IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 000266

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Steven John Bamblett
Date of birth:	11 September 1990
Date of death:	14 January 2020
Cause of death:	1(a) Hanging
Place of death:	80 Hume Street, Echuca, Victoria, 3564
Keywords:	Family violence; untreated mental illness; passing of Aboriginal man; regional Victorian context; suicide

INTRODUCTION

1. On 14 January 2020, Steven John Bamblett was 29 years old when was found to have passed on the veranda in the rear garden of his home in circumstances suggesting he had taken his own life. At the time, Mr Bamblett lived with his partner, Kasanne Burns, and their two children in Echuca, Victoria.

2. Mr Bamblett had been in a defacto relationship with Ms Burns since he was eighteen years old and the couple had two children together. Both Mr Bamblett and Ms Burns identified and identify as, Aboriginal.

THE CORONIAL INVESTIGATION

3. Mr Bamblett'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.

4. 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.

5. 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.

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

7. This finding draws on the totality of the coronial investigation into the death of Steven John Bamblett 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.[1]

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

Identity of the deceased

8. On 14 January 2020, Steven John Bamblett, born 11 September 1990, was visually identified by his partner, Ms Kasanne Burns who signed a formal Statement of Identification to this effect.

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

Medical cause of death

10. Forensic Pathologist Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination of Mr Bamblett's body in the mortuary on 16 January 2020 and provided a written report of his findings dated 22 January 2022.

11. Dr Bouwer advised that post-mortem CT scanning of the whole body conducted at VIFM showed increased lung markings and no other significant findings. External examination was consistent with the reported circumstances including a faint discolouration/ligature mark abound the upper neck.

12. Toxicological analysis of post-mortem samples identified delta-9-tetrahydrocannabinol[2] at a concentration level of 16 ng/mL but no alcohol or other commonly encountered drugs or poisons.

13. Dr Bouwer provided an opinion that the medical cause of death was 1 (a) Hanging.

14. I accept Dr Bouwer's opinion.

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[1] 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.

[2] Delta-9-tetrahydrocannabinol is the active form of Cannabis (Marijuana), the concentration levels detected were not contributory to the cause of death.

Circumstances in which the death occurred

15. As a result of an earlier family violence event, Victoria Police applied for a Family Violence Intervention Order (**FVIO**) in protection of Ms Burns, with conditions that Mr Bamblett not commit family violence against them or damage their property.[3]

16. On 14 January 2020, police attended Mr Bamblett's address at 9.46am to serve the Court issued application and summons in relation to this FVIO. Attending police stated that the paperwork was explained to Mr Bamblett and that he appeared *'co-operative with police and he did not appear alcohol or drug affected'*[4]. Mr Bamblett advised police that he had thought the matter had already been heard in Court and was informed that he would be required to attend Court the following day.

17. Following this police attendance, Mr Bamblett became distressed and enraged, causing Ms Burns to become fearful of him.[5] Ms Burn's mother, Vicki Taylor, was also present and recounted that Mr Bamblett had asked Ms Burns to change the FVIO and said that he was '*frightened to go to gaol'*.[6]

18. At the time, Mr Bamblett had also been attempting to organize a loan from Centrelink and was described as being '*stressed'*[7] and frustrated that he was unable to do so.

19. Ms Taylor attended the property to assist her son. During her visit, Mr Bamblett was aggressive towards Ms Taylor and Ms Burns requested that Ms Taylor call the police for assistance.

20. Ms Taylor's phone records indicate that she called the Echuca Police Station at 6:48pm for 50 seconds and again at 6:49pm for 117 seconds.[8] Police members on duty on 14 January 2020 stated they remembered receiving a call on that day but regarded it as a '*pocket dial'* and ended the call despite the officer receiving the call recalling "*yelling and screaming into the phone*".[9]

[3] Coronial Brief, 103-105.
[4] Coronial Brief, Statement of B McLeod, 34.
[5] Coronial Brief, Statement of K Burns, 13.
[6] Coronial Brief, Statement of V Taylor, 21 & 24.
[7] Coronial Brief, Statement of K Burns, 2.
[8] Coronial Brief, Appendix F, 117.
[9] Coronial Brief, Statement of police member, 36

21. After contacting police, Ms Burns and Ms Taylor waited for police attendance for some time before leaving the address. Ms Burns later returned to the property and undertook tasks within the home, she did not see Mr Bamblett during this period.

22. Later in the evening, Ms Burns entered the back garden to search for Mr Bamblett and located him hanging from the veranda. Ms Burns panicked and ran to a nearby relative's house across the road and emergency services were contacted to attend the property. Ambulance paramedics attended the premises at approximately 9.50pm and Mr Bamblett was pronounced deceased.[10]

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

23. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by an intimate partner is particularly shocking, given that all persons have a right to safety, respect and trust in their most intimate relationships.

24. For the purposes of the *Family Violence Protection Act 2008*, the relationship between Mr Bamblett and Ms Burns was one that fell within the definition of '*de facto partner'*[11] under that Act. Moreover, the history of verbal abuse and alleged physical violence between Mr Bamblett and Ms Burns constitutes '*family violence'*.[12]

25. In light of Mr Bamblett's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[13] examine the circumstances of his death as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[14]

History of family violence between Mr Bamblett and Ms Burns

26. The available evidence suggests that there was a significant history of family violence between Mr Bamblett and Ms Burns.

27. Mr Bamblett was described by friends and family as exhibiting periods of poor mental health, with frequent suicidal ideation and a suspected diagnosis of Attention Deficit Hyperactivity

[10] Coronial Brief, Statement of FC Fleming, 43
[11] Family Violence Protection Act 2008, section 9
[12] Family Violence Protection Act 2008, section 8(1)(a)
[13] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety
[14] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community

Disorder (**ADHD**).[15] Statements from Ms Taylor, suggest that Mr Bamblett did not wish to seek treatment for his mental health concerns and was not taking any regular prescription medications.

28. Ms Burns noted that Mr Bamblett would frequently contemplate suicide following arguments between them. Ms Burns also stated that:

…When we was [sic] arguing he would take his shirt off and try to do things with his shirt. He just kept wanting to do it every time we had an argument but this time he done [sic] it'[16]

29. Police records contained in the coronial brief confirm a pattern of self-harm behaviour, Mr Bamblett had threatened suicide during several police attendances for family violence. On 6 July 2017, police noted that Mr Bamblett was concerned that he would be charged with contravening a FVIO and '*threatened suicide by walking out onto the main road'*.[17] Following a similar incident on 6 February 2017, police appropriately placed Person Warning Flags on Mr Bamblett's LEAP record, noting he was at risk of suicide/self-injury and suffered a mental disorder.[18]

30. Throughout their relationship, Mr Bamblett and Ms Burns were involved in several family violence incidents and were both identified at various times as the affected family member and respondent. The majority of these instances of violence were recorded as being verbal in nature, with Mr Bamblett purportedly demonstrating jealous and controlling behaviour towards Ms Burns.[19] On 20 May 2017, Mr Bamblett was also accused of physically assaulting Ms Burns by striking her to the face and kicking her.[20]

31. On 9 December 2018, Victoria Police responded to an incident of family violence allegedly perpetrated by Mr Bamblett towards Ms Burns. Records from this incident note that Mr Bamblett and Ms Burns had initially had a verbal disagreement and that Ms Burns had asked Mr Bamblett to leave. Mr Bamblett reportedly refused, and Ms Burns called the police, who attended to assist. At this time, Mr Bamblett was subject to a Family Violence Intervention Order (FVIO) in protection of Ms Burns, prohibiting him from being at the property.[21]

[15] Coronial Brief, Statement of K Burns, 11; Coronial Brief, Statement of V Taylor, 18.
[16] Ibid.
[17] Victoria Police, LEAP Records of Steven Bamblett, 47.
[18] Ibid, 49-51.
[19] Victoria Police, LEAP Records of Steven Bamblett.
[20] Ibid, 31.
[21] Ibid, 13-19.

32. On 31 May 2019, Mr Bamblett was arrested and charged with contravening the FVIO and a court date was set for 23 July 2019. This was later adjourned to 22 July 2020.[22]

33. On 16 November 2019, police attended another incident of family violence between Ms Burns and Mr Bamblett. During this incident, Mr Bamblett was identified as the affected family member and Ms Burns as the respondent. Details from police records indicate that on this occasion, Ms Burns had been '*quite aggressive*'[23] before '*calming down*'[24] and leaving the property. This matter was considered a verbal dispute only, and no further civil action was taken by police.

34. On 4 January 2020, a further family violence incident was reported to police. On this occasion, Ms Burns and Mr Bamblett were reported to have engaged in a verbal disagreement before Ms Burns left the address with their daughter and went to her mother's house.[25] A short time after, Mr Bamblett attended this address and another verbal argument ensued. Mr Bamblett reportedly then took their daughter from the property and drove away with her. Statements from family members indicate that Mr Bamblett was intoxicated during this incident, however, police make no reference to this in their statements or records.[26]

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Steven John Bamblett, born 11 September 1990;

    b) Mr Bamblett passed on 14 January 2020 at 80 Hume Street, Echuca, Victoria, 3564;

    c) the cause of Mr Bamblett's passing is hanging; and

    d) the death occurred in the circumstances described above.

36. The available evidence supports a finding that Mr Bamblett was facing a number of life stressors at the time of his passing, including separation from his family, financial issues and mental ill health and that he intentionally took his own life.

[22] Ibid, 11; ibid, 120.
[23] Ibid, 10.
[24] Ibid.
[25] Ibid, 99.
[26] Ibid.

37. While I have made comments below that appear appropriate to me as they arise from the coronial investigation into Mr Bamblett's passing, the available evidence does not support a finding that there is any causal connection or contribution between the circumstances highlighted in the comments and Mr Bamblett's passing.

38. I convey my sincere condolences to Mr Bamblett's family for their loss.

COMMENTS

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

Victoria Police engagement with Aboriginal families and family violence investigation

39. On the day of the fatal incident, Victoria Police had served Mr Bamblett with an Application and Warrant for a FVIO in protection of Ms Burns earlier in the day. The application had caused Mr Bamblett to become very distressed.[27]

40. The available evidence is unclear as to whether police had reviewed previous police contact or the Person Warning Flags assigned to Mr Bamblett's record prior to the service of the Application and Warrant. The *Victoria Police Manual (VPM) – Procedures and Guidelines – Family Violence*, requires police members investigating family violence to:

> *…conduct a risk assessment prior to serving an intervention order.* [28]

And in relation to the service of FVIOS:

> *…conduct a LEAP check (including national check) of the respondent to establish any prior convictions or known history of violence, access to weapons or firearms, any history of mental illness or suicide attempts or other warning flags* [29]

41. In correspondence provided to the Court, Assistant Commissioner Lauren Callaway (**AC Callaway**), advised that whilst the above directives explicitly refer to the service of a FVIO, '*it is the [Chief Commissioner of Police's] expectation that members, employing professional judgement and common sense, will apply these requirements to the service of any type of documentation relating to a FVIO, including an application and summons'*.[30]

[27] Coronial Brief, Statement of B McLeod, 34; Coronial Brief, Statement of K Burns, 13.
[28] Victoria Police, *Victoria Police Manual – Procedures and Guidelines – Family Violence*, 19.
[29] Ibid.
[30] Victoria Police, Statement of Acting Commissioner of Police L Callaway, 3.

42. AC Callaway further advised that '*risk assessment'* is not defined in this policy but instead refers to the '*general operational understanding'*[31] of risk assessment, primarily outlined in the *Victoria Police Manual – Operational safety and the use of force*. This policy requires members to operate in compliance with the Operational Response Principles which prioritise service, safety and harm minimisation. In practice, AC Callaway advised that '*risk assessment involves consideration of the context in which an incident arises, information about the respondent, and the desired outcome of police action'*.[32] In instances of family violence, a prior positive engagement with a respondent may formulate the entirety of the risk assessment, whereas risk assessments may be more complex if there are concerns for the safety of a member, the respondent or a third party.[33]

43. AC Callaway further advised that '*risk assessments are fluid, dynamic and ongoing'*[34] and that it is not considered '*necessary or desirable to implement any policies, procedures or guidelines which specify prescribed tasks which members are required to undertake prior to engaging with members of the public and specifically when serving documentation'*.[35]

44. The service of an application and summons for a FVIO hearing can be a daunting and distressing time for a respondent in a family violence matter. Service of FVIO related documentation is a known stressor contributing to a perpetrator's suicide, this is a systemic issue identified in several coronial investigations.[36]

45. The available evidence indicates that Mr Bamblett was understood to be fearful of police following a traumatic experience several years earlier where he was physically restrained and arrested under Section 351 of the *Mental Health Care Act 2014* (Vic).[37] In addition to this, Mr Bamblett identified as Aboriginal. Research confirms that the engagement of police with Aboriginal communities in Australia can cause those who identify as First Nations to experience fear of arrest and incarceration due to colonisation and the ongoing poor treatment of Aboriginal people by Australian authorities.[38] It is likely that the attendance of police members on the day of the fatal incident was a significant trigger for Mr Bamblett.

46. Statements from the police members who interacted with Mr Bamblett on 4 and 14 January 2020 indicate that they did not contact the local Aboriginal Community Liaison Officer

[31] Ibid.
[32] Ibid.
[33] Ibid.
[34] Ibid.
[35] Ibid, 5.
[36] COR 2014/5831, COR 2018/1882, COR 2018/4185 and 2019/4563
[37] Victoria Police, LEAP Records of Steven Bamblett, 47-51; Statement of V Taylor, 18
[38] Police Accountability Project, *Racial Profiling*, <https://www.policeaccountability.org.au/issues-and-cases/racial-profiling/>.

(**ACLO**) or a Police Aboriginal Liaison Officer (**PALO**) to inform their dealings with Mr Bamblett prior to their engagement with him. ACLOs are positioned as a liaison point between Victoria Police and the Aboriginal community. The role of a ACLO includes the provision of support and training to Victoria Police in their engagement with Aboriginal Communities.[39] In contrast, PALOs are sworn members stationed across Victoria and '*have a liaison role, both independently and in partnership with ACLOs, to resolve issues concerning Aboriginal people within their local area'*.[40]

47. Since 2015 the Echuca Police Station has received resourcing for a part-time PALO.[41] Superintendent John Kearney of Echuca Police Station advised that the demand placed on resources as a result of the Covid-19 pandemic has reduced this role to approximately three days a week but that the 'goal is to increase it to a full-time role'.[42] The Echuca PALO also undertakes a monthly review of families where there have been repeat attendances by police for family violence matters in order to detect any parties who identify as Aboriginal and/or Torres Strait Islander, and will bring these matters to the attention of the Family Violence Liaison Officer.[43]

48. It is evident from the available evidence that Mr Bamblett was distressed in the lead up to the fatal incident and had ongoing fear of police. Having an understanding and appreciation of the traumas that Aboriginal people have endured and the impacts that this has had on their experience of police may have altered the approach taken by Victoria Police in their interactions with Mr Bamblett in the lead up to his passing and resulted in a more positive experience for Mr Bamblett. ACLOs and PALOs are well placed to provide this insight and support to police members so that they may be better equipped to provide culturally sensitive responses to Aboriginal community members.

49. Ms Taylor contacted Echuca Police Station on 14 January 2020 to report an incident of family violence between Ms Burns and Mr Bamblett. Available phone records in the coronial brief confirm that two calls were placed to the Echuca Police Station on the above date. Statements from relevant police members also confirm receipt of a call from whom they believed to be an Aboriginal person based on the '*tone of her voice'*.[44] This raises concerns about the

[39] Victoria Police, 'Aboriginal community liaison officers', <https://www.police.vic.gov.au/aboriginal-community-liaison-officer-program>.
[40] Ibid.
[41] Victoria Police, Statement of Superintendent J Kearney, 2 & 4.
[42] Ibid, 4.
[43] Ibid.
[44] Coronial Brief, Statement of police member, 36.

implications of such assumptions with respect to racial profiling and the management of the call by attending police members.

50. Echuca police members report receiving a call on 14 January 2020 and confirm that the woman appeared to be '*yelling and screaming into the phone'*[45] and that it sounded as though she was '*abusing someone else in the background'*[46]. The police member who received the call noted that he unsuccessfully attempted to engage the caller on several occasions before the phone was passed to a colleague who confirmed the same. The supervising Sergeant on duty noted that he became aware of the call and instructed police member attending to the call to hang up.[47]

51. The *Code of Practice for the Investigation of Family Violence* (**Code of Practice**) requires police to '*identify and investigate family violence'*[48] and '*assist in the prevention and deterrence of family violence in the community by responding to family violence appropriately'*. [49] The Code of Practice goes onto note that '*police will respond to and take action on any family violence incident reported to them, regardless of who made the report and how it was made'*.[50] The attending police member at Echuca Police Station confirmed that he could hear the caller having an argument with another party. Given the volume on the phone was high enough to cause the attending police member to remove the phone from his ear, it is concerning that no actions were taken to investigate further.

52. Victoria Police have confirmed that they are committed to an array of ongoing reforms aimed at improving their response to family violence, and that attention to developing greater cultural competency among members, as discussed below, may be of more benefit to improving Victoria Police responses to family violence within the local community.

53. Victoria Police also confirm that a number of recent reforms have been undertaken to improve engagement with the Aboriginal community. In 2008 Victoria Police established the *Police and Aboriginal Community Protocols Against Family Violence* (**protocols**).[51] These protocols '*are an agreement between local Aboriginal communities and Victoria Police that document the local police response to family violence where a person identifies as Aboriginal and/or*

[45] Ibid.
[46] Ibid.
[47] Coronial Brief, Statement of police member, 40-41.
[48] Victoria Police, *Code of Practice for the Investigation of Family Violence*, Edition 3 V4 2019, 10.
[49] Ibid.
[50] Ibid, 15.
[51] Victoria Police, Statement of Acting Commissioner of Police L Callaway, 5-6.

Torres Strait Islander'.[52] These protocols have since been locally established across 10 regions in Victoria, with the exception of Geelong and Echuca.[53]

54. The Victoria Police *Family Violence Reform Rolling Action Plan 2020-2023* specifies that the protocols will be revised and expanded to provide state-wide coverage by the end of 2022.[54] AC Callaway has also advised that Echuca protocols '*will be developed and finalised towards the end of 2021'*.[55]

55. To further develop cultural competency, all sworn Victoria Police members are also required to complete *Family Violence: Aboriginal Context 2020* training.[56] Victoria Police advise that this training seeks to '*promote a sense of cultural safety for Aboriginal people when providing police services, and improve members' compliance'*[57] when querying Aboriginal identity. It is understood that this training is delivered to members online, however, further information regarding the contents of the training or how this training was developed was not provided to the Court.

56. Victoria Police also advised that in 2019, the Aboriginal Portfolio of Priority Communities Division worked with registered Aboriginal training provider and consultant, Nyuk Wara Consulting, to '*revise existing cultural awareness training resulting in the Aboriginal Cultural Awareness Training package'*.[58] The Court has been advised that delivery of this package commenced in October 2020, with the training being transitioned to face to face and local delivery in September 2021.[59]

57. I support the reforms undertaken by Victoria Police to date and hope to see continued improvement in police responses to family violence and to our First Nations people in Victoria.

[52] Victoria Police, 'Family violence and Aboriginal communities', <https://www.police.vic.gov.au/family-violence-and-aboriginal-communities>.
[53] Ibid.
[54] Victorian Government, *Family Violence Reform Rolling Action Plan 2020-2023*, 21.
[55] Victoria Police, Statement of Acting Commissioner of Police L Callaway, 6.
[56] Ibid, 6-7.
[57] Ibid, 7.
[58] Ibid.
[59] Ibid, 8.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

Kasanne Burns, Senior Next of Kin

Vicki Taylor

Assistant Commissioner Lauren Callaway, Family Violence Command, Victoria Police

Linsey Walker, Victorian Government Solicitors Office

Senior Constable Alisha Bortolotto, Coroner's Investigator

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 17 January 2023

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.