IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 4563

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Jacqui Hawkins
Deceased:	Stanley Bruce Weaver
Date of birth:	17 July 1958
Date of death:	Between 25 August 2019 and 26 August 2019
Cause of death:	I(a) Hanging
Place of death:	Metropolitan Fire Brigade, District Command Centre, 450 Burnley Street, Richmond, Victoria, 3121

SUMMARY

1. Stanley Bruce Weaver was 61 years old at the time of his death. He lived with his wife, Gloria Weaver in Narre Warren. Mr Weaver did not have children of his own but raised his wife's two sons, Paul and Colin, from a previous relationship as his own.

2. Mr Weaver was born and raised in Frankston and upon graduating from secondary school, Mr Weaver joined the Australian Army. After his service in the Army, Mr Weaver sought out work as a security guard before joining the Metropolitan Fire Brigade (**MFB**) in 1985. During his more than thirty years of service with the MFB, Mr Weaver held several positions, notably his last position being Fire Service Communications Controller.

3. On 26 August 2019 Mr Weaver was found deceased at the MFB, District Command Centre.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame or determine criminal or civil liability.[1]

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Weaver's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

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

IDENTITY OF THE DECEASED

7. Mr Weaver was visually identified by his work colleague, Mr Ian Morris, on 26 August 2019. Identity was not in issue and required no further investigation.

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 6 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

MEDICAL CAUSE OF DEATH

8. On 28 August 2019, Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination on Mr Weaver's body and reviewed the Form 83 Victoria Police Report of Death and the postmortem computed tomography (**CT**) scan.

9. Toxicological analysis of postmortem blood detected the presence of diazepam, its metabolite nordiazepam, venlafaxine, its metabolite desmethylvenlafaxine, temazepam and oxazepam.

10. Dr Dodd reported that the external examination was in keeping with the clinical history. He provided an opinion that the medical cause of death was 1(a) *Hanging*. I accept and adopt this cause of death.

CIRCUMSTANCES IN WHICH THE DEATH OCCURED

11. On 24 July 2019 Mrs Weaver presented to Victoria Police seeking advice. She stated that she was concerned that Mr Weaver was stockpiling medication and was planning to suicide. She advised Police of his mental health history, and that he had attempted suicide several times in the past. She also reported that although Mr Weaver had never physically assaulted her, she was worried about how he would react if they separated.[2]

12. Mrs Weaver further reported that Mr Weaver was controlling and monitored her movements. In particular, she stated that he kept track of when their garage was opened using an app, and constantly questioned what she spent money on from their joint bank account.[3] A Family Violence Intervention Order (**FVIO**) was not applied for by Police on this occasion as they held no imminent concerns for the safety or welfare of Mrs Weaver.[4] Instead, Victoria Police provided Mrs Weaver with advice about obtaining a FVIO, speaking to a lawyer and calling the Police if she felt that she or Mr Weaver were in danger.[5]

13. Victoria Police arranged for a Police, Ambulance and Clinical Early Response (**PACER**) unit to attend Mr and Mrs Weaver's home later that day to conduct a mental health assessment of

[2] Statement of T Van Praag, Coronial Brief, pp 46-47; Victoria Police, LEDR Mk2 Summary Report, pp 1-2.
[3] Victoria Police, LEDR Mk2 Summary Report, p 1.
[4] Statement of O Wright, Coronial Brief, p 50.
[5] Statement of T Van Praag, Coronial Brief, p 48.

Mr Weaver.[6] When the PACER unit attended the property, however, Mrs Weaver would not let them into the home to speak with Mr Weaver and they were ultimately unable to assess him on this occasion.[7]

14. On 25 July 2019, Mrs Weaver was contacted by the Monash Health CAT Team. She advised them that she had removed the medications Mr Weaver had been stockpiling.[8] She also reported that Mr Weaver had been verbally and financially abusive towards her.[9]

15. The Monash Health CAT Team contacted Mr Weaver and visited him at home to conduct a mental health assessment with him. Mr Weaver admitted to previous depression and reported feeling better on his current medication, he was assessed as having good insight into his mental health and denied suicidal thoughts. It was assessed he did not meet the criteria for compulsive treatment and a plan was developed for him to liaise with his General Practitioner. Both Mr and Mrs Weaver were advised of numbers to contact if further concerns arose. [10]

16. On 4 August 2019 Mr and Mrs Weaver separated but remained living together under the one roof.[11]

17. On 21 August 2019 Mrs Weaver attended the Dandenong Magistrates' Court and obtained an interim FVIO against Mr Weaver.[12] The matter was adjourned to a further mention hearing on 24 September 2019.[13]

18. On 22 August 2019, a local Police member, Leading Senior Constable (**LSC**) Paul Clavering received a request to serve Mr Weaver with a notice that his shooters licence had been cancelled, as a result of the interim FVIO being issued. LSC Clavering ascertained that the FVIO had not yet been served on Mr Weaver and contacted the Dandenong Magistrates' Court who advised him that the file contained a notation that the interim FVIO was not to be served until 23 August 2019.[14] LSC Clavering was not provided with further details as to the

[6] Statement of S Becker, Coronial Brief, p 53.
[7] Statement of M Mitchell, Coronial Brief; Statement of S Becker, Coronial Brief.
[8] Statement of A Adaji, Coronial Brief, p 63; Monash Health, Medical records of Stanley Weaver, p 23.
[9] Statement of A Adaji, Coronial Brief, p 63; Monash Health, Medical records of Stanley Weaver, p 23.
[10] Statement of A Adaji, Coronial Brief, p 63; Monash Health, Medical records of Stanley Weaver, p 15.
[11] Dandenong Magistrates' Court, Application and summons for an intervention order dated 21 August 2019.
[12] Coronial Brief, extract of Family Violence Intervention Order, 147; Dandenong Magistrates' Court, certified extract of Family Violence Intervention Order dated 21 August 2019.
[13] Dandenong Magistrates' Court, certified extract of Family Violence Intervention Order dated 21 August 2019.
[14] Statement of LSC P Clavering, Coronial Brief, p 56.

reason for this,[15] although material provided subsequent to Mr Weaver's death suggests that this was to allow Mrs Weaver further time to put safety measures in place as she was concerned as to how Mr Weaver would react to being served with the interim FVIO.[16]

19. LSC Clavering attempted to call Mr Weaver and sent him a voice mail and text message asking that he contact Victoria Police in relation to the cancellation of his shooters license.[17]

20. On 24 August 2019, the interim FVIO was sent to Victoria Police to be served on Mr Weaver. LSC Clavering attended Mr Weaver's home at approximately 9.00am in the morning but no one answered the door so he left a letter requesting that Mr Weaver contact him in relation to the interim FVIO and cancellation of his shooters licence.[18] LSC Clavering attended again at 12.30pm and again received no response.[19] He then contacted Mrs Weaver who advised him that Mr Weaver should be at home and he had made contact with her which indicated that he was aware of the interim FVIO and that police wanted to speak to him.[20]

21. LSC Clavering sent a further text message to Mr Weaver indicating that he could obtain a warrant and Mr Weaver would be arrested.[21] At approximately 3.00pm, Mr Weaver attended the police station to hand in his firearm and firearms license. He reportedly stated that he was '*not impressed with being threatened'*[22] and expressed anger at the messages that had been left for him. However, after LSC Clavering explained the '*serious nature of the [FVIO] and the efforts [police were] required to make to serve it he calmed down*.'[23]

22. Later that day at approximately 4.54pm, Mr Weaver attended his MFB workplace on Burnley Street, Richmond and authored several emails to Mrs Weaver and others noting his decision to end his life.[24] A note located at the scene, dated 24 August 2019, and purportedly signed by Mr Weaver indicated that he had decided to take his own life.[25]

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[15] Statement of LSC P Clavering, Coronial Brief, p 56.
[16] Email from Dandenong Magistrates Court dated 28 August 2019, Coronial Brief, p 151.
[17] Statement of LSC P Clavering dated 26 August 2019, Coronial Brief, p 56.
[18] Statement of LSC P Clavering dated 26 August 2019, Coronial Brief, pp 56-57.
[19] Statement of LSC P Clavering dated 26 August 2019, Coronial Brief, p 57.
[20] Statement of LSC P Clavering dated 26 August 2019, Coronial Brief, p 57.
[21] Statement of LSC P Clavering dated 26 August 2019, Coronial Brief, p 57.
[22] Statement of LSC P Clavering dated 26 August 2019, Coronial Brief, p 57.
[23] Statement of LSC P Clavering dated 24 October 2019, Coronial Brief, p 60.
[24] Exhibits 7-10 - Emails sent by Stanley Weaver, Coronial Brief, pp 153, 155, 156.
[25] Exhibit 11 – Suicide note located at scene of death, Coronial Brief, p 157.

23. Mr Weaver's last recorded movements on the MFB security system using his FOB access was at 5.34am on 25 August 2019.

24. In the early morning on 26 August 2019 at 5.50am, Mr Weaver was discovered hanging from a rope in one of the small offices at the MFB workplace by his co-worker, Ian Morris.[26] Mr Morris checked Mr Weaver's pulse and was unable to find one. He then contacted emergency services.[27] Victoria Police members and paramedics arrived shortly after and Mr Weaver was pronounced deceased on scene.

CORONIAL INVESTIGATION

Referral to the Coroners Prevention Unit

25. Due to Mr Weaver's death occurring in a background of proximate family violence, I referred this case to the Coroners Prevention Unit (**CPU**) and specifically the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**) for a review of the service contact of agencies proximate to Mr Weaver's death as well as to the CPU Mental Health team to review mental health service contact with Mr Weaver.

Family violence review

26. The role of the VSRFVD is to provide assistance to Coroners to examine the circumstances in which family violence deaths occur. The VSRFVD also collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian community.

27. I directed investigators from the VSRFVD to obtain further records from Victoria Police and to review the appropriateness of their service contact with Mr Weaver and his family in the lead up to the fatal incident.

28. VSRFVD investigators reviewed the coronial brief of evidence and Victoria Police LEAP[28] records relating to Mr Weaver.

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[26] Statement of Ian Morris dated 26 August 2019, Coronial Brief, p 34.
[27] Statement of Ian Morris dated 26 August 2019, Coronial Brief, pp 34-35.
[28] The Law Enforcement Assistance Program (LEAP) online database is fully relational and stores information about all crimes bought to the notice of police as well as family incidents and missing persons. It also includes details on locations and persons involved.

Victoria Police

Family violence investigations and suspect welfare management

29. Victoria Police members had contact with Mr Weaver in the two days prior to his death and earlier in July 2019. Victoria Police also had prior contact with Mr Weaver in April 2018. In each of these instances Mrs Weaver relayed her concerns to Victoria Police regarding Mr Weaver's mental health and risk of suicide.

30. In my previous investigation into the death of *Andrew Stanyer*,[29] I discussed the issue of the increased suicide risk of perpetrators of family violence, and Victoria Police conceded that issue was worthy of attention and they would take steps to address it. My findings in that investigation commented on the expectation that Victoria Police implement awareness measures to operational police as a matter of priority, specifically publishing an article in the *Police Gazette*, distributing an alert on the Victoria Police Family Violence intranet and requesting that Family Violence Advisors and Team Leaders communicate and highlight the issue to their teams.

31. Victoria Police have confirmed that in response to my recommendations in *Andrew Stanyer*, they have developed a resource to be provided to family violence perpetrators when police attend an incident or serve a FVIO, and that perpetrator suicide risk was being incorporated into family violence training for police members.

32. The VP Form L17 (also referred to as a Family Violence Report) has also been updated and now contains explicit questions with respect to the mental health of a perpetrator, including whether they have any mental health issues and have expressed suicidal ideation. This assessment is based on the Multi Agency Risk Assessment and Management Framework (**MARAM**). It is noted that this risk assessment is focused on the risk of further family violence, as opposed to assessing the perpetrators risk of suicide.

33. Victoria Police have also implemented new family violence guidelines which direct members to consider the mental health of perpetrators during attendance at family violence incidents and note that any mental health concerns should take priority and be addressed during such interactions. Having these questions in the VP Form L17 as well should prompt police

[29] COR 2014 5831.

members to turn their minds to the mental health needs of perpetrators when interacting with them and take further action to address them if needed.

The relevance of including a Person Warning Flag

34. The Victoria Police Manual (**VPM**) - *Guidelines, Person of interest and person warning flags* suggests that person warning flags (**PWF**) should be submitted on an individual's LEAP record if there are concerns relating to their mental health or risk of suicide.[30] The VPM suggests that a flag with respect to mental disorders should only be placed if a disorder has been identified as such by a qualified medical or mental health practitioner.[31] The VPM also suggests that a flag with respect to suicide/self-injury risk should only be placed if a person has attempted or threatened suicide or inflicted injury intentionally to themselves.[32]

35. The available evidence in this case confirms that there was no PWF recorded in LEAP with respect to Mr Weaver's suicidal ideation or mental health. It is also unclear why such a flag was not recorded in Mr Weaver's LEAP records following his contact with police in April 2018 and July 2019 after being reported by his wife as a suicide risk.

36. The presence of a PWF may have impacted on the actions taken by LSC Clavering in his subsequent interaction with Mr Weaver and prompted him to actively enquire as to Mr Weaver's mental health. However, it is noted that Mr Weaver was reported to have a pattern of denying any suicidal ideation or acute mental health issues when directly questioned[33], as such it is unlikely that further supports would have raised an issue of prevention in this case.

Mental health review

37. The available evidence suggests that Mr Weaver had experienced several significant events throughout his life which resulted in a negative impact on his mental health. In 1981, Mr Weaver's mother passed away and Mrs Weaver noted that this was the first time she began to

[30] Victoria Police, *Victoria Police Manual - Guidelines, Person of interest and person warning flags* (21 September 2018), p 5.
[31] Victoria Police, *Victoria Police Manual - Guidelines, Person of interest and person warning flags* (21 September 2018), p 4
[32] Victoria Police, *Victoria Police Manual - Guidelines, Person of interest and person warning flags* (21 September 2018), p 4
[33] Statement of T Van Praag, Coronial Brief, p 46.

notice emerging mental health issues in Mr Weaver. She stated he '*started to become quiet [sic] solitary and could get angry easily, he could just flip a switch and be angry*.'[34]

38. In approximately April 2017, Colin, one of Mr Weaver's stepson's, suicided.[35] Approximately one year after Colin's death, during Easter in 2018, Mr Weaver disappeared for several days. Mrs Weaver reported him missing to Victoria Police and police records from this occasion suggest Mr Weaver sent Mrs Weaver text messages which expressed suicidal ideation during this time.[36] In particular, he purportedly stated he didn't want a funeral and provided instructions for how he wanted his ashes to be spread.[37]

39. Victoria Police located Mr Weaver on this occasion and arranged for a mental health assessment to be undertaken by the Monash Health Crisis Assessment and Triage Team (Monash Health CAT Team). Police records indicated that attending members and the Monash Health CAT Team assessed that Mr Weaver was *'not suicidal and [was] simply avoiding contact with his family friends and police*,'[38] and that the Monash Health CAT Team did '*not hold concerns for [Mr Weaver*]' [39] at that time.[40] Mr Weaver returned home after being missing for several days.

40. In late August 2018, Mr Weaver took extended leave from his employment at the MFB. He remained engaged with the MFB during his leave and commenced a gradual return to work in late April 2019.[41]

41. On 23 July 2019, Ms Weaver contacted the Monash Health CAT Team in relation to concerns for Mr Weaver's safety. She reported that Mr Weaver had been stockpiling medication and she was concerned he was planning to suicide.[42] She requested the Monash Health CAT Team attend unannounced to conduct a mental health assessment, but would not provide them with Mr Weaver's phone number as she was concerned he would abscond if they called ahead. The

[34] Statement of G Weaver, Coronial Brief, p 23.
[35] Statement of B Quinn, Coronial Brief, p 24; Statement of N Hunter, Coronial Brief, p 31.
[36] Victoria Police LEAP records relating to Stanley Weaver, p 18.
[37] Victoria Police LEAP records relating to Stanley Weaver, p 19.
[38] Victoria Police LEAP records relating to Stanley Weaver, p 18.
[39] Victoria Police LEAP records relating to Stanley Weaver, p 18.
[40] Monash Health, Triage Information Only Report dated 2 April 2018.
[41] Statement of B Quinn, Coronial Brief, pp 25, 27.
[42] Statement of A Adaji, Coronial Brief, p 61; Monash Health, Medical records of Stanley Weaver, p 8.

triage service advised her to contact the police as they would not be able to stop him from leaving if they did attend, and to inform them if anything changed.[43]

42. On 25 July 2019, Mrs Weaver was contacted by the Monash Health CAT Team. She advised them that she had removed the medications Mr Weaver had been stockpiling and she reported suspicions that he had been acting inappropriately towards their 5-year-old great granddaughter.[44] She also reported that Mr Weaver had been verbally and financially abusive towards her.[45]

43. The Monash Health CAT Team contacted Mr Weaver and conducted a home visit assessment with him. Mr Weaver admitted to previous depression and reported feeling better on his current medication, he was assessed as having good insight into his mental health and denied suicidal thoughts. It was assessed he didn't meet the criteria for compulsive treatment and a plan was developed for him to liaise with his General Practitioner. Both Mr and Mrs Weaver were advised of numbers to contact if further concerns arose.[46]

44. I directed mental health specialists within the CPU to also review the mental health services that had proximate contact with Mr Weaver including his General Practitioner (**GP**) and the Monash Health CAT Team. There were no identified issues with the services provided by these two medical professionals.

45. The Monash Health CAT Team conducted a thorough mental state and risk assessment on 25 July 2019, Mr Weaver denied suicide risk, reported compliance with his medication and engagement with his GP. Mr Weaver also declined further contact with the Monash Health CAT Team and did not have a mental disorder within the meaning of the *Mental Health Act 2014* (Vic) or serious and imminent risks that would necessitate involuntary treatment. It was appropriate that he was discharged from Monash Health CAT Team in the circumstances of this case.

46. Mr Weaver's GP had provided treatment to Mr Weaver for many years, had a positive therapeutic relationship with him and knew his mental health history and risk factors. Mr Weaver's GP reported that she assessed suicide risk at their last contact on 19 August 2019

[43] Statement of A Adaji, Coronial Brief, p 61; Monash Health, medical records of Stanley Weaver, p 12.
[44] Statement of A Adaji, Coronial Brief, p 63; Monash Health, Medical records of Stanley Weaver, p 23.
[45] Statement of A Adaji, Coronial Brief, p 63; Monash Health, Medical records of Stanley Weaver, p 23.
[46] Statement of A Adaji, Coronial Brief, p 63; Monash Health, Medical records of Stanley Weaver, p 15.

and Mr Weaver denied any intent or plan. Mr Weaver's GP reported that he was presenting as future focused; agreeing to follow-up with further appointments, referral to a psychiatrist, and stating that he would be attending work. There was no indication that he was at heightened risk of suicide requiring a more assertive intervention during their last contact.

47. Having considered the evidence I am satisfied that no further investigation is required.

FINDINGS

48. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

    (a) the identity of the deceased was Stanley Bruce Weaver, born on 17 July 1958;

    (b) Mr Weaver died sometime between 25 August 2019 and 26 August 2019 from 1(a) *Hanging*; and

    (c) in the circumstances described above.

49. A finding of suicide can impact upon the memory of a deceased person and can reverberate throughout a family for generations. Such a finding should only be made on compelling evidence, not indirect inferences, or speculation. It is often difficult to determine what may have precipitated a decision to end one's own life. There are sometimes issues known only to the deceased person and sometimes events in the person's life suggest a reason.

50. The available evidence suggests that Mr Weaver had a reported history of experiencing mental health issues throughout his life, particularly after the death of his stepson, Colin.

51. I find that Mr Weaver intended to end his life.

52. I wish to express my sincere condolences to Mr Weaver's family. I acknowledge the grief and devastation that you have endured as a result of your loss.

COMMENTS

53. Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death.

54. The current *Victoria Police Practice Guide - Family Violence* indicates that members should employ several suggested strategies to better identify perpetrators with mental health issues and offer assistance as required. This can include making a referral to a CAT Team or making further enquiries with the Affected Family Member or Respondent regarding the Respondents mental health.[47]

55. Further, the current *Victoria Police Practice Guide - Family Violence Priority Community Response* highlights the importance of considering mental health issues when investigating family violence. This includes guidance that the 'current mental health issues of either party must take priority' and that 'police should make a continual risk assessment of the person's mental health.'[48] However, at present these documents appear to only be guides, rather than mandated actions, and only appear to be applicable to the police response to a family violence incident report, and subsequent mandated completion of a VP Form L17.[49]

56. There is no indication that the guidance above also applies to the service of family violence related documentation including Family Violence Safety Notices or Applications to vary or extend an existing FVIO.

57. Victoria Police members did a commendable job in reacting to concerns raised by Mrs Weaver in previous reports of family violence and risk of suicide relating to Mr Weaver. However, whilst the actions taken by LSC Clavering during contact with Mr Weaver in relation to his firearms and later in relation to service of the interim FVIO was compliant with existing policies at the time, there is an opportunity for improvement in best practice when it comes to suspect welfare management in the early stages of the family violence investigation process.

58. This case highlights the need for clear and consistent guidance for Police members investigating family violence and serving family violence related documentation to consider the impact that the content of such documentation may have on a person suspected of or alleged to have committed family violence.

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[47] Victoria Police, Practice Guide, Family Violence Report L17 and Frontline Response, 3 August 2019, 9.
[48] Victoria Police, Practice Guide, Family Violence Priority Community Response, 28 June 2019, 20.
[49] The Victoria Police Form L17 refers to the Victoria Police Risk Assessment and Management Report that Victoria Police are required to complete after they have attended a family incident. The report is completed when family incidents, interfamilial-related sexual offences, and child abuse are reported to police

RECOMMENDATIONS

59. Pursuant to section 72(2) of the Coroners Act, I make the following recommendations connected with the death.

Recommendation One

I recommend that Victoria Police review the relevant Victoria Police Manual and Guidelines to ensure that there is clear and consistent guidance regarding suspect welfare management in relation to family violence perpetrators. Suspect welfare management should be considered in all interactions between Victoria Police and family violence perpetrators, including during the service of family violence related documentation. This guidance should be included in the updated *Code of Practice for the investigation of Family Violence* and be reflective of the advice already provided in the *Code of Practice for the investigation of Sexual Crime*.

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

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

Mr Weaver's family;

Mr Shane Patton, Chief Commissioner of Police

Mr Peter Ryan, Director of Legal Services, Monash Health;

Mr Adrian Bonacci, WorkSafe Victoria;

Civil Litigation Unit Manager, Victoria Police; and

Coroner's Investigator, Victoria Police

Signature:

JACQUI HAWKINS
Coroner
Date: 18 March 2021