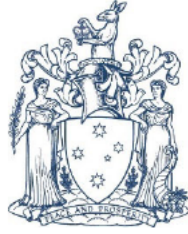

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 002791

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	EK[1]
Date of birth:	[redacted] 1976
Date of death:	1 June 2019
Cause of death:	1(a) Multiple injuries in a train incident
Place of death:	[redacted] Railway Station, [redacted], Victoria, [redacted]
Keywords:	Suicide, police contact death, suicide in persons suspected of sexual offences, suspect welfare considerations, health-led response

[1] This Finding has been de-identified by order of Coroner Ingrid Giles which includes an order to replace the name of the deceased, and the names of other persons related to or associated with the deceased, with a pseudonym of a randomly generated letter sequence for the purposes of publication.

INTRODUCTION

1. On 1 June 2019, EK was 43 years old when he died having been struck by a train in circumstances consistent with suicide.

2. EK was born to parents, Mrs QK and Mr HK and was raised alongside his two brothers, MK and SK.

3. As an adult, EK re-located overseas where he worked for a number of years before eventually returning to reside with his parents in Victoria. Upon his return, EK completed his tertiary education and secured employment providing disability support to families and young people. He was previously employed at a local community service provider, and at the time of his death, worked for a disability support company in Geelong.

4. EK lived with his parents for the final seven years of his life. Mrs QK and Mr HK describe him as *'sensible',* and recall that he abstained from drugs and partying, only occasionally drinking alcohol. They further recall that EK was *'very reserved with his feelings'* but report there *'was nothing to suspect that there was a mental health issue'* in the months preceding his death.

5. In 2018, EK purchased a property in [redacted] and was *'very excited about the move to the new house'*. He moved to the [redacted] property approximately one month prior to his death.

6. EK had an unremarkable medical history. He attended a regular General Practitioner (**GP**), upon whom he attended for ailments including back pain and fatty liver. EK did not report experiencing suicidal ideation and had not received any formal diagnoses of mental ill health.

7. In 2014 and 2018, EK reported *'feeling anxious'* and experiencing disturbed sleep, though these episodes were ascribed to changes in employment at the time.

THE CORONIAL INVESTIGATION

8. EK'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.

9. 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.

10. 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.

11. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of EK's death. The Coroner's Investigator conducted inquiries on the Court's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

12. Coroner Audrey Jamieson initially held carriage of this investigation until it came under my purview in July 2023 for the purposes of obtaining additional material, finalising the matter and handing down findings.

13. This finding draws on the totality of the coronial investigation into the death of EK 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]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

Background Circumstances

14. On 5 March 2019, a staff member of a community service provider reported an alleged 'inappropriate relationship' between a current client and former employee to the Geelong Sexual Offences and Child Abuse Investigation Team (**SOCIT**) of Victoria Police.

15. A Victoria Police detective from the Geelong SOCIT (**the SOCIT detective**) commenced an investigation.

16. On 15 April 2019, the SOCIT detective spoke to the complainant who described sexual offences allegedly committed by EK sometime between 2014 and 2017 while the complainant

[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.

was a minor and under EK's care. The complainant refused to provide a formal statement to police about the allegations.

17. As the complainant had '*disclosed sufficient information to establish an offence'*, the SOCIT detective's supervisor determined that EK should be interviewed about the allegations. It was considered '*not appropriate*' to approach EK at his home or workplace.

Proximate Circumstances

18. In lieu of meeting EK in person, at 7:30pm on 29 May 2019, the SOCIT detective telephoned him in order to schedule an interview with him. Of this telephone call, the SOCIT detective recalls:

> *'[EK] was advised that allegations had been made about him, he was not advised of the accuser nor the nature of the allegations. I advised him that the interview needed to be in person at a police station. He was advised that he would be spoken to and released on the day'.*

19. An interview was scheduled for three days' time, at 3pm on 1 June 2019.

20. In the time preceding EK's death, Mrs QK recalls a slight change in behaviour. She noted that he was more emotive than his usual reserved demeanour:

> *'EK was normally a man of few words, but he was a bit more thoughtful about the way he spoke. It was a slight change in his personality that he was deliberately speaking in a more caring way'.*

21. Further, Mrs QK recalls that he mentioned selling his ██████ property despite that he bought it some 12 months prior, and that he *'might get another job',* which she dismissed as *'flippant'* comments. There is no evidence to indicate that Mrs QK and Mr HK were aware of EK's recent interaction with Victoria Police.

22. On the morning of 1 June 2019, EK arrived at his parents' residence to walk their dog. EK and Mrs QK engaged in small talk before he said *'I have to go now. I might not be around for a while'.*

23. At 2:45pm, Victoria Police members of the ██████████ Station were advised of an individual having been struck by a train a short distance from the ██████████ Train Station. Upon arrival, Victoria Police members observed a deceased male on the tracks.

24. Victoria Police members spoke with the driver of the train, who reported that he was travelling between 80 and 90 kilometres per hour and was clearing a right-hand turn when he observed an individual place themselves directly in the train's path. There was insufficient distance to draw the train to a halt, and it impacted with the individual.

25. A backpack was located amongst vegetation on the periphery of the tracks. Inside, members located a wallet which contained identification bearing EK's name and photo, which bore a resemblance to the deceased individual at the scene.

26. Also located was a notebook, an entry made on the same day read, in part:

    'This is the best time in my life to say "Goodbye" …love always, EK'.

27. At 2:55pm, the SOCIT detective, unaware of the fatality at [redacted], arrived at the Geelong Police Station in anticipation of the interview with EK, scheduled to occur at 3pm. However, EK did not attend the appointment, and at 3:55pm, the SOCIT detective arrived at Mrs QK and Mr HK's residence, to enquire as to his whereabouts.

28. The SOCIT detective spoke with Mr HK, who advised her that EK recently moved into his [redacted] property. The SOCIT detective left her contact details with him and asked to have EK contact her.

29. In the days following his death, EK's day planner was located. Entries made by EK dated 1 June 2019 read *'Police interview'* and *'Goodbye'*.

IDENTITY OF THE DECEASED

30. Scientist Dr Linda Benton (**Dr Benton**) of the Victorian Institute of Forensic Medicine (**VIFM**) obtained deoxyribonucleic acid (**DNA**) samples from the deceased individual and compared them with DNA samples provided by EK's brother, MK. From the comparison, Dr Benton stated the probability of a sibling relationship between the deceased individual and MK was greater than 99.99% and provided an Identification Report dated 16 June 2019 to this effect.

31. My colleague, Coroner Audrey Jamieson, reviewed the available evidence including the Identification Report of Dr Benton, and determined that the cogency and consistency of all evidence relevant to identification supported a finding that the identity of the deceased was EK, born [redacted] 1976. Accordingly, her Honour signed a Determination by Coroner of Identity of Deceased (**Form 8**), dated 12 June 2019.

MEDICAL CAUSE OF DEATH

32. Senior Forensic Pathologist Dr Michael Burke (**Dr Burke**) from the VIFM conducted an examination of the body of EK on 3 June 2019. Dr Burke considered the Victoria Police Report of Death (**Form 83**) and post-mortem computed tomography (**CT**) scan and provided a written report of his findings dated 4 June 2019.

33. The post-mortem examination revealed multiple catastrophic injuries about the body.

34. Toxicological analysis of post-mortem samples identified the presence of ethanol (alcohol) at a concentration of ~ 0.02 g/100mL and paracetamol at a concentration of ~ 7 mg/L.

35. Dr Burke provided an opinion that the medical cause of death was 1(a) *multiple injuries in a train incident*.

36. I accept Dr Burke's opinion.

VICTORIA POLICE SUSPECT WELFARE CONSIDERATIONS: AN ANALYSIS

37. On the basis that EK's death occurred proximate to contact with Victoria Police, during which he was informed there were allegations against him that required a formal interview, the Court sought statements and materials from Victoria Police regarding its actions when engaging with EK following the allegations, as well as applicable policies and procedures.

<u>Actions of Victoria Police when engaging with EK</u>

38. The management of suspects of sexual offences by Victoria Police members is primarily governed by the Victoria Police Manual regarding 'Sexual Offence Investigations' (**the VPM**). The VPM, dated November 2018 and which was in force at the time of EK's death, identifies that when suspects become aware of investigations being undertaken by Victoria Police, they are at an increased risk of suicide and self-harm. It continues to identify the period *'shortly before or after police interview'* as one of heightened risk.

39. Further guidance is provided by additional documents including the Code of Practice for the Investigation of Sexual Crimes, Crime Investigative Guidelines and through training provided to Victoria Police members including specialised education for SOCIT members relating to the management of sexual offence investigations.

40. It is known by Victoria Police that suspects may present a higher risk of suicide and self-harm during these periods due to *'a lack of prior criminal histories or contact with the justice system, a significant loss of reputation, fear of prison life, rejection from family, and community and the unfamiliarity with the legal process'*.

41. Accordingly, the VPM establishes guidelines regarding officer conduct when interacting with such suspects. Of importance, the VPM states:

> *'members should avoid using phone messages, calling cards or arranging arrest by appointment'*.

42. The VPM continues that:

> *'arrest plans should include alternatives for situations where the suspect is not located which ensure the nature of the enquiry is not identified prior to arrest'*.

43. At first blush, it does not appear that the SOCIT detective's conduct, by first engaging with EK via telephone, providing a calling card to his father and arranging an arrest and interview by appointment, adhered to the requirements of the VPM.

44. In a statement to the Court, the SOCIT detective spoke of her decision to telephone EK instead of attending upon him:

> *'It was deemed that to attend at his home or workplace would have been intrusive and not appropriate in the circumstances.'*

However, in a separate statement, she relayed:

> *'Consideration was given to attending at the home or place of work to arrest [EK] but a decision was made not to do so due to there being no statement [of the complainant] in possession of the police'*.

45. The statement of the SOCIT detective does not address why attending EK's home or workplace would have been more inappropriate than in other circumstances where members are required to attend upon a suspect of sexual assault.

46. The SOCIT detective further stated with respect to the telephone call:

> *'I took the time as I do with any arrest by appointment in addressing the questions that the accused may have at the time and reassure them that the purpose of speaking to*

them is part of the investigation and providing them with the opportunity to hear the allegations and provide their account if they choose to. I also advise them that they are open to obtain legal advice prior to attending the police station and an opportunity to hear the allegations and provide their account if they choose to'.[3]

47. The VPM establishes guidelines regarding the *'post-interview welfare'* of suspects and requires members to *'provide a printed copy of the Information and Support Referral brochure to the suspect…This brochure contains information relating to the police investigation and how to access legal and support services'*.

48. The effect of the VPM is to ensure that, wherever possible, the first contact between Victoria Police and a person suspected of a child sexual offence occurs face-to-face and encompasses arrest, interview and provision of information and support. The SOCIT detective states that *'at the conclusion of the interview [EK] would have been provided with a copy of the Information and Support Referral [brochure] and if required additional supports via Barwon Health and other supports that could be identified for the accused'*.

49. When speaking of her telephone call to EK, the SOCIT detective recalled *'[he] gave me no indication during the conversation on the phone of the actions that he would eventually take prior to the interview being conducted'*.

50. I consider that, while acknowledging that police are not clinicians, telephone calls are not sufficient to comprehensively assess an individual's welfare or frame of mind at a particular point. Indications that an individual is at risk of suicide or self-harm, such as body language and behavioural shifts, are not conducive to being detected during a telephone call.

51. Unfortunately, because the SOCIT detective's first contact with EK was made via telephone, there was little or no opportunity to accurately identify and manage any risk to EK's wellbeing.

Position of Chief Commissioner of Police

52. In light of the SOCIT detective's apparent deviation from the VPM, a statement was sought from the Chief Commissioner of Police regarding the organisation's expectations of members when managing suspects of sexual offences.

[3] It is worth noting that a recording of the telephone call between the SOCIT detective and EK is not available.

53. A statement was provided by Assistant Commissioner Lauren Callaway (**AC Callaway**), on behalf of the Chief Commissioner of Police, who stated:

> *'Generally, it is not considered appropriate to make initial enquiries of a suspect by telephone message, calling cards or arranging an interview by appointment. This is because the risk of self-harm can be particularly acute when a suspect first becomes aware that they are being investigated for child sex offences'.*

54. However, AC Callaway continued:

> *'The guidance provided in [the VPM] is expressed in terms that allow members to exercise professional judgment'*

And that,

> *'In my opinion, [the SOCIT detective] appropriately considered [EK's] welfare regarding the impact of police attendance at either his residence or workplace and determined that the nature of contact to be intrusive and inappropriate for the presenting circumstances'.*

55. AC Callaway, in providing an evaluation of the appropriateness of the SOCIT detective's actions, concluded:

> *'It is my view that the actions taken by [the SOCIT detective] as described above, met Victoria Police expectations regarding suspect welfare'.*

56. AC Callaway acknowledged that she did not listen to the telephone call which occurred between the SOCIT detective and EK on 29 May 2019, and that she was *'not aware of whether a referral was offered'* on his behalf.

Changes made to the Victoria Police Manual in the time since EK's death

57. In the years since EK's death, Victoria Police have amended the VPM applicable to the management of suspects of sexual offences.

58. The VPM was updated in July 2020 to emphasise the importance of suspect welfare management, particularly at the time of initial police contact:

> *'When any in-person contact is made and the suspect becomes aware that they are under investigation, police are to conduct a thorough risk assessment by asking*

informal questions and responding to the outcome of that assessment….Police are to ensure that the suspect is provided with the Information and Support Referral brochure, regardless of the outcome of the assessment'.[4]

59. There was no substantive update to the requirement for members to avoid contacting suspects via telephone call, leaving calling cards or arranging interview or arrest by appointment.

60. In this connection, I consider it is paramount that, while the VPM need not be overly prescriptive in the ways in which offenders ought to be approached in relation to allegations of this nature, police members should indeed '*avoid using phone messages, calling cards or arranging arrest by appointment*' as per its explicit recommendation, unless compelling reasons exist otherwise.[5]

61. I consider it to be troubling that, even with the benefit of hindsight, the SOCIT detective stated she '*would still make the same decisions given the same set of circumstances again'*, despite the outcome, and that the SOCIT detective's approach has been endorsed on behalf of the Chief Commissioner of Police. While Victoria Police is to be commended for its actions in progressively improving processes for suspect welfare, I consider that it must also encourage, support and set the expectation that its members follow the best practice processes that are very clearly outlined in the VPM.

THE PREVALENCE AND TREND OF SUICIDES IN PERSONS INVESTIGATED FOR ALLEGED SEXUAL OFFENCES

62. Given that the circumstances of EK's death appeared to form part of a broader pattern of suicides amongst persons who are suspected of committing sexual offences, I engaged the Coroners Prevention Unit (**CPU**) to conduct background research into suicide among people who were being investigated for alleged sexual offences against children. Through understanding the prevalence of these suicides in Victoria and any common features among them, I hoped to gain some insight into opportunities to reduce the risk of further such suicides occurring in future.[6]

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[4] A further update was made in September 2021 that related to retention of evidence kits and is not relevant to the present case.

[5] It is noted in this connection that, despite that the language used in the VPM is said to allow for the exercise of professional judgment, the VPM itself cautions members that '*non-compliance with or a departure from [the VPM] may be subject to management or disciplinary actions*'.

[6] The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas

Data obtained by the Coroners Prevention Unit on similar suicides and the circumstances in which they occurred

63. The CPU searched coronial databases including the Victorian Suicide Register (**VSR**) and identified 150 suicides in Victoria between 2009 and 2022 of people who were being investigated for alleged sexual offences. In 100 cases, the deceased was being investigated regarding alleged contact offences against children. The remaining 50 cases involved sexual offences against adults and image-based offences. All deceased were male, with ages ranging from under 18 to over 85.

64. In the CPU's analysis of the 100 suicides among males under investigation for alleged contact offences against children, it became apparent to me, the varied circumstances in which the suicides occurred. For example, in 14% of cases, the alleged offending occurred within a week of allegations being made to police, but in 53% of cases, the alleged offending occurred more than a year prior, with many allegations pertaining to offending that occurred years or even decades ago. The majority of alleged victims (61%) were related to the deceased, being mainly children, step-children or grandchildren; and in most other cases the alleged victim was an acquaintance, such as the child of a friend or neighbour, a student at a school where the deceased taught, or similar. Alleged offences against strangers were extremely rare.

65. There was substantial variation in the intersection between the police investigation and the suicide. Around a third of the suicides occurred within a week of the deceased first becoming aware that police were investigating alleged offences; at the other end of the spectrum 13% of the suicides occurred more than year after the deceased became aware an investigation had commenced. EK's death falls within the former category, occurring within three days of becoming aware of the police investigation. In 12% of cases, the deceased suicided before police could make first contact with them regarding the investigation. Most suicides occurred either between the deceased being interviewed and charged regarding the alleged offences (38%) or after they had been charged and were on bail in the community awaiting court proceedings (38%).

66. Further to the above, the CPU advised that 53% of the suicides occurred within a week of a key point in the police investigation. These included cases where the deceased suicided in the

including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

week after their first in-person contact with police (25% of all cases), and cases where the deceased suicided in the week leading up to a court hearing date (16%).

67. In considering these cases, I was struck by the prevalence of evidence explicitly linking the alleged offending and police investigation to the deceased's decision to suicide. As a coroner with a degree of experience investigating suicides, I am cognisant that the act of suicide is most often the culmination of multiple stressors and mental ill health experienced across the person's life. By contrast, the prevalence of mental ill health among males who suicided while under investigation for alleged contact offences against children was quite low (around 30%, compared to over 50% in the general population of males who suicide in Victoria).

68. In 63% of cases, there was direct evidence linking the act of suicide with the allegations and police investigation. Upon examining this link, several recurring themes emerged, including the deceased stating they were suiciding because the allegations ruined their future lives and irreparably damaged their reputations; they feared going to prison; they were unable to handle the stress associated with the events; and they could not live without their children and family.

69. I note that these are the risk factors which are identified by the VPM when managing the welfare of individuals suspected of sexual offences.

70. In around half of these cases the deceased professed to be innocent of the alleged offences. The themes in the suicide notes and other articulations of intent for this group included that regardless of their innocence, they would be tarnished by the accusations forever; and that they suicided to protect their family's reputation, to save them the distress and shame of going through the legal process. Among those who admitted guilt, they most often apologised to the victims and expressed shame at their actions, shame at the harm they had caused, and shame at the broader community finding out what they had done.

71. It is important that I reiterate that text messages sent by EK, and a 'suicide note' left by him at the scene of his death, did not directly address his recent interactions with Victoria Police. Nor did these materials reveal the extent of his knowledge of the nature of the allegations against him. However, and while making no comment on the veracity of the allegations, I consider that, given his diary entries and change in behaviour in the days leading up to death, as well as the timing of stepping in front of the train, EK's decision to take his own life was connected with his fears of the upcoming police interview and potential implications of the same.

Research literature on suicides among alleged sexual offenders

72. In addition to collating data and advice for me, the CPU conducted a literature review of studies internationally on suicide among both alleged and convicted sex offenders. They noted a general finding of heightened suicide risk among people in this group, with studies estimating their suicide risk to be up to 100 times or more greater than the general population.

73. Several findings in the international literature were consistent with the Victorian data the CPU collated. For example, multiple studies found suicides may be more likely to happen during developments in the investigation, such as just after allegations are made, and when legal proceedings are due to commence. Population-level factors such as history of mental ill health may be less important for suicide risk in this group than in the general population; rather, the evidence suggests many suicides are occurring directly as a result of the allegations and investigation, which impacts on all aspects of their lives and can cause shame, loss of social standing, family breakdown and so on.

74. When I considered my prevention role as a coroner, I was struck by a United States study into the far-reaching effect of trauma, specifically beyond the deceased's immediate family. The researchers noted that as a consequence of these suicides, alleged victims are rendered unable to resolve their allegations through the legal system, often left to process the trauma of abuse compounded by the trauma of the suicide. Where the deceased leaves behind notes professing innocence, the alleged victims may be exposed to family members and others who continue to doubt the allegations. Police members may feel responsible for the suicide of people they are investigating, particularly when others blame them for the suicide.[7] In these and many other ways, the suicide can precipitate a wave of new trauma.

Current suicide rates in Victoria

75. I also asked the CPU whether the rate of suicide among males under investigation for alleged contact offences against children in Victoria was as high as rates published in the international literature. The CPU made efforts to establish this, but ultimately was unable to offer a definitive answer. The reason was, a rate calculation requires an estimate of how many people are in the group being examined, in other words, an estimate of the size of the underlying population within which the suicides are occurring. In this instance, the CPU required an

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[7] For a discussion of these impacts see Hoffer TA, Shelton L, Behnke S and Erdberg P, "Exploring the impact of child sex offence suicide", *Journal of Family Violence*, 25, October 2010, pp. 782-784.

estimate of how many Victorian males each year are charged with alleged contact sexual offences against children. The CPU was unable to find a published estimate of this population.

76. In its search, the CPU noted that the Crime Statistics Agency publishes data on annual alleged offender incidents involving sexual offences generally.[8] Using this as an estimate of the annual number of people in Victoria charged with sexual offences, the CPU converted the 150 suicides in Victoria between 2009 and 2022 of people who were being investigated for alleged sex offences into an average annual rate. The CPU advised that the average annual suicide rate among males under investigation for alleged sex offences (319.5 suicides per 100,000 males per year) was around **21 times higher** than the average annual suicide rate among males generally in Victoria (15.9 suicides per 100,000 males per year) across the period from 2009 to 2022.

Past findings made by Victorian coroners on the issue of suicides among alleged sexual offenders

77. My investigation builds on the work and insights of other Victorian coroners who, over the past decade or more, have considered how to reduce the risk of suicide among people under investigation for alleged sexual offences.

78. Reviewing past findings, I note the primary locus of suicide prevention efforts in this area to date has been the police investigation and legal proceedings. One reason for this is, both the Victorian deaths and the international research literature show that these suicides tend to occur more frequently around developments in the investigative and legal process. Police contact and court hearing dates are particularly important in this respect, and present logical opportunities for intervention. It has been considered by Australian researchers that:

> *'[...] the criminal justice system has responsibility for the health and safety of those under its authority. That is, there may be legal liability as well as legislative obligations that need to be upheld.'*[9]

79. There have been at least five major sets of Victorian coronial recommendations to date regarding the police role in managing the welfare of people suspected of sexual offences.[10]

[8] Crime Statistics Agency, "Data Tables Alleged Offender Incidents Visualisation Year Ending December 2023 (XLSX, 395.12 KB)", published March 2024, downloaded via <https://www.crimestatistics.vic.gov. au/crime-statistics/latest-victorian-crime-data/download-data>, accessed 8 May 2024.

[9] J Gullotta M, et al, "Self-harm and suicidality among three subgroups of male sex offenders: results from an Australian prisoner cohort", *Health & Justice*, 9(19), 2021, p.2.

[10] In chronological order: Coroner Susan Armour, finding without inquest in the death of XY (identity suppressed), reference COR 2010 004056, delivered 13 September 2012; Coroner Caitlin English, finding without inquest in the

Victoria Police have historically had positive responses to coronial recommendations in this regard. It has generally accepted and incorporated recommendations and over time, evolved their management of suspects of sexual offences. Over the past decade or so, Victoria Police have periodically updated the governing Victoria Police Manuals, implemented suspect welfare management training, introduced a Code of Practice for the Investigation of Sexual Crime, and updated Crime Investigative Guidelines regarding the psychological and social implications of being interviewed for charges regarding sexual offences. This coincides with the development of the Information and Support Referral Brochure provided to persons contacted regarding sexual offences. These efforts are to be highly commended.

80. My impression is that Victoria Police have been responsive to Victorian coroners' past recommendations regarding how to manage suicide risk in people being investigated for alleged sexual offences. While it remains that the Victoria Police have a crucial role in the welfare management of individuals suspected of sexual offences (and ought to follow the relevant VPMs in this regard), I am of the view that (when followed) the policies and procedures identify and address the relevant risk factors of self-harm and suicide in a manner that provides guidance while allowing for members to exercise professional discretion. In the context of my prevention role as a coroner, and at this stage, I have not been able to identify any significant further opportunities for Victoria Police to improve their policies and practices in this area.

A Health-Led Approach to Prevention

81. In recognising the efforts Victoria Police have made to manage suicide risk in people being investigated for alleged sex offences, I simultaneously acknowledge their role is necessarily limited. Members can structure their interviews and other interactions with suspected sex offenders with a view to minimise suicide and self-harm risk and can provide information to help offenders who are at risk of self-harm such as the Information and Support Referral Brochure. Nonetheless, the members are not mental health professionals and cannot be expected to perform clinical tasks, including to clinically evaluate a suspect's suicide risk.

death of James Tomlinson, reference COR 2011 002865, published 13 September 2012; Coroner Rosemary Carlin, finding without inquest not published, reference COR 2015 006525, delivered 5 September 2017; Coroner Darren Bracken, Finding without inquest in the death of Anthony Jenkins, reference COR 2017 004333, published 14 December 2018; Coroner Simon McGregor, Finding without inquest not published, reference COR 2021 001629, delivered 3 May 2023.

82. I then turned to consider the role, if any, of the healthcare system in the effort to reduce the suicide risk amongst individuals under investigation for alleged sexual offences.

83. There are undoubtedly several barriers to involving the health system in this effort. One such challenge being that research indicates when sex offenders try to obtain help from health professionals they can be treated with revulsion and thus retreat from engagement with the health system. Another challenge discussed in the United States literature is that treatment for alleged sex offenders presents potential legal issues that may have parallels in Australian law:

> *'[The] unique dynamics of traditional sex offender treatment can impinge on a pretrial defendant's rights against self-incrimination under the Fifth and Sixth Amendments. Sex offender treatment, which often includes polygraph testing and full disclosure of sexual and deviant behavior, puts the pretrial defendant in a precarious legal position.'*

84. However, I was interested to read of the Sharper Future program, developed by the Central District of California's US Pretrial Services Office in collaboration with local courts and mental health services. The program's aim is to manage symptoms of anxiety, depression and suicidality among sexual offence defendants in the community awaiting trial, through a range of modules and programs including crisis intervention, support group sessions, healthy coping skills classes, and cognitive behaviour therapy. The Sharper Future program was established in 2005, and in 2012 a detailed evaluation was published. Key findings demonstrated that participation among defendants was high, the program had a generally positive impact on defendants' daily functioning, and no participants suicided.

85. In a 2021 systematic review examining international research on suicidal behaviour among people accused or convicted of child sex abuse or indecent image offences, the Sharper Future program was the only therapeutic intervention that the authors could identify. The authors of the systematic review concluded that there is a need to explore:

> *'[…] the potential for increased co-working between law enforcement, custodial staff, and mental health services to develop a pathway to identity risk of suicide and support CSA [child sex abuse] and IIOC [indecent images of children] offenders'*

86. I concur that the prevention focus ought to be shifted solely from policing and the legal system, to consider the role of the healthcare system. That is not to say this ought to be a purely clinical

approach, and I am of the view that such a concerted effort would be best led by criminal justice initiatives. This is because the target cohort, of alleged sex offenders under investigation, is defined by the legal system not a clinical profile. (Supporting this last point, and as already outlined, the CPU analysis of the 100 suicides showed that there was a low prevalence of pre-existing mental ill health, and that suicidality was in many cases linked to the investigation and legal process.)

87. At this preliminary stage, I am unable to say with certainty whether a program akin to California's Sharper Future program is that which would be practical and suitable to be implemented in Victoria. At the time of writing, there does not appear to be any published, recent evaluations of the Sharper Future program and its success. Accordingly, I consider it appropriate to make the following recommendation in general terms.

RECOMMENDATION

88. Pursuant to section 72(2) of the Act, I make the following recommendation:

    a) That the **Secretary of the Department of Justice and Community Safety**, in tandem with the **Secretary of the Department of Health**, explore the development of a program in contact with relevant health experts, to support mental health and coping mechanisms with the view to reduce suicidality among Victorian persons who are under investigation for alleged sexual offences.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was EK, born 1976;

    b) the death occurred on 1 June 2019 at Railway Station, , Victoria, , from multiple injuries in a train incident; and

    c) the death occurred in the circumstances described above.

90. Having considered all of the circumstances, I find that EK placed himself in the path of an oncoming train with the intention to take his own life. I have considered the circumstances proximate to EK's death, including that he had no history of ongoing mental ill health nor of suicidal ideation, and that he underwent an observable shift in behaviour around the time he was first contacted by Victoria Police.

91. At the time of EK's death, he had not yet been arrested, interviewed or charged with any offences. He was therefore not officially '*on notice*' as to the precise nature of the allegations against him. However, the phone call from the SOCIT detective on 29 May 2019 alerted him to the fact there were allegations against him that required formal interview at a police station three days from that date.

92. I do not, therefore, consider it a coincidence that EK suicided following this initial contact with Victoria Police alerting him of these allegations; indeed, his suicide occurred just 20 minutes before the scheduled interview at the police station. As a person who was otherwise well and who lacked any history of suicidal ideation, I find that EK suicided as a result of becoming aware of the Victoria Police investigation against him.

93. I have carefully considered the actions of Victoria Police members involved in the investigation of EK. While Victoria Police members appropriately acknowledged the increased risk of self-harm and suicide in EK, as an individual suspected of a sexual offence, I nonetheless find that the actions of the SOCIT detective, in contacting EK by telephone to make an appointment for a police interview, rather than engaging him face-to-face, did not correspond with the best practice process outlined in the Victoria Police Manual on Sexual Offence Investigations (**VPM**), which was amended in 2018 to include an explicit requirement to '*avoid using phone messages, calling cards or arranging arrest by appointment*'. I consider that no compelling explanation has been provided for departure from this 'best practice' standard.

94. By initiating contact via telephone, there was little to no opportunity for Victoria Police members to comprehensively assess EK's welfare, including to accurately identify and mitigate risks to his wellbeing. Nor was there the opportunity for EK to be directed to wellbeing options, including the Information and Support Referral Brochure which contained pertinent information regarding the criminal justice and prosecution process and avenues for him to engage with support services.

95. However, I cannot find that EK's death would have been prevented had Victoria Police managed its initial contact with him in a different manner; such a finding would be unduly speculative and it cannot now be known whether a face-to-face approach would have led to a different outcome for EK. Further, the coronial jurisdiction ought not to involve considerations of blame, and it is certainly not my intention to venture into such territory in

finding a connection between the suicide of EK and police notifying him that certain allegations had been made against him.

96. Further, while Victoria Police plays a pivotal role in addressing suspect welfare considerations for suspected sexual offenders, and has been highly responsive to strengthening its approach to this issue over recent years, I consider that a health-led response (as evidenced in jurisdictions in the United States) is now required to complement existing Victoria Police approaches to managing suspect welfare and preventing suspects' suicides before the completion of the criminal law process, given the heavy burden such suicides can place on victims and their families (and indeed on investigating members) where the justice process is abruptly and permanently truncated before any outcome can be rendered.

I convey my sincere condolences to EK's family for their loss. I also convey my sympathies to first responders and all others impacted by the sudden and traumatic circumstances of EK's death.

ORDERS AND DIRECTIONS

Pursuant to section 73(1B) of the Act, I order that a de-identified version of this finding 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:

Mr HK and Mrs QK, Senior Next of Kin

Mr Shane Patton, Chief Commissioner of Victoria Police

Ms Liana Buchanan, Commissioner for Children and Young People

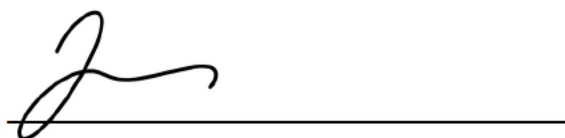
The Secretary of the Department of Justice and Community Safety

The Secretary of the Victorian Department of Health

Sharper Future

Detective Senior Sergeant Mark Guthrie, Coroner's Investigator

Signature:



Ingrid Giles

CORONER

Date: 25 October 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.