IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 001076

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	RB[1]
Date of birth:	24 June 1974
Date of death:	27 February 2019
Cause of death:	1(a) NECK COMPRESSION IN THE CIRCUMSTANCES OF HANGING
Place of death:	4 / 455 St Kilda Street, Elwood, Victoria, 3184
Keywords:	Suicide; rape; sexual assault; mental health; post-traumatic stress disorder; victims of crime support; trauma informed approaches

[1] A pseudonym. The name of the deceased is included at Appendix A to these findings, which is not for publication.

INTRODUCTION

1. On 27 February 2019, RB was 44 years old when she was found deceased in her home. At the time of her death, RB lived alone in Elwood.

THE CORONIAL INVESTIGATION

2. RB's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. Coroner John Olle originally held carriage of this investigation. Detective Acting Sergeant Georgia White initially prepared the coronial brief and Sergeant Yvette Lippold subsequently acted as the Coroner's Investigator for the investigation of RB's death.

6. In October 2022 I took carriage of this matter for the purposes of finalising the investigation, and this finding.

7. This finding draws on the totality of the coronial investigation into the death of RB including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

[2] 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.

BACKGROUND

8. RB was born on 24 June 1974 and grew up in New South Wales. She was one of four children and had a close relationship with her parents and siblings.

9. RB excelled during her secondary education and then completed a Bachelor of Arts, majoring in communications, at the University of Canberra.

10. After completing her tertiary studies, RB moved to England for approximately two and a half years, working in hospitality while she travelled. Upon returning to Australia, RB moved to Sydney, where she resided for approximately 10 years, developing a career in film editing. She then settled permanently in Melbourne.

11. RB worked in the television industry as an editor, working under contract on a variety of reality television shows. This work often required her to travel internationally, including to Spain and South Africa. Colleagues of RB described her as talented and stated that her work in the industry was highly respected.

12. In July 2014, RB met Glenn Hartland (**Hartland**) via an online dating service and they commenced a relationship which continued until October 2014.

13. On 4 October 2014, RB invited Hartland to collect a pair of jeans from her apartment. That evening, Hartland attended at the apartment and, after RB allowed him inside the premises to collect the clothes, he raped her.

14. On 5 October 2014, RB reported the rape to Victoria Police. She subsequently attended Monash Health for a physical examination and made contact with the South East Centre Against Sexual Assault (**SECASA**).

15. RB's parents and friends all stated that the rape had a profound impact upon her. They reported that after the incident, RB stopped exercising, gained weight, withdrew socially, and began using alcohol to excess. This account was corroborated by mental health clinicians who had contact with RB – they noted the detrimental impact the crime had on both her mental and physical health.

16. On 17 October 2014, RB withdrew her complaint against Hartland, indicating that she no longer wanted to pursue the matter due to the emotional impact recalling the event was having upon her. She stated that she wanted to put the matter behind her. Consequently, the criminal brief was not authorised for prosecution.

17. On 19 October 2015, a Victoria Police Family Violence Command Taskforce (**FVCT**) began operation. The FVCT focused on identifying high risk perpetrators responsible for serious family violence crime, including historical or unreported offences committed against multiple victims.

18. In 2016, RB resigned from her work on a reality television series, telling a friend that she was not coping following the rape.

19. Later that same year, the FVCT identified Hartland as a repeat high risk family violence perpetrator. The taskforce took over several individual investigations involving Hartland and began an overarching investigation codenamed Operation HYPERION-2016. This investigation was recorded in the Victoria Police electronic case management system known as Interpose, which contained an investigation plan, victim management plan, applications for specialist services, and investigation and management updates, including notable events and contact with victims. Detective Acting Sergeant Chris Madden (**Madden**) was assigned to the investigation.

20. On 20 and 21 October 2016 Madden contacted RB. He advised her of the role of the FVCT and asked her whether she would be willing to have her report against Hartland re-opened and investigated. He confirmed that there were other women who had also made similar allegations against Hartland. Madden advised RB that the investigation may be delayed and drawn out because it involved multiple other complainants. RB agreed to have her complaint re-opened.

21. Throughout the following criminal investigation and court proceedings, RB and the other complainants against Hartland sought out contact with each other, developing a support network and close friendships. They commenced a group chat on the 'WhatsApp' messaging service where they spoke about day-to-day affairs and matters relating to the court case. For the purposes of this finding the other complainants are referred to as Ms A, Ms B, and Ms C.

22. During his interactions with RB, Madden offered to refer her to appropriate support services, however she declined, advising him that she had previously utilised the services of SECASA, and would contact them if she required further support or counselling. In the following weeks, RB began to experience anxiety associated with the prospect of providing a further statement for the criminal investigation. She made an appointment with SECASA for counselling.

23. On 23 November 2016, RB advised Madden that she was struggling. He provided her with several options for referrals and counselling and obtained her consent to send a referral for her

to the Victims Assistance Program (**VAP**). Madden submitted this referral and made a follow up call to request that the VAP prioritise the referral.

24. The VAP linked RB with a Victims Assistance Worker at Windermere, Claudia Iannou. Madden spoke with Ms Iannou about the work of the FVCT and maintained contact with her regarding RB's wellbeing.

25. On 21 December 2016, Ms A contacted Madden and advised him that RB had attempted suicide on 11 December 2016. Ms A stated that she had provided support to RB on this occasion, and that RB had declined to seek any medical or mental health assistance afterwards. Ms A asked Madden to not tell RB that she had provided this information to him.

26. Madden contacted RB to check on her welfare. She advised him that she was doing well and was engaged with SECASA and Windermere. Madden also contacted Ms Iannou. He advised her of the reported suicide attempt and asked her to contact RB that day. Madden also contacted Ms Iannou the following day to confirm that she had contacted RB. Ms Iannou confirmed that she had, and reported that RB was coping well, and had not disclosed any suicidal thoughts or attempts.

27. On 10 January 2017, Madden spoke with RB. He stated that she appeared to be in good spirits and said that she had found counselling to be beneficial. Madden advised her that Hartland would be arrested and interviewed in the coming weeks, and they would be applying for a Family Violence Intervention Order (**FVIO**) for her protection.

28. In January 2017, RB was working in South Africa with a male friend and colleague. Her friend observed that RB was consuming excessive amounts of alcohol, showing up late and occasionally missing shifts, which was very out of character for her. During this time, RB talked to him about the rape and on several occasions, usually whilst intoxicated, she made comments suggestive of suicidal ideation. The friend noted that RB also spoke about the FVCT and advised him that she felt supported by police.

29. On 27 February 2017, Hartland was arrested by the FVCT and interviewed in relation to the allegations made by RB and the other victims. He was released from custody pending further enquiries into the criminal matters, and FVIOs in protection of the victims were issued the following day.

30. At this time, RB was sharing her flat with a male friend. Her housemate stated that, after Hartland's arrest, RB "was terrified that [Hartland] was going to come to the apartment and she

would often ask him to check outside if she heard the slightest noise, like she was on edge that he was out in the community".

31. On 7 May 2017, a committal mention hearing was held at the Melbourne Magistrates' Court and the matter was listed for a four-day committal hearing commencing on 15 January 2018. Hartland was released on bail.

32. On 28 May 2017, RB called a male friend and stated that she was not coping, and that she was distressed that Hartland was not yet in jail. Later that evening, she sent a text message to him which suggested that she planned to suicide. The friend was subsequently unable to reach RB and so they contacted Victoria Police.

33. A Police and Clinician Early Response (**PACER**) unit, consisting of Victoria Police members and a mental health clinician from the Alfred Mental and Addiction Health (**AMAH**) team, attended RB's residence. After an initial assessment, RB was conveyed under section 351 of the *Mental Health Act 2014* (Vic) to the Alfred Hospital for further assessment.

34. RB disclosed that she had Major Depression and Post-traumatic Stress Disorder (**PTSD**). She reported that she had been experiencing fluctuating suicidal ideation for the preceding two years, following the rape, and that her suicidal ideation had been exacerbated by recent court proceedings. She denied planning or intent to act on her thoughts.

35. RB remained in the Emergency and Trauma Centre (**E&TC**) at the Alfred Hospital overnight. During this time, she was assessed by the mental health team, who encouraged her to reduce her alcohol intake and continue taking her prescribed antidepressant medication, venlafaxine. RB was offered an admission to the psychiatric unit, which she declined. However, she agreed to daily follow-up contact with the Crisis Assessment and Treatment Team (**CATT**).

36. Significantly, members of the FVCT were not made aware of this incident and a Mental Disorder Transfer form was not entered onto the Victoria Police Law Enforcement Assistance Program (**LEAP**).[3]

37. On 30 May 2017, RB reported to the CATT that she was experiencing suicidal ideation. They conveyed her to the Alfred Hospital, where she stayed overnight before accepting a voluntary admission to the psychiatry inpatient unit the following morning.

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[3] The Victoria Police Law Enforcement Assistance Program (LEAP) is an electronic database which, among other functions, stores information about members of the public with whom the police have had interactions.

38. On 1 June 2017, RB was reviewed by a consultant psychiatrist. She acknowledged that her use of alcohol was complicating her PTSD symptoms and agreed to abstain from alcohol. Her venlafaxine prescription was increased from 75mg to 150mg. RB asked to be discharged and agreed to attend her General Practitioner (**GP**) to arrange mental health and addiction counselling, and to link in with her SECASA counsellor. She was discharged with a plan to receive intensive community follow-up from the CATT.

39. On 8 June 2017, RB was discharged from the CATT service as her mental state had settled, and she was well supported by her GP and her SECASA counsellor. She also accepted a referral to psychologist, Amy Joyce. RB was reportedly "future focussed" and denied suicidality at the time of her discharge.

40. In June 2017, RB began consultations with Ms Joyce. During these sessions, Ms Joyce diagnosed RB with PTSD in the context of a sexual assault. Ms Joyce also noted that RB's symptoms included hyper vigilance, exaggerated startle effects, poor sleep, loss of interest in activities, and suicidal thinking.

41. In July 2017, RB advised a male friend that she had attempted to hang herself. Her friend visited and observed that she had a welt around her neck. It is unclear whether RB received any medical assistance after this incident.

42. RB continued to attend counselling sessions with Ms Joyce until October 2017. During this time, Ms Joyce noted that RB engaged in strategies to manage her PTSD symptoms, her mood had improved, she denied any further suicidal thinking and was positive about her future.

43. Ms Joyce noted that RB appeared to be well supported by the other victims, her friends, and Victoria Police. Ms Joyce also noted that she felt that their "intervention and rapport was fairly superficial and [RB] was keen to push any residual trauma symptoms and anxiety down, and push on". RB eventually ceased her sessions in October 2017, with Ms Joyce's agreement, after her fifth counselling session.

44. On 3 October 2017, RB expressed suicidal ideation to a friend via text message and he contacted Victoria Police, who then conducted a welfare check. RB was at home but did not open the door until an attending police member contacted her on her mobile phone. RB explained that she was frightened of Hartland and consequently never answered her door. She stated that the criminal proceedings were causing her a lot of stress but denied feeling suicidal.

45. RB spoke to a PACER clinician via telephone. The clinician was satisfied that she was not suicidal and further assessment was not needed on this occasion. The clinician arranged for the AMAH team to make a follow up call with RB the following day.

46. Again, FVCT investigators were not made aware of this incident.

47. On 10 October 2017, Madden met with RB at a café in Elwood and served her with a witness summons in relation to the upcoming committal hearing in January 2018. Madden reported that RB was her usual self and did not raise any issues at this time.

48. On 11 December 2017, Hartland was arrested and remanded in custody after it was reported that he had breached a FVIO and his bail conditions by approaching Ms A. Police notified RB of this development.

49. On 27 December 2017, RB contacted the AMAH Psychiatric Triage phone line and expressed suicidal ideation. She was assessed by the CATT the same day at her home. During this assessment, RB stated that her mood had deteriorated, she felt isolated over Christmas, and she had continued to misuse alcohol.

50. The following day, RB was reviewed by the CATT. She reported that her mood had improved, she had more hope and optimism regarding the criminal proceedings and was future focussed regarding an upcoming work trip to South Africa. She described her recent suicidal ideation as impulsive and situational and denied any further suicidal ideation. The CATT discussed RB's alcohol abuse and its link to her increasing suicidal ideation and actions. However, RB was ambivalent about her use of alcohol, describing it as a pleasure and comfort. She told clinicians that she was well supported by Ms Joyce and SECASA and she did not require further assistance from the CATT. The CATT then sent a copy of her assessment notes to her GP.

51. On 10 January 2018, Madden, legal representatives from the Office of Public Prosecutions (**OPP**) and a Victim and Witness Assistance Service (**VWAS**) worker engaged in a pre-committal conference with RB where they discussed the committal process and expectations.

52. A committal hearing was held at the Melbourne Magistrates' Court from 15 to 18 January 2018. RB gave evidence on 16 January 2018 and met with Madden afterwards. She told him that she was relieved that it was over. At the conclusion of these proceedings, Hartland was committed to stand trial. A directions hearing was held on 19 January 2018 and the trial was scheduled to commence 29 October 2018. Hartland was granted bail with reporting conditions, geographical

restrictions, and a prohibition regarding contact with any witnesses for the prosecution except the police informant.

53. Despite being granted bail on the charges which were the subject of the committal proceedings, Hartland remained in custody in relation to pending charges for breaching the FVIO.

54. On 4 February 2018, Madden transferred to the Wyndham Crime Investigation Unit at Werribee. He remained the informant in the prosecution of Hartland, however a decision was made that the management of victim welfare and concerns remained the responsibility of the FVCT. This was not recorded on Interpose or on any of the complainant's 'Event' records, however Detective Senior Sergeant Brett Meadows (**Meadows**) also confirmed that the management of the investigation remained with the FVCT following Madden's transfer.

55. On 8 February 2018, Hartland pleaded guilty to charges relating to breaching the FVIO and was sentenced to 60 days imprisonment. This sentence amounted to time already served on remand for the charges and he was released from custody.

56. In May 2018, RB travelled to Majorca to work as an editor on a reality television show. She reportedly enjoyed this work and her manager at this time reported that she appeared to be in a "good place". However, a male friend stated that RB continued to send him messages which expressed suicidal ideation.

57. In September 2018, RB attended the MC Medical and Dental Clinic and reported that she was experiencing anxiety associated with the upcoming trial.

58. In October 2018, Hartland's lawyers advised the OPP that he was intending to enter a plea of guilty regarding the rape and sexual assault charges. On 22 October 2018, an arraignment hearing was held at the County Court in Melbourne. The trial scheduled to commence on 29 October 2018 was vacated and Hartland was bailed to attend a plea hearing on 29 March 2019.

59. Madden subsequently asked RB to complete a Victim Impact Statement for the upcoming plea hearing. He submitted referrals for her to receive support to complete the Victim Impact Statement and followed up with both RB and her support worker to ensure she was sufficiently supported.

60. In early November 2018, RB became aware that Hartland had an account on the social media platform Snapchat. RB created an anonymous Snapchat account which she used to contact Hartland on 9 November 2018. They had a brief exchange, during which Hartland was able to

view RB's location using the application's location services. He sent RB a screenshot of her residential location and sent her a message calling her a "False Accuser".

61. On 11 November 2018, RB made a statement to Detective Senior Constable David McCann (**McCann**) regarding her contact with Hartland on Snapchat. During this meeting, RB stated that she had felt pressured by Ms B to contact Hartland and she was very distressed by the resulting interaction with him. RB also stated that she was experiencing distress as a result of her interactions with Ms B, indicating that she wanted to get on with her life and did not want to keep thinking about the court case constantly.

62. RB advised McCann that she only wanted to be contacted by police in relation to information that she really needed to know, stating that she "didn't want to be called frequently as all that did was remind her of all her pain… [and] kept her in a bad head space".

63. McCann discussed RB's mental health and welfare with her. He offered to make additional referrals for her, which she declined. RB said that she was well supported by family and friends and was aware of appropriate crisis supports. McCann provided her with his mobile number and advised her that he would only have access to the phone during business hours. He advised her to call '000' if she needed immediate help or assistance.

64. On 12 November 2018, RB visited a GP at the MC Medical and Dental Clinic. She reported experiencing panic symptoms since the weekend, and a recent exacerbation of her anxiety symptoms due to Hartland not being in custody. She was given a prescription for Valium.

65. The same day, Hartland was arrested for breaching the conditions of his bail and the FVIO between himself and RB. The criminal investigation for these charges was recorded on Interpose (Operation HAIRBALL-2018) by McCann and Hartland was remanded in custody.

66. On 14 and 15 November 2018, RB sent text messages to McCann indicating that she was feeling increasingly stressed because of recent media coverage of the proceedings and her interactions with the other victims.

67. On 16 November 2018, RB met with Meadows and Detective Sergeant Jane Arnold (**Arnold**) at a café in St Kilda. Meadows noted that, during this meeting, RB appeared stressed and emotional due to the ongoing court proceedings. She also raised concerns regarding her recent interactions with Ms B, who she claimed was pressuring her to engage with the media. Meadows and Arnold agreed to contact Ms B to ask her to give RB some space. They discussed

RB's mental health, and she informed them that she was receiving appropriate professional help and had an upcoming appointment.

68. On 18 November 2018, a friend of RB contacted St Kilda Police Station after receiving text messages from RB expressing suicidal ideation. Police attended RB's home and she advised them that she was depressed because of the criminal proceedings. She denied plans to suicide, but indicated she was considering going to hospital for an assessment. She eventually decided she wanted to stay at home, and declined police offers to submit referrals for further support, noting she had a support network already in place. Police provided her with contact numbers for Lifeline and the Alfred CATT and subsequently emailed Meadows to advise him of their interactions with RB. Meadows forwarded the email to McCann and asked him to contact RB.

69. On 21 November 2018, Ms B sent a text message to Meadows expressing concerns about RB stating she was "not in a good way", was "in a really angry place and lashing out at all of us". Ms B stated that they were not sure that RB was properly supported or attending work and asked Meadows to check in with her.

70. Meadows replied that they had been meeting and speaking with RB and were aware of the issues raised by Ms B and confirmed that they would contact RB. Meadows advised Ms B to notify police if she became concerned that RB was a risk to herself.

71. On Thursday 22 November 2018, RB telephoned the AMAH Psychiatric Triage service and expressed suicidal ideation. She appeared to be intoxicated at this time. The phone call ended abruptly and RB did not respond to subsequent attempts from AMAH to contact her, so they contacted police.

72. Police attended RB's home at 1.23am on Friday 23 November 2018. She advised them that she was intoxicated and had been triggered by media coverage of the criminal proceedings, causing her to feel suicidal. Police arranged for an ambulance to attend and convey RB to the Alfred Hospital for a mental health assessment.

73. During her mental health assessment, RB told clinicians that her mental state had been stable for the preceding 11 months, however she had recently experienced a deterioration associated with the imminent court proceedings, associated media coverage, and the release of Hartland on bail. She reported that she had increased her reliance on alcohol and her dosage of venlafaxine but had disengaged from Ms Joyce. She also reported "practising" self-strangulation in recent times, saying it provided some relief from distress and a means of escape

if her distress became overwhelming. RB declined drug and alcohol supports or hospital admission and denied suicidal intent, stating she was focused on maintaining her regular work schedule. She agreed to ongoing contact with the CATT.

74. A mental health transfer form was completed and submitted with the police patrol duty return for submission on LEAP. However, for unknown reasons it was not uploaded to LEAP. As a result, the FVCT were not aware of this incident.

75. Between 24 November 2018 and 4 December 2018, the Alfred CATT attempted daily contact with RB, however she did not always respond. RB appeared ambivalent about her engagement with mental health services and minimised concerns regarding her suicide risk. She indicated that she was busy with work and did not find CATT home visits helpful.

76. On Saturday 24 November 2018, RB sent a text message to McCann which stated, “I know it’s not cool messaging on a sat night, I’ve just been in a bad place and don’t know who to talk to, I don’t want to go up to a psych ward or anything. Sorry, my timing of meltdowns is always terrible”.

77. McCann did not receive this message until Monday 26 November 2018, at which point he sent her a message in response to arrange a time to speak to her.

78. On 26 November 2018, a meeting was held with RB at the OPP to discuss the upcoming criminal proceedings. McCann and a worker from VWAS were also present to support RB.

79. After this meeting, McMann discussed RB’s mental health with her and confirmed she had a plan for when she was feeling suicidal or had thoughts of self-harm. RB stated she would call ‘000’ or her local mental health service when she was feeling suicidal. McMann offered to submit referrals for further support, but RB declined. She also advised McMann that she did not want to be contacted by police frequently as it reminded her of Hartland and “put her in a bad head space”.

80. In the early hours of the morning on Wednesday 28 November 2018, RB contacted the AMAH Psychiatric Triage and stated that she had placed a rubber band around her neck with a plan to strangle herself. She was able to be de-escalated during this phone call. She denied further suicidal actions or intent, and agreed to undertake a CATT review the following day as she did not want to go to hospital, saying that she would find that distressing.

81. Several hours later RB contacted '000' stating that she had attempted to suicide by hanging herself from a door handle whilst intoxicated. Police and Ambulance Victoria paramedics attended, and RB advised them that the attempt had occurred in the context of recent conflict with one of the other victims. RB was detained under the *Mental Health Act* and transported to the Alfred Hospital for a mental health assessment.

82. RB was assessed overnight by the Emergency Psychiatry Service (**EPS**) and by consultant psychiatrist Dr Tracy Long later that day. RB reported experiencing continuing symptoms of depression and PTSD, withdrawal from her supports, including Ms Joyce, escalating alcohol use, and recent episodes of self-strangulation. RB was remorseful regarding her attempts and denied further suicidal intent or plans. She declined offers of a private or public hospital admission, drug and alcohol treatment, a change to her antidepressant medication, CATT support, or a re-referral to Ms Joyce. She did not meet the criteria for compulsory treatment under the *Mental Health Act* but accepted a referral to the Hospital Outreach Post-suicidal Engagement (**HOPE**) team, with CATT follow up in the interim.

83. FVCT members were not made aware of RB's mental health transfers on 23 and 28 November 2018.

84. In the weeks following these incidents, RB was managed by the Alfred CATT and HOPE team. On 29 November 2018, the CATT attempted to phone RB without success. On 30 November 2018, they conducted an unscheduled home visit and RB advised them that she did not want to engage with them any further. The CATT undertook a clinical review and decided that support would be offered to RB through telephone calls. However, RB did not engage with the CATT during subsequent phone calls – she said she was very busy and did not find speaking with the CATT on the telephone helpful.

85. There were insufficient grounds to compel RB to accept further CATT input or hospital admission. The CATT provided her with referrals and encouraged her to engage with the HOPE Team, which could provide flexible outreach support over a three-month period. RB was discharged from the CATT service on 4 December 2018.

86. On 11 December 2018, RB sent a text message to the HOPE team saying that she was "doing fine" and that she was going overseas for work and did not require any further support. This message was acknowledged, and no further attempts to contact RB were made by the HOPE team.

87. On 20 December 2018, RB attended an appointment with her GP for a matter unrelated to her mental health. This was her last contact with her GP.

88. In January 2019, RB was employed by ITV Australia to work in South Africa on a reality television show. During her time in South Africa, RB had a short relationship with a male who was also associated with the production. This relationship ended abruptly.

89. RB's friends and colleagues stated that she was drinking excessively after work, and was turning up to work late and missing shifts. RB reported to family and friends that she was struggling with writing her Victim Impact Statement. She declined offers from a friend to help her write it. RB's father stated that he believed his daughter was anxious about completing her Victim Impact Statement as it required her to relive what had happened and how it had affected her life.

90. On 10 January 2019, Hartland pleaded guilty to contravening a FVIO and using a telecommunication device to harass in relation to his contact with RB on Snapchat. He was sentenced to 60 days imprisonment and would be released from custody on 12 January 2019 after allowance for time already served on remand. The bail conditions relating to the rape and sexual assault proceedings remained in place following his release. McCann contacted RB to advise her of this development on 11 January 2019.

91. Meadows stated that Victoria Police requested the OPP to revoke Hartland's bail in relation to the rape and sexual assault matters however this request was declined.

92. On 24 January 2019, Ms B met with the Director of Public Prosecutions, the Solicitor for Public Prosecutions, Meadows and other representatives of both agencies at the Department of Justice and Community Services (**DJCS**). Ms B stated that during this meeting she raised concerns about Hartland being released on bail, as well as her concerns that the impacts of the proceedings upon RB's mental health were not being appropriately considered.

93. On 5 February 2019, RB sent a text message to a friend which stated, "I guess this is the end". At or around this time she also sent a message to her mother, stating "I can't live like this anymore, super barbs my beneficiary". RB's parents then telephoned her and she assured them she was fine.

94. On the evening of 6 February 2019, RB told a friend (who was working with her at the time) that she had twice attempted to hang herself in the preceding two days. Her friend observed

ligature marks on her neck during this conversation and he reported this information to the on-site medical team.

95. On 7 February 2019, an on-site psychologist employed by ITV Australia, Mark Matheson, conducted a risk assessment with RB and concluded that it was unsafe for her to return to work. He recommended that she be repatriated to Australia where the majority of her personal and professional supports were located, however RB refused.

96. Mr Matheson successfully negotiated with RB for her to be taken to the Akeso Clinic in Nelspruit, South Africa, for a mental health assessment. At the clinic RB was assessed by a psychiatrist who recommended that she be admitted to the facility for supervision. However, RB declined.

97. When RB returned to work later that day, she was advised by ITV Australia that they had decided to send her back to Australia. RB was angry and distressed by the decision, as she wanted to finish her job and go on a holiday she had planned. She also told colleagues that she believed being sent home would negatively impact her career.

98. RB's parents were notified by ITV Australia that she had experienced a mental health episode and had been taken to hospital for assessment and that she would be returning home. They arranged for RB's mother to meet them in Perth and escort RB home from there.

99. The same day, McCann sent a text message to RB and the other victims to check whether they had been contacted by the Victims Assistance Program. RB did not reply. McCann then emailed RB, who advised him that she was being sent home from South Africa. She confirmed that she had been in contact with a Victim Support Worker.

100. On 8 February 2019, RB flew to Perth in the company of Mr Matheson and they met RB's mother at the airport.

101. Mr Matheson told RB's mother of his recommendations for RB's ongoing support and care. These included that, ideally, she be immediately assessed at an emergency department or receive immediate follow-up from her GP and psychologist, or that her mother maintain supervision until regular assessment and follow up could be arranged.

102. RB's mother assumed her daughter's mental health episode was an anxiety attack similar to previous incidents RB had experienced. RB's mother stated that she was advised that her daughter was on suicide watch but was not told that she had made a suicide attempt.

103. RB's parents asked her to come and stay with them in Queensland, but their offer was declined. Instead, RB's mother flew from Perth to Melbourne with RB and stayed with her for several days. RB's mother stated that, during this time, RB initially appeared very angry with her employer for sending her home. After a few days, RB began sleeping most of the day and was not eating. RB's mother also noticed that her daughter was secretly drinking alcohol.

104. Mr Matheson and ITV Australia contacted RB in the days following her return to Australia, encouraging her to engage with her care plan and offering her further support through their Employee Assistance Program, as well as financial support for any medical treatment she required. RB confirmed she had made an appointment with her treating psychologist.

105. During this period, at approximately 4.00am one morning, RB's mother found RB lying on the kitchen floor, visibly distressed, with an exercise band tied tightly around her neck. RB's mother removed the band and tried to talk to her about the incident without success. She appeared to be intoxicated. RB's mother stated that although she knew that her daughter had anxiety and panic attacks and had called the CATT in the past, this was the first time she was aware of a suicide attempt.

106. The following day RB assured her mother that she was fine. They agreed that RB would see her psychologist, Ms Joyce, and that RB's mother would return home to Queensland. Over the following weeks, RB's parents maintained frequent contact with her via telephone. They reported that, during this time, her mental health appeared to have improved, she was going out, had taken a paddle boarding class, and she was looking forward to a new job with Channel 7.

107. On Friday 15 February 2019, RB sent McCann text messages at 4.44pm and 4.45pm stating, "Had some shit things happen in SA, company endorsed security guys. Nothing I can do I guess" and "And they say lightning doesn't strike twice. I have no more fight left in me".

108. McCann did not receive these messages until Tuesday 19 February 2019. At 12.45pm that day he tried to call RB but she did not respond and so he sent a text message. McCann noted that it was not unusual for RB to not respond to calls or messages for a considerable period. He stated that he attempted to call RB, but was unable to reach her, and that he informed Meadows and another manager of the messages.

109. On Friday 22 February 2019, RB spoke to a friend by telephone. RB appeared to be intoxicated and said that she wanted to suicide but did not actually intend to do so. During the conversation they discussed what had occurred in South Africa and RB expressed concern that it might affect

her career and future employment. RB also spoke about preparing her Victim Impact Statement and what she wanted to put into it. RB also told her friend that she thought she might be pregnant. RB's friend stated that, at the end of this conversation, she did not believe RB was going to attempt to suicide.

110. On Saturday 23 February 2019, RB had an appointment with Ms Joyce. Ms Joyce stated that RB presented as "troubled and sad" and "confused at another deterioration in her mental state". RB was reportedly angry and resentful about having been sent home from South Africa. She told Ms Joyce she had admitted to a colleague that she was suicidal but denied any intention. Since her return to Melbourne, RB reported she had experienced a re-emergence of significant anxiety and trauma symptoms in the context of the criminal proceedings and had increased her alcohol intake. She agreed she needed more intensive psychological support and made an appointment to see Ms Joyce again on 2 March 2019.

111. On Sunday 24 February 2019, RB spoke with her parents. They stated that she sounded happy and upbeat and was speaking positively about the future and her new job. RB also spoke to two friends who stated that she sounded positive about the future during their conversations.

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

Circumstances in which the death occurred

112. On Monday 25 February 2019, RB was due to start work under a new contract as an editor with the Channel 7 network. However, she did not attend work that morning.

113. On Wednesday 27 February 2019, Channel 7 staff contacted RB's father to advise him that they had been unable to contact RB. Her parents then contacted various friends of RB who reported that they had not heard from her since Sunday, 24 February 2019. RB's parents then contacted Victoria Police to ask for a welfare check.

114. At 4.30pm police attended RB's apartment and found it locked. They observed that her car was present but there was no answer at the front door. After further inquiries the police were able to obtain a key to the apartment from RB's former housemate.

115. At 6.40pm police entered the apartment and discovered RB hanging from a door handle at the end of the hallway, with a ligature tied around her neck. They determined that she was deceased.

The examination of the scene and wider police investigation did not identify any suspicious circumstances connected with RB's death.

116. A notebook was found in the apartment which contained two undated entries, one of these appeared to be a suicide note.

117. On 10 May 2019, Hartland was convicted of three counts of rape, one of which related to his offending against RB, and one count of sexual assault. He was sentenced to a total effective term of imprisonment of 14 years and 9 months, with a non-parole period of 11 years. With respect to his offending against RB, his sentence was a term of imprisonment of 6 years and 6 months.

Identity of the deceased

118. On 27 February 2019, RB, born 24 June 1974, was visually identified by her friend.

119. Identity is not in dispute and requires no further investigation.

Medical cause of death

120. Forensic Pathologist Dr Victoria Francis, of the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 28 February 2019 and provided a written report of her findings on 1 March 2019.

121. The post-mortem examination revealed a ligature mark on RB's neck which showed features in keeping with the ligature located with her body. A post-mortem CT scan showed no other injuries or illnesses that may have contributed to RB's death.

122. Toxicological analysis of post-mortem samples identified the presence of ethanol, diazepam, nordiazepam, venlafaxine and desmethylvenlafaxine.

123. Dr Francis provided an opinion that the medical cause of death was 1 (a) Neck compression in the circumstances of hanging.

124. I accept Dr Francis' opinion.

CONCERNS SUMBITTED TO THE COURT

125. Several concerns regarding RB's death were submitted to the court by Ms B. In particular, Ms B alleged that police failed to appropriately consider RB's mental health issues throughout the criminal proceedings against Hartland. Ms B noted that she raised her concerns with the DJCS, the OPP and members of the FVCT, during the criminal proceedings and after RB's death.

126. Ms B acknowledged that RB did not share her views that the police had not supported her appropriately.

127. Both RB's parents stated that RB felt well supported by police. They suggested that other stressors including the ongoing criminal proceedings, her interactions with the other victims, the completion of the Victim Impact Statement, and concerns about the impact of the recent cessation of her employment in South Africa were significant stressors for her.

FURTHER INVESTIGATIONS

128. Given the concerns raised about the support provided to RB during the criminal proceedings, and concerns raised about the impact of the criminal proceedings on her mental health, Coroner Olle referred this matter to the Coroners Prevention Unit (**CPU**) Mental Health and Disability Team for review.[4]

129. Victoria Police Professional Standards Command also conducted an oversight investigation in relation to RB's death, and a copy of the Interim Oversight Report was provided to the court.

130. The court also requested further information from the DJCS, and obtained a statement from the Victoria Police, Assistant Commissioner of Family Violence, Lauren Callaway, and an expert opinion from Dr Cathy Kezelman from the Blue Knot Foundation.

Adequacy of support services engagement with RB

131. The CPU noted that RB was supported by her family and friends, a public mental health service, Victoria Police, a sexual assault service, victim support services, her general practitioner, and a private psychologist.

[4] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

132. The CPU opined that all the services who supported RB appeared to have worked within their expected remit and in accordance with expected clinical practice.

133. The CPU also noted however, that although these services provided treatments and offered appropriate support, RB was not effectively engaged with any of these support services once the criminal proceedings were progressing to trial. There was a clear escalation in her risk-taking behaviours and suicidal thinking and distress during this time.

Victoria Police approach to RB to re-open her complaint

134. The CPU and Dr Kezelman noted that approaching a victim survivor to re-open a complaint is an interaction that needs to be managed sensitively to ensure their wellbeing, as there is a significant risk of re-traumatisation. Dr Kezelman noted that victim survivors are more likely to experience further trauma in interactions which are not trauma-informed. She stated:

> *Talking about the trauma especially when approached to do so after having moved away from focussing on it, can precipitate overwhelm and retraumatisation. The propensity of many traumatised people to dissociate and compartmentalise means that reminders of trauma can precipitate (`trigger') immobilisation and even collapse.*

135. The CPU noted that it is important that police adopt a trauma-informed approach when engaging with victim survivors. Given the nature of the work undertaken by the FVCT, which involves contact with victim survivors who have experienced a range of trauma, the CPU suggest that it is reasonable to expect that the FVCT taskforce engage with victim survivors in a way that minimises re-traumatisation.

136. It is unclear what type of support was offered to RB when she was approached by the FVCT in 2016 and asked to re-open her complaint against Hartland. It was also unclear the way in which this approach occurred.

137. Assistant Commissioner Callaway stated that the FVCT has a proactive approach to victim survivors of family violence and that victim engagement and disengagement risk assessments are completed and approved prior to engaging with a victim survivor. This includes considering how initial contact is made and developing a victim approach strategy.

138. Assistant Commissioner Callaway noted that under the *Victims' Charter Act 2006* (Vic) police must ensure that the investigation process is explained, and that the victim survivor is kept informed of the key stages in an investigation and prosecution.

139. During their initial contact with victim survivors, police will provide the contact details for relevant local services and a copy of the *Victims Guide to Support Services and the Criminal Justice System* (Form L1). This guide contains information concerning the court process and contact details of victim support services. The *Reporting Sexual Assault to Police* booklet is also provided to ensure victim survivors are provided with consistent information. This sets out each stage of the investigation process, the court process, and details support and welfare information.

140. Assistant Commissioner Callaway noted that prior to approaching a victim about reopening a complaint, a risk assessment is completed which is usually limited to information recorded on LEAP and Interpose, intelligence reports and information shared with other agencies. The FVCT complete an Interpose Victim Engagement Template for the initial risk assessment which captures information including the victim's engagement with family violence services, relationship status, whether the victim lives with children, any intervention orders and historical and current risks including substance abuse and mental health concerns. In addition, a Victim Management Plan is completed, which is targeted at protecting each police division's identified highest risk victims.

141. Assistant Commissioner Callaway also noted that police are not qualified to make psychological assessments in relation to any impact upon victims arising from a complaint being reopened, however investigators monitor and assess any obvious signs of distress or psychological impact on an ongoing basis and, as part of this process, offer referrals to appropriate support services.

142. The CPU reviewed relevant sections of the Victoria Police Manual (**VPM**) and the Standard Operating Procedures of the FVCT. The CPU noted that the relevant procedures and guidelines have a victim centric approach which recognises the vulnerability of victim survivors, encourages a 'no-pressure' approach, emphasises victim stories and experience, and offers support throughout the process.

143. However, the CPU also noted that trauma-informed services are based on a body of evidence that could consolidate the approach of the FVCT and expand the skills of individual members in engaging with and supporting victim survivors. This is especially important when

approaching victim survivors who have not followed through on an original complaint and through a court system that is, by its nature, retraumatizing.

144. The CPU suggested that the FVCT could undertake further training about trauma and its impacts, as well as trauma informed principles, and use this training to inform a review of the adequacy and appropriateness of the way they re-engage with victim survivors regarding a previous complaint, as well as a review of the Victim Management Plan used by the FVCT.

145. Whilst I broadly agree with this suggestion, there is no clear evidence that a training deficit exists in this regard. Consequently, I am not satisfied it is necessary for the suggestion of additional training to be reflected in a broad recommendation for training and review as contemplated.

146. The CPU also suggested it would be reasonable to expect that the FVCT make every attempt to ensure that contact is made with a victim survivor with the presence of a support service, especially in cases where follow up contact is being made with someone who previously withdrew their complaint. Where a victim survivor is already involved with a support agency, consideration should be given to arranging for the initial contact to be made in consultation with that agency.

147. There are however significant practical difficulties with the suggestion in circumstances where the victim survivor has not previously been engaged with support services or those services cannot be identified. To have a support worker (previously unknown to the victim survivor) present at the initial contact would involve depriving the victim survivor of the choice whether to be involved with a support worker at that moment, or at all, or with that particular support worker. Furthermore, for the support worker to be effective at the initial contact, it is highly likely that they would first have to be briefed with confidential information from the criminal investigation. Again, this would amount to a step taken without a choice having been made by the victim survivor.

148. The value in having a support worker available to the victim survivor as soon as practicable after initial police contact is clear. However, this step must be the choice of the victim survivor.

149. This conclusion sounded in a draft recommendation which was provided to Victoria Police for submission. In a letter to the court dated 31 May 2024, the legal representatives for Victoria Police submitted that the draft recommendation should be altered to reflect the fact that, ultimately, Victoria Police cannot control the availability of a trauma or specialist support

service counsellor. I accept the submissions in this regard and the product of this issue is reflected in Recommendation One.

Management of RB's wellbeing by Victoria Police

150. RB told family and friends that she felt well supported by the FVCT. It is clear from the available evidence that members of the FVCT made themselves available to her for support, made efforts to meet with her when appropriate, submitted appropriate referrals, engaged with RB's support workers, repeatedly offered to make additional referrals for support, repeatedly checked to ensure that RB was linking in with appropriate support services, and developed safety plans.

151. An Interim Oversight Report completed by Detective Acting Senior Sergeant Reece Campbell (**Campbell**) found that Madden conducted himself professionally in relation to the investigation and made all appropriate referrals, including referrals in relation to the completion of the Victim Impact Statement.

152. The Interim Oversight Report noted that there were deficiencies in the recording and sharing of information with respect to RB. However, it was considered that these deficiencies did not appear to have been contributory to RB's death. I accept this conclusion.

153. With respect to the lack of information sharing about RB's mental health transfers, Campbell noted that the VPM sections on mental health were silent regarding the submission of the Mental Disorder Transfer Form (VP42) to LEAP, and so there was no obligation on the member detaining persons under the *Mental Health Act* to submit this form to LEAP.

154. In response, Detective Acting Sergeant Georgia White made a submission to Victoria Police Corporate Policy requesting that the VPM be amended to mandate the recording on LEAP of apprehended persons under the *Mental Health Act*. This will increase the likelihood that the FVCT will have timely information about a victim survivor's contact with Police and public mental health services.

155. Campbell also noted that there were deficiencies in the recording of contact between the FVCT and RB. In particular, some of the contacts between Madden and McCann were not appropriately recorded in Interpose or LEAP. This was acknowledged by both Madden and McCann in their written statements.

156. Since RB's death, the FVCT has altered its practices with respect to the recording of victim management and contact with victims, which will now be recorded via Interpose 'Tasks'. This will ensure that it is clear who has responsibility for victim contact and that any such contact is appropriately recorded and accessible to all who have access to the Interpose record. This will also allow access certificates to be given to members who transfer out of the FVCT during an investigation and may still require access.

Completion of the victim impact statement

157. The statements of family, friends, and colleagues who supported RB indicate that she was distressed by writing her Victim Impact Statement. This was also the experience of the other victims involved in the criminal proceedings against Hartland. The DJCS advised that there are several ways to support a victim of crime when preparing a Victim Impact Statement. These include the Victims of Crime Helpline (**the Helpline**) which provides support, assistance and further referrals, and the Victoria Police electronic Referral (**VPeR**) which enables police to refer a victim of crime to the Helpline. Victims of Crime can also be referred via the Helpline or VPeR to the VAP which can offer information, support and ongoing case management where required. Both the Helpline and the VAP can provide information, support and assistance in relation to completing a Victim Impact Statement.

158. Victims of crime can also receive support from other services when composing a Victim Impact Statement. These include, the OPP's VWAS, legal counsel or private professional services such as psychologists and counsellors.

159. It is apparent that multiple people made repeated offers to support RB with her Victim Impact Statement, including friends, members of the FVCT and support services. Unfortunately, she did not accept any of these offers or meaningfully engage with the respective services.

160. Dr Kezelman noted that

> *The risks associated with a victim making a victim impact statement are not clear. This is because victims, their levels of emotional distress, circumstances and backgrounds are all unique…*
>
> *…While victim impact statements provide an opportunity for a victim to revisit their narrative, articulate the harm experienced, have their experience validated, and potentially make meaning of what happened to them, the risks/benefits depend on each person, their current internal resources, and support systems, as well as*

psychological readiness for this process. While preparing and delivering victim impact statements including publicly can be empowering for some, victims may fear public exposure and scrutiny in court, as well as outside it. The fear and shame of the original assault can predominate and a victim, especially one who has not chosen to complete a victim impact statement can be overwhelmed, destabilised and substantially retraumatised.

Victim survivor groups

161. As noted above, RB and the other complainants against Hartland formed an informal support group with each other, communicating in a group chat on the application WhatsApp. This does not appear to have been a formal group arranged by the FVCT or any other support service.

162. Dr Kezelman noted that there can be both risks and benefits to victim survivors in the same proceedings forming a connection or support group. She stated:

Victims often feel a sense of alienation from people who have not been assaulted but intense connection and identification with fellow victims. This draws victims together in a collective purpose. In this context a victim may pay less attention to their personal wellbeing. They are also at that point not only exposed to revisiting their own trauma but additionally immersed in the trauma of others, with the risk of flooding their own internal resources and strategies which help them to ground and self-soothe.

163. Dr Kezelman also stated that:

…being part of a multiple victim investigation exposes a victim not only to reminders of their own trauma but traumatic material, distress and intense emotions collectively. This risks retraumatisation, vicarious traumatisation and collective traumatisation…

…Sometimes, shared pain leads to solidarity that promotes healing because, individuals may defend against a common experience and find meaning in their experience together. If a group can align their emotions, thoughts, and awareness of the impacts of traumatic stress they can co-regulate. The risk however is that multiple victims whose trauma is unresolved, who are activated by the process will be overwhelmed individually and collectively.

164. The CPU noted that there is a lack of information available to victim survivors about the benefits and risks associated with engaging with a group of victim survivors in circumstances that include current, and potentially protracted, court proceedings.

165. Furthermore, there is evidence to suggest that RB experienced stress associated with some aspects of the informal support group she was engaged in.

166. The CPU suggested that DJCS should develop public information, such as a fact sheet, with information that provides a balanced discussion of the risks and benefits of becoming part of a victim survivor group outside of a therapeutic environment and without oversight. This information should be readily accessible to victim survivors, family, friends and supporting services.

167. This suggestion was framed as a draft recommendation and the DJCS was provided an opportunity to make submissions upon it. In a letter to the court dated 27 May 2024, the DJCS identified various risks associated with the draft recommendation. Among the risks, it submitted that it was not appropriate to attempt to provide a "balanced discussion" or be seen to endorse an informal support network when the essential aspects of the network would be unknown to the department. It also submitted that the recommendation should allow more flexibility in the delivery of information to victim-survivors, aligned with the body of evidence around risks of re-traumatisation, Finally, the DJCS proposed an alternate framing of the proposed recommendation. I accept these submissions and the product of this issue is reflected in Recommendation Two.

FINDINGS AND CONCLUSION

168. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the overlay of caution described in *Briginshaw v Briginshaw*.[5] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

169. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was RB, born 24 June 1974;

    b) the death occurred on 27 February 2019 at 4/455 St Kilda Street, Elwood, Victoria, 3184, from neck compression in the circumstances of hanging; and

    c) the death occurred in the circumstances described above.

170. RB suffered significant stress in the lead up to her death, including ongoing trauma from the rape, the ongoing criminal proceedings related to the rape, and the premature cessation of her employment in South Africa.

171. There is no presumption for or against a finding of suicide. Nevertheless, a finding that a person has deliberately taken his or her life can have long lasting ramifications for their family and friends. Therefore, a finding of suicide should only be made when there is clear and cogent evidence.

172. In this case, I am satisfied that RB acted with the intention of taking her own life. In reaching this conclusion I have taken into account the lethality of means chosen, her mental health history, her history of previous suicidal ideation and attempts, and the numerous stressors she was experiencing.

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[5] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: '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…'.

173. It is abundantly clear that the rape had a profound impact on RB's mental health, and the ongoing criminal proceedings against Hartland were a very significant cause of stress for her in the years preceding her death.

174. RB had a sound support network in place, including her friends and family. I am satisfied that the support services who engaged with RB acted appropriately and within their respective remits.

175. RB's social supports included the other victims of Hartland's crimes, and it is apparent they cared for her. They took steps to raise concerns with the FVCT when they felt that RB was not coping. However, it appears that RB joined this group without any information regarding the risks of engaging in such groups, and without a supportive framework around the group to address risks such as retraumatisation. This led to RB experiencing stress associated with certain group interactions.

176. I make no criticism of the conduct of any complainant within the group, or the conduct of the group as a whole. Rather, these comments concern the risks that may arise generally from engaging in such groups. Due to their very nature, the risks include retraumatisation.

177. Involvement in victim survivor support groups carries both risks and benefits. I am satisfied that information about such risks and benefits should be communicated to victim survivors when they are forming, or considering whether to join, such groups.

178. With respect to RB's interactions with Victoria Police, I am satisfied that the initial approach to RB to re-open her complaint was conducted appropriately. I am also satisfied that Victoria Police have appropriate procedures in place to consider the wellbeing of victim survivors in such circumstances.

179. Collaboration between Victoria Police and support services when engaging with victim survivors of rape and sexual assault is clearly encouraged within the applicable policies and procedures. However, such engagement is not mandated as the degree to which collaboration occurs between Victoria Police and support services must be determined by the victim survivor.

180. I am satisfied that the FVCT had appropriate ongoing contact with RB and were responsive when concerns arose for her welfare. They repeatedly offered to link her with further support and RB consistently assured them that she had appropriate supports in place. They also collaborated and shared information with her support workers. The steps the FVCT took to

support her were appropriate, based on the information available to them, and it is clear that RB felt well supported by them.

181. There were deficiencies in the management and sharing of information regarding RB within Victoria Police. This included multiple occasions when RB had contact with Victoria Police for mental health transfers but this information was not shared with the FVCT or uploaded to LEAP. I do acknowledge, however, that the uploading of mental health transfer forms to LEAP was not required by the policies and procedures applicable at that time and appropriate changes have been made to ensure such information is included in the Interpose record of an investigation.

182. I am not satisfied that a different approach to the sharing of this information would have altered the course of events. In this regard I note that RB was linked with appropriate mental health services following each of the mental health transfers and she had a significant support network in place. Nonetheless, this was important information that would have assisted the FVCT in supporting RB and should have been shared.

183. These deficiencies have been acknowledged by Victoria Police, and I am satisfied that they have taken appropriate steps to address these issues and ensure improved management and sharing of victim welfare information.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

Recommendation One

That the Victoria Police FVCT update its operating procedures to include that, following the FVCT's initial approach to the victim survivor, police members are required to offer to make a referral to a trauma or specialist support service counsellor on behalf of the victim survivor. If the victim survivor agrees to a referral, the referral should be made as soon as practicable. This requirement should also apply in circumstances where investigators make a renewed approach to a victim survivor.

Recommendation Two

That the Department of Justice and Community Safety – Victim Services, Support and Reform publish additional information for victims of crime that provides guidance on the key elements of safe and effective victim support services, including the importance of receiving support through structured and trauma informed processes. This information is to be readily accessible to victim survivors, family and friends and supporting services.

COMMENTS AND DIRECTIONS

I convey my sincere condolences to RB's family and friends for their loss.

I thank the Coroner's Investigator and those police members assisting for their work in this investigation.

Pursuant to section 73(1B) of the Act, I order that this finding, save for Appendix A, be published on the Coroners Court of Victoria website in accordance with the rules.

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

RB's parents, Senior Next of Kin

Lauren Callaway, Assistant Commissioner, Family Violence Command, Victoria Police

Detective Acting Senior Sergeant Reece Campbell, Victoria Police, Professional Standards Command

Detective Sergeant Brendan White, Victoria Police, Professional Standards Command

Sally Robertson,Victorian Government Solicitors Office

Enver Erdogan MP, Minister for Victim Support

Sergeant Yvette Lippold, Coroner's Investigator

Signature:

___________________________________**CORONER PAUL LAWRIE**

Date : 27 June 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.

Appendix B – List of Abbreviations

AMAH	Alfred Mental and Addiction Health
CATT	Crisis Assessment and Treatment Team
CPU	Coroners Prevention Unit
D/A/S	Detective Acting Sergeant
D/A/S/S	Detective Acting Senior Sergeant
D/S/C	Detective Senior Constable
D/S/S	Detective Senior Sergeant
DJCS	Department of Justice and Community Safety
E&TC	Alfred Hospital Emergency and Trauma Centre
EPS	Emergency Psychiatry Service
FVCT	Family Violence Command Taskforce
FVIO	Family Violence Intervention Order
GP	General Practitioner
Helpline	The Victims of Crime Helpline
HOPE	Hospital Outreach Post-suicidal Engagement
LEAP	Victoria Police Law Enforcement Assistance Program
OPP	Office of Public Prosecutions
PACER	Police and Clinician Early Response
PTSD	Post Traumatic Stress Disorder
SECASA	South East Centre Against Sexual Assault
VAP	Victims Assistance Program
VIFM	Victorian Institute of Forensic Medicine
VIS	Victim Impact Statement
VPeR	Victoria Police Electronic Referral
VPM	Victoria Police Manual
VSR	Victorian Suicide Register
VWAS	Victim and Witness Assistance Service