death was a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (**the Act**) because his death having occurred in Victoria, was unexpected, appears to have resulted from an accident or injury and/or not from natural causes.[5]

39. The Act requires a coroner to investigate reportable deaths such as Mr McDonnell's and, if possible, to find:

    (a) The identity of the deceased;

    (b) The cause of death; and

    (c) The circumstances in which death occurred.[6]

40. For coronial purposes, "*circumstances in which death occurred*",[7] refers to the context and background to the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death relevant circumstances are limited to those which are sufficiently proximate to be considered relevant to the death.

[5] *Coroners Act 2008* (Vic) s 4.
[6] *Coroners Act 2008* (Vic) preamble and s 67.
[7] *Coroners Act 2008* (Vic) s 67(1)(c).

41. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[8] It is not the Coroner's role to determine criminal or civil liability,[9] nor to determine disciplinary matters.

42. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through comments made in findings and by making recommendations.

43. Coroners are also empowered to:

    (a) Report to the Attorney-General on a death;[10]

    (b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[11] and

    (c) 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.[12]

Standard of Proof

44. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[13] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[14] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of proof; there is no such thing as a "*Briginshaw Standard*" or "*Briginshaw Test*" and use of such terms may mislead.[15]

45. Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[16] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[17] Proof of facts

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[8] *Keown v Khan* [1999] 1 VR 69.
[9] *Coroners Act 2008* (Vic) s 69 (1).
[10] *Coroners Act 2008* (Vic) s 72(1).
[11] *Coroners Act 2008* (Vic) s 67(3).
[12] *Coroners Act 2008* (Vic) s 72(2).
[13] (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
[14] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.
[15] *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].
[16] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[17] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the content of the finding based on those facts.[18]

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

Identity of the Deceased - Section 67(1)(a) of the Act

46. On 22 January 2019, AB identified the deceased as her boyfriend, Brett McDonnell, born 28 July 1982.

47. Mr McDonnell's identity is not in dispute and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

48. On 23 January 2018, Dr Heinrich Bouwer, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an external examination upon Mr McDonnell's body. Dr Bouwer provided a written report, dated 13 March 2018, in which he opined that the cause of Mr McDonnell's death was '*Hanging*'. I accept Dr Bouwer's opinion.

49. Toxicological analysis of post-mortem samples detected the presence of ethanol (alcohol) 0.09g/mL, methylamphetamine[19], and the following medications which had been prescribed to Mr McDonnell over the preceding 12 months: desmethylvenlafaxine, temazepam[20], oxazepam[21], diazepam [22]and nordiazepam.

Circumstances in which the death occurred - Section 67(1)(c) of the Act

50. On 20 January 2018, Mr McDonnell had an argument with AB during which he pushed her against a wall and grabbed her arm, leaving a bruise. That evening the couple went to dinner at his mother's house. AB stayed at Mr McDonnell's apartment that night, but feeling uneasy about the relationship, went home the following day.

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[18] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.

[19] A powerful highly addictive stimulant also known as ICE".

[20] Pristiq

[21] Benzodiazepine used to treat insomnia

[22] Benzodiazepine

51. On the evening of 21 January 2018, AB spoke to Mr McDonnell by phone and asked him for some *"space"*. They continued to send each other text messages, those from Mr McDonnell escalating until AB eventually blocked his number.

52. At approximately 8pm, Mr McDonnell attended at AB's apartment in Essendon. When she refused to let him in via the main entrance, he climbed three floors and entered her apartment via the balcony. AB locked herself in her room but Mr McDonnell forced the door open. AB described him as being in hysterics, crying and begging her not to leave him. He eventually asked her to tell him if the relationship was over to which she replied that it was over, whereupon Mr McDonnell left her apartment.

53. On the morning of 22 January 2018, AB sent text messages to Mr McDonnell's mother and his neighbour asking them to check on him.

54. At approximately 10.30am, Mr McDonnell's neighbour responded saying that he had knocked on Mr Mc Donnell's door but there was no answer.

55. Mrs McDonnell stated that, on receipt of the text message from AB, she called Mr Mc Donnell and sent him a message at approximately 10.15am but received no response. She assumed he was at work - it was not uncommon for him not to respond.

56. At 7.50pm, AB went to Mr McDonnell's apartment and let herself in. She located Mr McDonnell hanging by a dog lead in the wardrobe. She tried to take his weight by lifting him while telephoning Mr McDonnell's neighbour for assistance. Other neighbours, responding to AB's screams, attended at the apartment and cut the dog lead allowing Mr McDonnell to be lowered to the floor. Emergency services were notified and paramedics who attended shortly afterwards declared Mr McDonnell deceased at the scene.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

57. Mr McDonnell sought help from medical practitioners for depression from at least 2015, however, it appears that he was less than forthcoming in providing meaningful history which would have allowed appropriate assessment. Dr Ramsay referred Mr McDonnell to a psychologist, but Mr McDonnell failed to act on the referral. In 2016, when Dr Lischenko again raised referral to a psychologist, Mr McDonnell indicated that he was not interested. This lack of engagement with his treating medical practitioners doubtless deprived Mr McDonnell of the opportunity to improve his mental health thereby equipping him to better withstand the stressors to which he was subjected.

58. I note the inaccurate Broadmeadows CCS "Suicide and Self-harm Risk Screening Suite' ("Suite") assessment and JARO's concession that an Advanced Case Manager should have been allocated to Mr McDonnell.

59. CV advised me that the decision to allocate an Advanced Case Manager is based on the type of sentence being served, in this case, a term of imprisonment combined with a CCO:

> *"The ACM role was primarily established in response to the rapid growth in the number of CCOs combined with imprisonment orders recognising that these offenders are often more complex to manage than offenders who are sentenced to a supervised court order alone, having transitional support needs associated with having spent time in custody immediately prior to commencing their order. They also have significantly lower success rates in completing their supervised court order"*

60. Regretably and despite the opportunity, CV provided no explanation for why Mr McDonnell was not allocated an Advanced Case Manager.

61. The Broadmeadows CCS "Suicide and Self-harm Risk Screening Suite" (**the Screening Suite**) is a three-page document that requires the person administering it to ask a number of simplistic questions and do little more than check a number of boxes.

62. CV advised me that CCS staff undergo a one-day training program (facilitated by Forensicare) on "*Understanding suicide and self-harm"* as part of the Order Administration program and Offender Management 1 Program. CV also advised me that, in Mr McDonnell's case, the Screening Suite as applied to him was negative and "*it does not appear that the case manager had any concerns".*[23]

63. I am left with the impression that administering the Screening Suite is perceived to be simply perfunctory. Simply accepting sufficient information to 'tick the right box' facilitates little insight into a person's state of mind vis-à-vis suicide or self-harm intentions. Simply accepting what may be glib answers to questions and completing the form is of very limited utility. There is no evidence in relation to how long an interview takes to complete the from, my impression from the document is that it may not be very long. The Screening Suite itself refers to the person administering it 'reading out the questions' and recording the result (largely by ticking boxes).

[23] Response from Corrections Victoria dated 30 November 2020

64. The purpose of such an interview may better be achieved through a nuanced, probing discussion that occurs over what may be more than the short period of time that it would take to read-out the questions and tick the boxes. The purpose of that discussion might usefully be aimed at gaining substantive insight into the person's state of mind as it relates to proximate self-harm and suicide threats. It is significant that the person interviewed understands that the process is more than summary. It may be that only a process such as this and insight gained can properly identify any need for support. Such a process and insight may also help to prevent inaccuracies becoming inculcated into assessments as occurred here. There is no evidence of further or additional training subsequent to the one-day training program earlier referred to. The assessment route of this tool is a particularly significant one. Periodic formal reinforcement of its significance through ongoing 'refresher' training may assist in ensuring that those to who administer it remain cognisant of its significance.

65. That having been said, it is not clear to me that even if Mr McDonnell had been provided with an Advanced Case Manager and perhaps a more thorough screening, that is more support that his untimely death would have been avoided. That conclusion does not however gainsay the assertion that the process for assessing people in Mr McDonnell's circumstances should be improved.

66. A finding that a person died as a result of suicide is a finding of great moment which can impact upon the memory of a deceased person. It can also reverberate throughout a family for generations. Such a finding should only be made on compelling evidence, not indirect inferences or speculation.

67. It is often difficult to determine what may have precipitated a person's decision to end their life. The decision is sometimes influenced by issues known only to the deceased person; sometimes events in the person's life suggest a reason. The recent hearing at the Magistrates Court, period of imprisonment, financial stress, further pending criminal charges with the potential for a custodial sentence together with the breakdown of his relationship with AB against a background of depression are likely significant factors.

68. Having considered the available evidence I am satisfied that Mr McDonnell intentionally took his own life, and that no further investigation is required. I am satisfied, having considered all of the available evidence, that no further investigation into Mr McDonnell's death is required.

FINDINGS AND CONCLUSION

69. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

(a) The identity of the deceased was Brett McDonnell, born 27 July 1982;

(b) Mr McDonnell's death occurred;

i. on 21-22 January 2019 at 301/201, Buckley Street, Essendon;

ii. from hanging; and

iii. in the circumstances described in paragraphs 50 – 56 above.

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

(a) Mrs Nola McDonnell, equal senior next of kin;

(b) Mr Jeffrey McDonnell, equal senior next of kin;

(c) Ms Michelle Gavin, JARO;

(d) Ms Erica Paddle, Community Operations, Corrections Victoria; and

(e) First Constable Yasmin Hughes, Coroner's Investigator, Victoria Police.

Recommendation

I recommend that the Corrections Victoria obtain detailed relevant professional advice about the adequacy and effectiveness of the "Suicide and Self-harm Risk Screening Suite" together with the qualifications and training of those who administer it as well as the manner in which it is administered with a view to improving insight into the state of mind of those upon whom the Screening Suite is conducted specifically in relation to the likelihood of proximate suicide and self-harm risk. Such advice ought to contemplate the best way to maximise effectiveness and efficiency and consider the utility of recommending a minimum time-period over which the Screening Suite ought to be administered and periodic 'refresher' training.

Pursuant to section 73(1) of the *Coroners Act* 2008 I direct that a copy of this finding be published on the Coroners Court of Victoria website.

Signature:

DARREN J BRACKEN

CORONER

Date: 31 DECEMBER 2020