IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 3862

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Jacqui Hawkins
Deceased:	JC
Date of birth:	18 December 2001
Date of death:	23 July 2019
Cause of death:	I(a) Hanging
Place of death:	[redacted] Skye, Victoria, 3977

SUMMARY

1. JC was 17 years old at the time of his death. He lived with his father, MC, stepmother, SW, and stepsister, CZ.

2. JC's biological mother was KK and she had two children with MC, JC and his older sister, JCC. JC grew up in Carrum Downs and continued to live with his parents until they separated in August 2014. JC moved in with his father after his parents' separation. MC started a new relationship with SW shortly after separating from JC's mother. SW and her daughter, CZ, moved in with MC and JC in December 2015.

3. JC attended Monteray Secondary College in Frankston until year 7. At some stage during that year, the school staff became aware of a pact between JC and another female student to step in front of a train and intervened. JC was enrolled in the Stepping Stones Program at Monash Hospital and after his discharge, he refused to go back to school. From this time, JC would stay in his room playing on his Xbox or going out with friends. After an incident in September 2017 when JC was the victim of a serious assault on the Frankston foreshore, JC's behaviour became reportedly aggressive and he was observed by family to be "*always angry"*.

4. On 23 July 2019 at approximately 9.30am, JC's father found JC deceased in his bedroom. His death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008.*

5. 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]

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

[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw* v *Briginshaw* (1938) 60 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.

7. 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

8. JC was visually identified by his stepmother, SW, on 23 July 2019. Identity was not in issue and required no further investigation.

MEDICAL CAUSE OF DEATH

9. On 24 July 2019, Dr Yeliena Baber, Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination on JC's body and reviewed the Form 83 Victoria Police Report of Death and the postmortem computed tomography (**CT**) scan.

10. Toxicological analysis of postmortem blood detected the presence of diazepam, its metabolite nordiazepam, amphetamine, its metabolite methylamphetamine, dextromethorphan and paracetamol.

11. Dr Baber reported that the external examination was in keeping with the clinical history. She 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

12. The available evidence suggests that JC perpetrated family violence against both MC and SW, particularly in the six months leading up to his death. MC noted that JC often put holes in the walls when he was angry, "*if I wouldn't take him where he wanted to go he would get angry and put a hole in the wall. He was pretty much angry all the time.*" SW also noted that there were "*holes in the lounge room, the hallways, my room and cupboard. Whenever JC was told 'no' he would lash out*."

13. In June 2019, JC called MC to come home and call an Ambulance because he thought he had overdosed on methylamphetamine. JC went to Frankston Hospital on this occasion but ended up walking out and discharging himself when he could not answer some of the questions asked by medical staff, and was assured that he could not overdose by smoking methylamphetamine.

14. SW described an incident approximately three months prior to JC's death, where JC allegedly threatened to '*cut'* her. This reportedly occurred after JC returned home with an unknown

person wanting to gain access to the house but was unable to enter as the locks had been changed to avoid strangers coming through the house.

15. On 22 July 2019, the day prior to JC's death, at around 3.00pm, MC called Victoria Police to report a family violence incident after JC purportedly pushed him, punched a hole in the wall and smashed a television. Police officers attended the residence at around 3.30pm and provided advice to MC about applying for a Family Violence Intervention Order **(FVIO)**. The police officers spoke with JC and he returned to his bedroom. The officers informed MC that JC had someone coming to pick him up later.

16. At approximately 12.46am on 23 July 2019, JC was purportedly playing music loudly when SW asked him to turn it down. SW states that JC yelled and swore at her and opened the door to his bedroom whilst holding a knife. SW asked JC if he was threatening her with the knife, and he denied it, appearing as though he did not realise he had been holding it. JC told SW, and later attending police officers, that he was scared that a group of people were coming to assault him and had armed himself in response.

17. SW contacted Victoria Police, who attended the residence shortly afterwards at around 1:45am. SW advised attending police officers that JC had been holding a knife and "*waving it around as they argued, but that he had not threatened her or anyone with the knife, and he had not made any direct threats*." SW had, nonetheless, felt threatened by JC waving the knife around during their argument.

18. The attending police officers arrested JC and conveyed him to Frankston Police Station for interview at around 2.45am. Whilst he was in their custody, they submitted an after-hours Application and Summons for a FVIO which was processed by an afterhours registrar who issued an interim FVIO with conditions excluding JC from his home.

19. JC was served with the application documentation along with the interim FVIO before he was released at approximately 7.00am that morning. Police statements confirm that they made enquiries to obtain alternate accommodation for JC whilst he was in custody and provided him with the details for the Salvation Army, Frankston, suggesting that he visit them that morning to obtain assistance with housing.

20. MC came to pick JC up from the Frankston Police Station after he was released at approximately 7.15am and drove him home, in contravention of the conditions of the interim FVIO. They returned home at around 8.20am and JC went into his bedroom.

21. At around 9.25am, MC went to check on JC and found him hanging by his neck in his bedroom wardrobe. Despite all best efforts at resuscitation by MC, SW, and attending paramedics, JC was declared deceased at the scene at approximately 10.00am.

22. Attending police officers immediately commenced a coronial investigation and canvassed JC's bedroom for evidence, there was no notes left by JC and no evidence to suggest that JC's death was suspicious.

CORONIAL INVESTIGATION

Referral to the Coroners Prevention Unit

23. Due to JC'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 JC's death.

24. 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.

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

26. VSRFVD investigators reviewed the coronial brief of evidence and Victoria Police LEAP[2] records relating to JC. The conclusion of this investigation identified concerns regarding Victoria Police contact with JC in the lead up to the fatal incident and the vulnerability of youth adolescents who are excluded from the home due to their use of violence.

27. I directed that a response be sought from the Chief Commissioner of Police regarding the concerns with Victoria Police contact with JC and his family in the period leading to the fatal incident. I also requested a statement from the Department of Health and Human Services

[2] 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.

(**DHHS**) about developments from the Royal Commission into Family Violence[3] (**the Royal Commission**) regarding adolescents use of violence in the home.

28. DHHS provided a statement dated 9 June 2020, outlining developments following the Royal Commission, specifically Recommendation 124. Similarly, the Chief Commissioner of Police provided a response dated 17 July 2020, both responses are discussed in more detail below.

Victoria Police

The decision to apply for a Family Violence Intervention Order

29. Victoria Police have several options they can exercise when responding to an incident of family violence. These range from a formal warning to an application for a FVIO or criminal charges. The decision on how to proceed is made by attending officers based on the circumstances of each incident and should take into account the wishes of the Affected Family Members as well as a family violence risk assessment.

30. When a young person is the perpetrator of family violence, the *Code of Practice for the Investigation of Family Violence* (**Code of Practice**) also prompts police members to consider that the young person's behaviour "*can be largely due to issues such as [the young person] being a previous victim of family violence or having witnessed violence in their home, mental health issues, bullying or alcohol and drug abuse*." However, there is no further guidance provided as to how these matters should be taken into account.

31. Given that there had been a weapon involved during the family violence incident, and SW was fearful of JC, it appears that Victoria Police acted in accordance with the existing Code of Practice and it was reasonable for them to apply for a FVIO excluding JC from his home on this occasion.

32. Notably the Code of Practice provides limited guidance to Victoria Police members in assessing appropriate actions to take in cases involving adolescent perpetration of family violence, and the family violence risk assessment does not appear to take into account whether the perpetrator is a young person.

33. The Royal Commission considered the issue of adolescents who use family violence and noted that this type of family violence should be recognised by the family violence system "*as different from adult-perpetrated family violence.*" The Royal Commission noted that there

[3] *Royal Commission into Family Violence* (Final Report, March 2016) vol 4.

were conflicting views as to the "*effectiveness of police-initiated family violence intervention orders that direct removal of the child from the home.*" It was further noted that such action "*can be devastating for the young person"* and may also "*alienate them from their family*."

34. The Royal Commission stated that criminal justice proceedings should be a last resort and that priority should be given to "*specialist therapeutic responses that work with the young person and their families as early as possible*." In addition, it was advised that the removal of a young person from their home should be avoided and that appropriate accommodation should be provided where there is no other option. The Royal Commission did note, however, that the level of intervention needs to be appropriate to the level of risk to family members.

35. In their final report the Royal Commission stated:

> *we consider that the Victoria Police Code of Practice should be amended to include guidelines about police-initiated intervention order applications against children and referral pathways for families experiencing adolescent violence in the home. The Code should prioritise cautions and diversion*.

36. However, this was not a formal recommendation of the Royal Commission and the current iteration of the Code of Practice does not contain such guidelines. The Chief Commissioner of Police confirms that the Code of Practice is currently being reviewed.

The written application for a Family Violence Intervention Order

37. In issuing a FVIO excluding a child from their residence, a Judicial Registrar must be satisfied that the child will have appropriate alternative accommodation and appropriate care and supervision before doing so. Section 83(3) of the *Family Violence Protection Act 2008* (**FVPA**) states that:

> *…the court **may** include an exclusion condition in an order only if it is satisfied that if the child is excluded from the residence the child **will have appropriate** alternative accommodation and appropriate care. [emphasis added]*

38. The available evidence suggests that the Judicial Registrar was initially resistant to including a condition that excluded JC from his home and eventually relied upon information provided by Victoria Police in issuing the interim FVIO against JC in the belief that JC would have appropriate accommodation even though this was never ultimately secured.

39. The application for a FVIO submitted by Victoria Police stated that they had "*organised crisis accomm[odation] via St Kilda Crisis"*, however, this was incorrect. Although Victoria Police

did attempt to arrange accommodation for JC, they were unable to secure any such accommodation and ultimately advised him to visit the Salvation Army for housing assistance after his release.

40. In a submission to the Royal Commission, Victoria Police noted that where a young person is removed from the home there are "*limited accommodation options for the young persons, unless a friend or family agree to have them*." That issue is reflected in this case.

41. Whilst the Code of Practice states that police should liaise with the Department of Health and Human Services - Child Protection (**Child Protection**) prior to applying for a FVIO in relation to a child respondent, in this case Child Protection were unable to offer any assistance to JC due to his age. This was due to the fact that Child Protection's statutory responsibility under the *Children Youth and Families Act 2005* (Vic) (**CYFA**) is to provide child protection services for identified at risk children in Victoria under the age of 17 years or, when a protection order is in place, children under the age of 18 years.

42. Despite efforts to make enquiries, Victoria Police were also unable to secure any accommodation for JC. Whilst I commend the efforts to try and secure accommodation for JC and explore housing options, I note that Victoria Police still have responsibility to ensure that appropriate accommodation arrangements have been confirmed. As indicated above, even though the FVPA does not require accommodation to be secured for a youth perpetrator being considered for exclusion, it would be best practice for police to ensure that appropriate accommodation arrangements have been confirmed before releasing them from police custody. JC ultimately left the police station at 7.00 am with his father to return to his home in breach of the interim intervention order and left with a referral to action on his own.

43. The lack of appropriate accommodation and support for adolescent perpetrators of family violence was acknowledged by the Royal Commission, who in the form of Recommendation 124, recommended that the Victorian Government:

> *develop additional crisis and longer term supported accommodation options for adolescents who use violence in the home. This should be combined with therapeutic support provided to end the young person's use of violence in the family*.

44. In their response to the Court dated 6 June 2020, DHHS confirms that they are currently working with the housing sector, young people and the broader Victorian community to design and cost options that better meet the individual needs of young people and ensure they develop independence and resilience and receive support to address violent behaviours.

45. DHHS also confirmed that they are involved in funding and developing Village 21, an accommodation and support program, based around a village concept, assisting at-risk young people aged 18–21 years who are leaving out-of-home care or are already post care. This includes young people who have used violence in the home. It has been reported that many young people are ill-equipped with the skills to live independently, with 39% of care leavers ending up homeless in the first year after they turn 18. Village 21 is designed to interrupt this spiral by providing relocatable studios for young people to live in, with support, for two to three years.

46. DHHS has also funded a range of other accommodation and intensive support programs for young people in response to Royal Commission Recommendation 24 – Support service providers to develop a broader range of supported accommodation options for young people and Recommendation 14 – Increase the number and range of crisis and emergency accommodation. This includes the Frontyard Youth Refuge that offers young people crisis accommodation staffed by a multidisciplinary support team. The 18-bed refuge has been operational for over 12 months. This service is targeted to young people aged 16–25 years who have high and complex support needs and includes young people who use violence in the home.

47. A new youth refuge will open in Melton in July 2020. This new 10 bed refuge offers young people short-term crisis accommodation and intensive support. This refuge is targeted to young people who require emergency accommodation and support, including young people who use violence in the home.

48. In addition to the two new youth refuges, a long-term supported youth accommodation facility is also being developed in Werribee. This 10-bed service will offer young people an opportunity to stabilise their life circumstances and receive support to address individual needs and establish education, employment and career goals. This facility commenced construction in January 2020 and is scheduled to be completed by January 2021.

49. In responding to young people who have experienced significant trauma and a range of complex needs, it is necessary for a range of support and accommodation options be provided.

FINDINGS

50. 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 JC, born on 18 December 2001;

    (b) JC died on 23 July 2019 from 1(a) *Hanging*; and

    (c) in the circumstances described above.

51. 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.

52. The available evidence suggests that JC had a history of experiencing complex interpersonal issues with family members and likely lacked the skills and maturity to understand and resolve them. Any suicide is a tragedy, adolescent suicide is particularly devastating because they are on the cusp of adulthood and have such enormous untapped potential.

53. I find that in a moment of impulsivity, JC intended to end his life.

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

COMMENTS

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

56. The Royal Commission acknowledged that adolescent violence in the home is a distinct form of family violence. It exists across all communities and geographic areas. It can have a devastating impact on family members, including both poor mental health and potential homelessness. Whilst it is important to protect vulnerable family members from violence within the home, removing a child can be devastating for the young person and adversely affect their development, wellbeing and financial security, as well their ability to continue

schooling. FVIOs may also alienate a young person from their family, which can increase risk factors and decrease important protective factors.

57. It seems that there are clear gaps in support for adolescents who are issued with a FVIO with a condition excluding them from family home. When there is no alternative accommodation option available for a young person, issuing a FVIO means that if they return to the family home like in JC's circumstances, they breach the order which undermines the purpose of it in the first place. Alternatively, if they do not return to the family home, they have to find their own means of accommodation which can include the undesirable option of homelessness. This does not seem an appropriate outcome and creates additional pressures for vulnerable youth.

58. Victoria Police need to work towards being more proactive and appreciate the importance of referral pathways for vulnerable youth. Where Victoria Police intervene in family violence incidents involving youth who use violence in the home, it is critical to ensure that appropriate accommodation arrangements have been confirmed before releasing them from police custody. The Royal Commission fell short of making a recommendation in relation to this but considering there is still a gap and Victoria Police are currently reviewing the Code of Practice, I have made a recommendation consistent with this – see Recommendation One.

59. This case highlights the need for specialist youth services and accommodation to be available to support young adolescents after hours, particularly when family violence incidents may result in a young person being excluded from the family home. I consider more work needs to be done by DHHS and Victoria Police to understand the incidence and numbers of youth that are issued with FVIO and require emergency crisis accommodation to identify any areas in Victoria that may need this assistance. I also consider the existing support services available to vulnerable youth should extended to a 24-hour operational model. I have made two recommendations in relation to these issues. – see Recommendation Two and Three.

60. I support the initiatives in relation to short-term crisis and supported accommodation being developed and implemented by DHHS in response to Recommendation 24 and 14 of the Royal Commission. These are excellent initiatives and had JC been referred to something like this he may have felt better supported. I encourage and endorse more resources and funding be invested into emergency and short-term crisis accommodation. I endorse Recommendation 124 of the Royal Commission that the Victorian Government should develop additional crisis and longer term supported accommodation options for adolescents

who use violence in the home. This should be combined with ongoing therapeutic support provided to end the young person's use of violence in the family.

61. Under the FVPA, JC met the definition of child. However, he did not meet the criteria for DHHS involvement given he was 17 years of age and he was not on any existing child protection order pursuant to the CYFA. Consequently, Child Protection did not have a mandate to assist JC with locating appropriate accommodation or providing access to therapeutic intervention, which appears to be a gap and leave 17 year old youths in a similar situation vulnerable. Therefore, I have made a recommendation consistent with this – see Recommendation Four.

RECOMMENDATIONS

62. 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 amend the *Code of Practice for the Investigation of Family Violence* to include guidelines about police-initiated intervention order applications against children and young people, and ensure police are aware of appropriate referral pathways for families experiencing adolescent violence in the home, including alternate accommodation options. The Code of Practice should also prioritise cautions and diversion where appropriate.

Recommendation Two

I recommend that the Secretary of the Department of Health and Human Services and Victoria Police conduct a joint review on the incidence and numbers of youth that are issued with a FVIO and require emergency and short-term crisis accommodation, to identify any areas in Victoria that may be in need of these additional resources. The review should inform funding decisions by the Secretary of the Department of Health and Human Services to provide additional youth crisis accommodation in targeted areas where the demand has been identified.

Recommendation Three

I recommend that the Secretary of the Department of Health and Human Services consider funding existing specialist youth services to extend their services and support to vulnerable youth to a 24-hour operational model.

Recommendation Four

I recommend that the Victorian Government and the Secretary of the Department of Health and Human Services explore options to address the legislative anomaly between the *Family Violence and Protection Act 2008* (Vic) and the *Children Youth and Families Act 2005* (Vic) in relation to the definition of "*child"*.

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

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

JC's family;
Mr Shane Patton, Chief Commissioner of Victoria Police
Ms Kym Peake, Secretary, Department of Health and Human Services;
Dr Neil Coventry, Chief Psychiatrist, Office of the Chief Psychiatrist;
Ms Amber Salter, Legal Counsel, Peninsula Health;
Ms Annette Lancy, Acting Chief Executive Officer, Family Safety Victoria;
Detective Sergeant Chris Corbett, Professional Standards Command, Victoria Police; and
Coroner's Investigator, Victoria Police

Signature:





JACQUI HAWKINS
Coroner
Date: 28 September 2020