IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 006727

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Amended pursuant to Section 76 of the Coroners Act 2008 on 2 September 2024[1]

Inquest into the death of Bridget Erin Flack

Findings of:	Coroner Ingrid Giles
Delivered on:	29 August 2024
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Hearing dates:	27-29 November 2023 21 February 2024
Appearances:	Ms Gemma Cafarella, Counsel Assisting the Coroner, instructed by Ms George Carrington, Coroner's Solicitor Mr Sebastian Reid on behalf of Austin Health, instructed by Lander & Rogers Ms Fiona Ellis on behalf of Monash Health, instructed by K&L Gates Ms Erin Gardner on behalf of the Department of Health, instructed by the Department's in-house lawyers

[1] This version is an amended version of the Finding into the Death of Bridget Flack dated 29 August 2024, amended to insert an enhanced Table of Contents to improve navigability and to correct minor typographical errors.

	Ms Amanda Dickens on behalf of the Chief Commissioner of Police, instructed by the Victorian Government Solicitor's Office Ms Jasmine Still on behalf of Detective Senior Constable Garside, instructed by Hall & Wilcox Mr Christopher McDermott (27-29 November 2023) and Mr Chris Kais (21 February 2024) on behalf of Transgender Victoria, instructed by Allens
Catchwords	Suicide; transgender; gender diverse; LGBTIQA+; access to mental health services; access to gender-affirming care; cultural safety and wellbeing; postvention supports; missing persons; Victoria Police.

Readers are advised that this finding contains discussion of suicide. Readers are warned that there may be words and descriptions that may be distressing.

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SUMMARY

1. On 1 December 2020, Bridget Flack (**Bridget**) was reported to police as a missing person by her close friend and former partner, Mx Hal Leigh (**Mx Leigh**).[2] Mx Leigh had concerns for Bridget's safety and wellbeing, including that Bridget was suicidal. Bridget had recently taken time off work and had been seeking admission to a private mental health facility for her declining mental health.

2. Bridget was located deceased 11 days later, on Friday 11 December 2020. Her body was found by two members of the LGBTIQA+ community at the Kew Billabong at approximately 5pm. She was 28 years old when she died.

3. Bridget is described by those who loved her as intelligent and passionate; her sister noted her to be affectionate, smart, creative, fiercely loyal, and opinionated.[3] Many of her creative outputs, including her writing, art, and music, reflected her complex and multifaceted experience as a transgender woman, including feelings of comfort and pride in being transgender, in addition to related struggles.

THE CORONIAL INVESTIGATION

Jurisdiction

4. Bridget's death was a *'reportable death'* under section 4 of the *Coroners Act 2008* (Vic) (**the Act**), because it occurred in Victoria and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury.

Purpose of the Coronial Jurisdiction

5. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial.[4] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

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[2] Statement of H. Leigh in coronial brief (**CB**), pp. 38-50.
[3] Evidence of A. Pucci-Love, T-47 lines 1-7.
[4] *Coroners Act 2008* (Vic) s 89(4).

6. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

7. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

8. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

9. Coroners are empowered to:

   (a) report to the Attorney-General on a death;

   (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

   (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.

   These powers are the vehicles by which the prevention role may be advanced.

10. The powers to comment and make recommendations are inextricably connected with, rather than independent of, the power to enquire into a death or for the purpose of making findings. They are not separate or distinct sources of power enabling a coroner to enquire for the sole or dominant reason of making comment or recommendation.[5]

11. Consequently, the power to comment is not free ranging but rather is limited to the power to comment '*on any matter connected with the death*'.[6]

[5] *Harmsworth v The State Coroner* [1989] VR 989 at 996.
[6] *Coroners Act 2008* (Vic) s 67(3).

12. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[7] It is important to stress that coroners are unable to determine civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a Finding, a comment or any statement that a person is, or may be, guilty of an offence.[8]

13. Whilst it is sometimes necessary to examine whether a person's conduct falls short of acceptable or normal standards, or was in breach of a recognised duty, this is only to ascertain whether it was a causal factor or background circumstance. That is, an act or omission will not usually be regarded as contributing to death unless it involves a departure from reasonable standards of behaviour or a recognised duty. If that were not the case, many perfectly innocuous preceding acts or omissions would be considered causative, even though on a common-sense basis they have not contributed to death.

14. It is also important to recognise the benefit of hindsight and to discount its influence on the determination of whether a person has acted appropriately.

Standard of Proof

15. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[9] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[10]

16. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[11] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

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[7] *Keown v Khan* (1999) 1 VR 69.

[8] *Coroners Act 2008* (Vic), s 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. *See* sections 69(2) and 49(1) of the Act.

[9] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.

[10] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

[11] (1938) 60 CLR 336.

17. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[12] Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences. Rather, such proof should be the result of clear, cogent, or strict proof in the context of a presumption of innocence.[13]

The coronial investigation and clustering of the proceedings

18. Deputy State Coroner Caitlin English (as she then was) initially held carriage of the investigation into Bridget's death, followed by then-Deputy State Coroner Jacqui Hawkins. In July 2023, I assumed carriage of the investigation for the purposes of conducting further investigations, holding an Inquest, and making Findings. Detective Senior Constable Daniel Garside (**DSC Garside**) was assigned as the Coroner's Investigator. DSC Garside compiled the coronial brief in relation to Bridget's death, which underwent four iterations.[14]

19. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown. The circumstances of Bridget's death did not involve any such considerations; therefore, whether or not to hold an Inquest was a matter of discretion under section 52(1) of the Act.

20. Pursuant to this provision, coroners have absolute discretion as to whether to hold an Inquest. However, a coroner must exercise the discretion in a manner consistent with the preamble and purposes of the Act.

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[12] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

[13] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at pp 362-3 per Dixon J: '*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…'*.

[14] A second coronial brief called, referred to as the 'Collated Brief' was compiled by the Court in relation to the common issues in the cluster investigation. To accompany this brief, a statement of facts in relation to each deceased's circumstances of passing was prepared following input being invited from Interested Parties.

21. In deciding whether to conduct an Inquest, a coroner should consider factors such as (although not limited to), whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process; whether there is a likelihood that an Inquest will uncover important systemic defects or risks not already known about, and, the likelihood that an Inquest will assist to maintain public confidence in the administration of justice, health services, or public agencies.

22. The convening of an Inquest into a suicide or suicides is rare. However, shortly prior to and following Bridget's death, which occurred in late November or early December 2020, the Coroners Court received reports of a number of suicides of transgender women, including:

- Natalie Wilson (COR 2020 4857, who died on 2 September 2020) (hereinafter, '**Natalie**');
- Matt Byrne (COR 2021 1636, who died on 30 March 2021) (**Matt**);
- The person known by the pseudonym 'AS'[15] (COR 2021 2415, who died on 9 May 2021) (**AS**); and
- Heather Pierard (COR 2021 2457, who died on 11 May 2021) (**Heather**).

23. These were not the only suicides of transgender and/or gender diverse people (hereinafter '**TGD people**')[16] reported to the Coroners Court throughout this period, or subsequently thereto. However, there were a number of common features identified in relation to the circumstances of the deaths of these five people; namely the deceased were all young people who had affirmed or were on a journey to affirming their gender identity as female. Some were known to each other. The deceased had also experienced mental ill health. Some had been linked with service providers from a young age, and also faced a degree of social isolation during the COVID-19 lockdown periods.

[15] This person is required to be referred to as 'AS' pursuant to a pseudonym order issued on 28 August 2023 in these proceedings – *see* explanation further below. Further persons referred to in this Finding (including H. Leigh) are not formally covered by the pseudonym order but are referred to by chosen names (*see* T-113, lines 6-16).
[16] This definition will be further explored later in my Finding.

24. On the basis of these common factors, the cases were referred to the Coroners Prevention Unit (**CPU**) for joint consideration and advice.[17] The CPU identified and engaged a number of entities to provide statements and submissions to assist the Court's consideration of the issues common to the circumstances of each deceased, with the following organisations ultimately providing submissions:

- Victorian Department of Health;
- The Office of the Chief Psychiatrist of Victoria;
- Monash Health Gender Clinic;
- Austin Health Gender Clinic;
- Thorne Harbour Health, which includes the Equinox Gender Diverse Health Centre;
- The Royal Children's Hospital Melbourne;
- Royal Australian College of General Practitioners;
- Australian Psychological Society;
- Royal Australian and New Zealand College of Psychiatrists;
- Drummond Street Services;
- Victorian Commissioner for LGBTIQA+ Communities;
- Switchboard Victoria; and
- Transgender Victoria.

25. Given the complexity of the issues outlined in these submissions and which would require findings to be made thereupon, a decision was made to convene an Inquest into the five deaths.

26. The inquest proceeded on 27-29 November 2023 and 21 February 2024, over four days in total, with Ms Gemma Cafarella appointed as Counsel Assisting the Coroner, and the Chief

[17] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

Commissioner of Police (**CCP**), the Secretary to the Department of Health, Monash Health, Austin Health, DSC Garside and Transgender Victoria all represented at Inquest.

27. Many members of the five deceased's family, chosen family and friends were present during these proceedings, with some choosing to attend the courtroom, and others following the proceedings online.

Scope of Inquest

28. Although the coronial jurisdiction is inquisitorial rather than adversarial,[18] it should operate in a fair and efficient manner.[19] When exercising a function under the Act, coroners are to have regard, as far as possible in the circumstances, to the notion that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death.[20]

29. In *Harmsworth v The State Coroner*,[21] Nathan J considered the extent of coroners' powers, noting they are not '*free-ranging*' and must be restricted to issues sufficiently connected with the death being investigated. His Honour observed that if not so constrained, an inquest could become wide, prolix, and indeterminate. His Honour stated the Act does *not* provide a general mechanism for an open-ended enquiry into the merits or otherwise of the performance of government agencies, private institutions, or individuals. Significantly, he added:

> *Such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc. Such an inquest could certainly provide material for much comment. Such discursive investigations are not envisaged nor empowered by the Act. They are not within jurisdictional power.*[22]

[18] Second Reading Speech, *Legislative Assembly: 9 October 2008, Legislative Council: 13 November 2008*.
[19] *Coroners Act 2008* (Vic), s 9.
[20] *Coroners Act 2008* (Vic), s 8(b).
[21] (1989) VR 989.
[22] *Ibid*.

30. In *Lucas-Smith v Coroners Court of the Australian Capital Territory*[23] the limits to the scope of a coroner's inquiry and the issues that may be considered at an inquest were also considered. As there is no rule that can be applied to clearly delineate those limits, '*common sense*' should be applied. In this case, Chief Justice Higgins noted that:

> *It may be difficult in some instances to draw a line between relevant evidence and that which is too remote from the proper scope of the inquiry ...[i]t may also be necessary for a Coroner to receive evidence in order to determine if it is relevant to or falls in or out of the proper scope of the inquiry.*

31. Ultimately, however, the scope of each investigation must be decided on its facts and the authorities make it clear that there is no prescriptive standard that is universally applicable, beyond the general principles discussed above.[24]

32. Given the issues under consideration, the scope of the present Inquest was crafted to be systems-focused. Rather than examining the circumstances of death of each individual, which were sufficiently documented in the written evidence, the aim was to examine the broader systemic issues impacting TGD people and their experience in accessing health and other services. There were also two discrete scope items relating to Bridget and the missing persons search undertaken for her by Victoria Police.

33. A Directions Hearing was held on 13 October 2023 and Interested Parties were invited to provide submissions on the proposed scope. The settled scope of the inquest was as follows:

> *<u>Relating to the passing of Bridget Flack</u>:*
>
> *1. Approach of Victoria Police to the missing persons search for Bridget Flack, including by reference to relevant policies and procedures;*

[23] [2009] ACTSC 40. *See also* the comments regarding the limits of a coroner's inquiry, including that factual questions related to cause will generally be within the scope of the inquest.
[24] *See* Ruling No.2 in the 'Bourke Street' *Inquest into the deaths of Matthew Poh Chuan Si, Thalia Hakin, Yosuke Kanno, Jess Mudie, Zachary Matthew Bryant and Bhavita Patel* (COR 2017 0325 and Ors), Coroner Hawkins, 23 August 2019, para. 55.

2. *Victoria Police policies, procedures, training, and initiatives relating to the transgender and gender diverse (**TGD**) community;*

Relating to all deaths within the cluster:

3. *The evidence base concerning the incidence of mental ill health and suicidality in the TGD community, including the reasons for this;*

4. *Availability of and issues concerning provision of culturally-appropriate gender-affirming care to TGD people in Victoria, including where there are intersecting mental health issues and diagnoses;*

5. *Availability of and issues concerning provision of culturally-appropriate suicide prevention and postvention supports to TGD people in Victoria;*

6. *Availability of and issues concerning provision of culturally-appropriate social and emotional wellbeing supports to TGD people in Victoria; and*

7. *Prevention opportunities flowing from the above.*

Pseudonym order

34. Prior to a Directions Hearing in this matter being convened on 13 October 2023, on 28 August 2023, I issued a pseudonym order in this matter pursuant to section 55(2)(e) of the Act. The order required that, in order to assist the Court in referring to the deceased persons in a respectful and culturally appropriate manner in these proceedings, they should be referred to by the names that were in use prior to passing (even where not 'legally changed'), and which had been chosen by the deceased to correspond with their gender identity (**chosen names**).

35. Further, I ordered that one of the deceased be referred to by the pseudonym 'AS', which I considered to be necessary to secure the proper administration of justice in this proceeding, including to ensure AS's family's capacity to participate in the Inquest and to limit trauma and the impacts of the proceeding on her family's wellbeing.

36. On this basis, all deceased were referred to by what the evidence established to be their chosen name, or in the case of 'AS', a pseudonym. All deceased were referred to by 'she/her' pronouns, noting that, while their preferred pronouns may have changed over time, the evidence pointed to all five deceased using 'she/her' pronouns in the lead-up to passing.

Witnesses

37. The following witnesses were called to give *viva voce* evidence on the first day of Inquest:

    (a) **Elisabeth Lane**, the Court's lived experience expert;[25]

    (b) **Angela Pucci-Love**, Bridget's sister;

    (c) **Detective Senior Constable Garside**, Coronial Investigator; and

    (d) **Deputy Commissioner Neil Paterson**, Victoria Police.

38. Thereafter, the Court convened two expert panels, each comprised of a number of experts who were considered appropriate to give evidence concurrently. On the second day of inquest, the first expert panel (**Medical Panel**) was made up of:

    (a) **Professor Jeffrey Zajac**, Austin Health Gender Clinic, medical practitioner and Head of Endocrinology Unit at Austin Health;

    (b) **Dr James Morandini**, Australian Psychological Society, Clinical Psychologist;

    (c) **Mrs Bailey Nation-Ingle**, Victorian Department of Health, State Suicide Prevention Response Adviser;

    (d) **Dr Gurvinder Kalra**, Monash Health Gender Clinic, Consultant Psychiatrist;

    (e) **Dr Neil Coventry**, Office of the Chief Psychiatrist, Chief Psychiatrist of Victoria (as he then was);

[25] It is worth noting that a number of the other witnesses in this Inquest had their own lived experience as members of the TGD community.

(f) **Dr Peter Jenkins**, Royal Australian and New Zealand College of Psychiatrists (**RANZCP**), Consultant Child and Adolescent Psychiatrist;

(g) **Dr Mark Dalgleish**, Royal Australian College of General Practitioners (**RACGP**), General Practitioner;

(h) **Dr Tram Nguyen**, Royal Melbourne Children's Hospital Gender Service, Psychiatrist; and

(i) **Ms Carolyn Gillespie**, Director of Services, Thorne Harbour Health.

39. On the third day of inquest, the second expert panel (**Community Supports Panel**) was made up of:

(a) **Mr Elliot McMahon**, Drummond Street Services, Program Manager;

(b) **Mr Joe Ball**, Switchboard, Chief Executive Officer**;**

(c) **Ms Anna Bernasochi**, Switchboard, Suicide Prevention Manager**;**

(d) **Dr Son Vivienne**, Transgender Victoria, Chief Executive Officer**;**

(e) **Ms Michelle McNamara**, Transgender Victoria, Committee Board Member;

(f) **Mx Vic Harden,** Thorne Harbour, TGD Health Lead; and

(g) **Dr Todd Fernando**, Victorian Commissioner for LGBTIQ+ Communities **(**as he then was)

40. On the third day of inquest, I also heard coronial impact statements from Angela Pucci-Love (Bridget's sister), Kedra Pierard (Heather's mother) and Rachel Byrne (Matt's mother).

Closing submissions

41. On 21 February 2024, following the close of oral evidence, Counsel Assisting and legal representatives of Interested Parties were invited to provide closing submissions, having provided a written outline of those submissions in the lead-up to this hearing. In the course

of those closing submissions, legal representatives addressed the Court on the findings that they submit are open to be made on the evidence, as well as on the comments and recommendations open to be made, including on matters relating to public health and safety and/or the administration of justice.

Sources of Evidence

42. This Finding draws on the totality of the product of the coronial investigation into Bridget's death and the cluster investigation. That is, the court records maintained during the coronial investigation, the Coronial Briefs, further material sought and obtained by the Court, the evidence adduced during the Inquest and oral submissions provided by Counsel Assisting and Counsel representing the Interested Parties.[26]

43. A further source of evidence for this investigation was the Victoria Police Operational Safety Committee Incident review into the missing person investigation for Bridget, completed by Inspector Scott Brennan on 1 December 2021 (**OSCIR**). This was an internal police review commissioned by Deputy Commissioner Neil Paterson and provided to the Court as an annex to his first statement dated 8 September 2023.[27]

44. In writing this Finding, I do not purport to summarise all of the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does not imply that it has not been considered.

BACKGROUND[28]

45. Bridget was born on 18 August 1992. Bridget was assigned male at birth. She had one sibling, Angela Pucci-Love (**Angela**).

[26] In the interests of certainty, this includes: (i) the Court file, inclusive of correspondence from Genspect; (ii) Coronial Brief version 4, dated 3 November 2023; (iii) Collated Brief version 4, dated 3 November 2023; (iv) Summary of Material Facts dated 16 November 2023; (v) Additional Materials 1-11; and (vi) Transcripts of evidence from 27-29 November 2023 and submissions hearing on 21 February 2024.
[27] *See* annex to Statement of Deputy Commissioner Neil Paterson, CB, pp. 485-506.
[28] This section, and the section that follows, is derived from the 'Summary of Material Facts' in relation to Bridget Flack, dated 16 November 2023.

46. When Bridget was born, the family lived in Lower Templestowe. When she was three months old the family relocated to Ballarat, where Bridget's family purchased a pub.

47. Angela describes the family environment as '*not…the happiest of homes*'.[29] Bridget's parents' relationship was marked by conflict. From a young age, Angela sought to protect Bridget, and looked after her during the long hours that their parents worked.[30]

48. Bridget's parents separated at around the end of 1995, and there were family violence intervention orders in place between them. Bridget and Angela lived with their mother, who began to abuse alcohol and drugs. Bridget reportedly became more dependent on Angela at this time.[31]

49. Bridget's mother developed a relationship with a man who moved in with the family, and who she eventually married. Angela describes him as abusive.[32] Angela reported that she ran away from home and became engaged in the foster care system. Angela attempted to have Bridget removed too, but was unsuccessful.

50. Eventually, Bridget's father secured housing in Ballarat and obtained shared care of the children. Angela stated she stayed as long as she could. She moved out of home shortly before she turned 18 years old, but visited every day that Bridget was with him.[33]

51. Bridget had some close friends at primary school but was bullied. She was reportedly relatively isolated and preferred the company of books and music.[34]

52. In early 2005, Bridget's mother was diagnosed with terminal cancer. Bridget's mother spent a long period of time in hospital, during which time Bridget lived with her stepfather.[35]

[29] Statement of A. Pucci-Love, CB, p. 52. *See also* evidence of A. Pucci-Love, T-47 line 21 to T-48 line 4.
[30] Evidence of A. Pucci-Love, T-46 lines 21-28.
[31] Statement of A. Pucci-Love, CB, p. 53.
[32] Statement of A. Pucci-Love, CB, p. 53.
[33] Statement of A. Pucci-Love, CB, p. 53.
[34] Statement of A. Pucci-Love, CP, p. 54.
[35] Statement of A. Pucci-Love, CB, pp. 54-55.

53. Bridget's mother died on 23 June 2005, when Bridget was 13 years old, which affected her deeply. Angela describes her as '*full of grief and anger and hurt*'.[36]

54. In 2007, Bridget told her father that she was gay. This was reportedly taken quite well,[37] though Bridget reported in a subsequent mental health assessment that she ran away from home when her father found this out.[38]

55. In 2007, Bridget started engaging in self-harm. At around the same time, Bridget and Angela moved to Melbourne and Bridget commenced living with her sister. Angela tried to get her to access mental health supports as she could see Bridget was struggling.

56. Bridget completed her Victorian Certificate of Education in 2010, and then enrolled in a Social Science degree at La Trobe University in 2012, graduating with Honours.[39]

57. On occasion, Bridget disclosed to Angela that she was struggling with mental ill health, and would seek help.[40] She was admitted as an in-patient to a public hospital mental health service in 2013 but reported this to be a negative experience for her.[41]

58. During this period, Bridget was in a five-year relationship with Mx Leigh, who she remained very close with following their break-up in 2019.[42] Bridget discussed with Mx Leigh in depth '*her feelings about her gender and the dysphoria she experienced for multiple years prior*.'[43] Mx Leigh described that Bridget was socially affirming her gender as a woman from approximately 2017.[44] Around this period, Bridget moved into an apartment in Flemington that she had purchased.

59. In June 2018, Bridget commenced the process of medical gender affirmation at the age of 25. She attended at the Equinox Gender Diverse Health Clinic (**Equinox**) for a series of in-depth consultations, during which she reported she had contemplated affirming her gender

[36] Statement of A. Pucci-Love, CB, p. 55; Evidence of A. Pucci-Love, T-50, lines 10-12.
[37] Statement of A. Pucci-Love, CB, p. 55.
[38] Statement of Dr N. Saad, CB, p.103.
[39] Statement of A. Pucci-Love, CB, p. 56.
[40] Statement of A. Pucci-Love, CB, p. 56.
[41] Statement of H. Leigh, CB, p. 40.
[42] Statement of H. Leigh, CB, pp. 38 and 49.
[43] Statement of H. Leigh, CB, pp. 38-39.
[44] Statement of H. Leigh, CB, pp. 38-39.

for eleven years and noted her history of mental ill health. She was found to meet the criteria for an informed consent pathway.[45] Bridget was subsequently commenced on gender-affirming hormone therapy. She was well-supported by her General Practitioner (**GP**) at Equinox and had appointments on approximately ten occasions between June 2018 and her death in early December 2020.

60. Bridget was engaged with mental health support and counselling during the period she was affirming her gender identity. She told Angela that '*there were some great trans focused psychologists however they were impossible to get into*'.[46]

61. Bridget is reported to have been happy at the time she commenced her gender affirmation.[47] Bridget was linked in with a close group of transgender friends and mentors. She told Mx Leigh that she was happy about the changes to her body, and that she felt much more comfortable than she did prior to affirming her gender.[48]

62. In 2019, Bridget told Angela that she was affirming her gender, who found it '*a little confronting*' initially, but was ultimately supportive of this news. Angela observed her to be '*happier and more confident*'.[49] However, when Bridget told her father about her gender affirmation, he reportedly did not understand or accept it.[50] Bridget was selective about who in her family knew about her gender affirmation.

63. While Bridget reportedly felt positive following her decision to commence medical gender affirmation, she had struggled with mental health difficulties from an early age which continued throughout this time. She experienced depression and anxiety, had reported diagnoses of borderline personality disorder (**BPD**) and post-traumatic stress disorder (**PTSD**), as well as a history of self-harm and suicidal ideation. She reported feeling increasingly isolated during the COVID-19 pandemic.

[45] Statement of Dr A. Brownhill, CB, p. 74.
[46] Statement of A. Pucci-Love, CB, p. 57; Evidence of A. Pucci-Love, T-62 lines 10-28.
[47] Statement of A. Pucci-Love, CB, p, 57.
[48] Statement of H. Leigh, CB, p. 39.
[49] Evidence of A. Pucci-Love, T-55 line 10-11.
[50] Statement of A. Pucci-Love, CB, p.57.

64. In 2019, she engaged privately with Dialectical Behavioural Therapy (**DBT**) to work on tolerance and emotional regulation skills. From May 2019 until 25 November 2020, Bridget also accessed counselling sessions with two counsellors specialising in TGD clients to address issues including the impacts of trauma and gender dysphoria on her relationships.[51] She continued to engage well with her Equinox GP, who she last saw in August 2020.[52]

65. Bridget was made a permanent employee of the United Workers Union in 2020, where she had worked sporadically for some years prior, and which was reportedly a source of happiness and pride for her.[53]

CIRCUMSTANCES IN THE LEAD-UP TO BRIDGET'S DEATH

66. On 15 November 2020, Bridget spoke to Angela about her declining mental health, which had occurred in the context of a relationship breakdown and concerns about her work. Bridget sought financial support to obtain an inpatient mental health admission in a private facility as she did not then have private health insurance. Bridget's goal was to enter a specific four-week program at the Melbourne Clinic that would include DBT. Her contingency plan was to obtain an admission with the general patient stream.[54] Angela told Bridget that she would support Bridget unequivocally, as did her close friend Mx Leigh.

67. On the same day, Bridget also called Mx Leigh in distress. She '*still adamantly did not want to go into acute care in the public health system,*'[55] as she was optimistic that she would be able to receive a hospital bed in a private facility, with the cost being supported by Angela. Bridget moved from her apartment in Flemington to Mx Leigh's place at this time, as she found being alone in her apartment too distressing. During this period, Mx Leigh offered to call the Crisis Assessment and Treatment Team when Bridget reported feeling suicidal, and offered Bridget support in trying to secure an inpatient admission.[56]

[51] Statement of K. Field, CB, pp. 78-79; Statement of G. Lee, CB, pp. 83-85.
[52] Statement of Dr A. Brownhill, CB, pp. 75-76. During the last consultation on 12 August 2020, Bridget's hormone medication was switched from medroxyprogesterone to cyproterone to better align with her gender-affirming goals.
[53] Statement of A. Pucci-Love, CB, p. 58.
[54] Statement of A. Pucci-Love, CB, pp. 59-60.
[55] Statement of H. Leigh, CB. p. 45.
[56] Statement of H. Leigh, CB, p. 45.

68. In the immediate lead-up to Bridget's passing, she was in contact with multiple organisations to seek assistance for her mental health. This is evident in the text messages between Bridget and Angela between 15-29 November 2020.[57]

69. On 18 November 2020, Bridget contacted NorthWestern Mental Health Psychiatric Triage Service (**PTS**) and was referred to Inner West Area Mental Health Service (**IWAMHS**). IWAMHS contacted Bridget on 20 November 2020 and offered her an intake appointment for 25 November 2020.

70. On 19 November 2020, Bridget had also contacted Drummond Street Services (**DSS**) and left a voicemail seeking assistance with obtaining inpatient care. A senior intake worker called her back within an hour and discussed some options with her. A safety assessment was done, and Bridget was referred to the LGBTIQ+ Aftercare Program at Mind Australia. An offer was made for further counselling with DSS' Queerspace program, but Bridget declined because she wanted to focus on her immediate mental health concerns and finding inpatient care. On 20 November 2020, DSS sent Bridget an email about a possible referral to Q Health. Bridget replied and said that she was happy for a referral to be made, and DSS made the referral.

71. On 20 November 2020, Bridget's GP referred her to 'Bed Brokers' (an administrative service that assists referrers to potentially secure a bed and an accepting doctor for private health facilities) to find her an inpatient treatment option. Her GP also commenced her on escitalopram, an anti-depressant, while awaiting admission.[58] On 24 November 2020, Bed Brokers contacted Delmont Private Hospital (**Delmont**) to ask if Bridget would be appropriate for admission, and it appears that the referral was initially accepted, with Bridget being contacted on 25 November 2020 by the intake coordinator at Delmont to discuss an admission and the costs associated with an inpatient stay. She texted her sister on this day, stating '*I got admitted to Delmont!*'.[59]

[57] Statement of A. Pucci-Love, CB, p. 59-67
[58] Statement of Dr P. Chan, CB, p.96 and corresponding medical records of the Neighbourhood Clinic, p.9.
[59] Statement of A. Pucci-Love, CB, p. 66. *See also* notation at top-right corner of CB, p. 87, that includes a tick symbol next to the name of a Delmont psychiatrist.

72. Also on 25 November 2020, Bridget had an appointment with IWAMHS. She was comprehensively assessed and at that time, she was noted to be a low-medium risk of suicide. While she reported passive suicidal thoughts, she had no plan or intent. It was noted that Bridget was help-seeking and had a good relationship with her GPs and mental health care practitioners. She reported to her assessing clinician that she had recently re-commenced the anti-depressant escitalopram, with a plan to increase the dose. Given she did not want a voluntary admission, she was accepted for community-based treatment progressing to a potential admission to Prevention and Recovery Care (**PARC**).

73. Later that evening, Bridget spoke with her counsellor who assessed her suicide risk as '*high'*. A safety plan was discussed with Bridget, and she was described as '*motivated and optimistic about obtaining in-patient care*'.[60]

74. On 26 November 2020, IWAMHS contacted Bridget, who informed them there was a planned admission to Delmont to commence either 27 or 28 November 2020. Bridget requested to stay involved with IWAMHS for follow-up care following her planned admission, and it was agreed that IWAMHS would call her the following week.

75. However, given that Bridget would be self-funding her admission and did not have private health insurance, there were issues with finding a private psychiatrist to care for Bridget at Delmont. On 29 November 2020, Bed Brokers were advised that Delmont were unable to accept Bridget, and this was communicated to Bridget on 30 November 2020.[61] A plan was devised for her to seek an out-patient referral via her GP.

76. At approximately 2pm on the same day, 30 November 2020, Bridget told Mx Leigh that she was going for a walk but did not return to Mx Leigh's home, where she had been staying.

[60] Statement of S. Grace Lee, CB, p. 85

[61] Bed Brokers Contact Log, CB, p. 91. It appears that Bridget attempted to call Delmont on 28 November 2020, but Delmont did not take a record of the conversation (CB p. 93). It also appears that Bed Brokers attempted to call Bridget on 29 November 2020 but there was no answer, and they left a voicemail (CB, p. 91).

77. On 1 December 2020, having searched for her the previous evening and into the early hours of 1 December, Mx Leigh reported Bridget missing to police. Police identified that Bridget's phone had last 'pinged' off phone towers in Alphington and Kew.

78. The LGBTIQA+ community subsequently organised a community effort to search for Bridget. Within days, over 6,000 people had joined a Facebook group dedicated to finding Bridget. The 'ping' location for Bridget's phone was shared with the community by Angela via the Facebook page.

79. The Victoria Police search for Bridget included sweeps of the Yarra River and 'fly-overs' using the Victoria Police Air Wing Service. The Victoria Police search for Bridget will be addressed in further detail below.

80. On 11 December 2020, Bridget was found deceased by two community members in Kew, near the Kew Billabong, in circumstances suggestive of suicide.[62] Emergency services attended, and Bridget's body was conveyed into the care of the Coroners Court.

IDENTITY OF THE DECEASED

81. On 24 December 2020, Bridget Erin Flack, born 18 August 1992, was identified by way of DNA comparison with her sister, Angela Pucci-Love.

82. I note for completeness that: (i) the Coroners Court; (ii) Births Deaths and Marriages Victoria (**BDM**); and (iii) the Victorian Institute of Forensic Medicine (**VIFM**) are apprised of the details of Bridget's registered name, which differs from her chosen name, as part of the formal identification and death registration process. This entails specific details being provided by the Coroners Court to the BDM Registrar in order to maintain the integrity and completeness of records across these entities.[63]

[62] Bridget was found hanging from a rope attached to a tree.

[63] For example, under section 49(2) of the Coroners Act, the Court's Principal Registrar must notify the Registrar of Births, Deaths and Marriages, without delay, of the prescribed particulars found by the coroner following an investigation of a death. Under Regulation 16 of the Coroners Regulations 2019 (**Coroners Regulations**), those particulars are:
(a) the deceased's full name; and
(b) the deceased's date of birth or, if unknown, the deceased's age at death; and

83. These formalities aside, my findings under section 67(1)(a) of the Act require me to make findings as to a deceased person's identity, which is a broader proposition than a person's registered name. I formally find the identity of the deceased to be Bridget Erin Flack.

84. I consider that identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

85. On 14 December 2020, Forensic Pathologist Dr Michael Burke (**Dr Burke**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination. Dr Burke reviewed the post-mortem computed tomography (**CT**) scan and Victoria Police Report of Death Form 83, and provided a written report of his findings.

86. The post-mortem CT scan showed no skull or facial fracture.

87. An abraded injury and furrow were noted to the deceased's neck, which is consistent with the circumstances reported in the police report of death that Bridget was found hanging from a tree.

88. The external examination was otherwise unremarkable. There were no findings in Dr Burke's report pointing to suspicious circumstances.

89. Toxicological analysis of post-mortem specimens identified the presence of 0.13g/100ml of ethanol (alcohol) and 0.03mg/L of citalopram.[64] It is noted that the onset of decomposition can change the concentration of any drugs and poisons if they were present at death and may even prevent the detection of drugs and poisons by the presence of decomposition substances. Drugs such as citalopram are subject to post-mortem redistribution making interpretation of the concentrations difficult.

(c) the cause of death; and
(d) the date and place of death; and
(e) the sex of the deceased; and
(f) if known, whether the deceased was Aboriginal or Torres Strait Islander.

[64] Citalopram and escitalopram are selective serotonin reuptake inhibitors (**SSRIs**) that increase serotonin neurotransmitter action in the synapse.

90. The analysis of vitreous humour or urine can assist in determining the degree to which postmortem formation of ethanol (alcohol) has occurred. Vitreous humour and urine were not available for ethanol analysis.

91. Dr Burke provided an opinion that the medical cause of death was '*1 (a) compression of the neck and 1 (b) hanging'.*

92. I accept Dr Burke's opinion.

FOCUS OF CORONIAL INVESTIGATION AND INQUEST

1 – The approach of police to the missing persons search for Bridget

93. The first item in the scope relates specifically to Bridget Flack, and is the '*[a]pproach of Victoria Police to the missing persons search for Bridget Flack, including by reference to relevant policies and procedures'.*

Missing Persons Report

94. Bridget was reported missing by Mx Leigh on 1 December 2020. According to the statements provided in the coronial brief, Mx Leigh phoned Melbourne North Police Station at 1:49pm and spoke to a Constable Matt Slaney (**Constable Slaney**) and reported they had not heard from Bridget since approximately 2pm the previous day. Mx Leigh noted that Bridget was a transgender woman with PTSD, anxiety, and depression, and that they believed Bridget to be suicidal. Certain other details (including a description of Bridget's clothing) were also provided at Constable Slaney's request. Constable Slaney then attempted to contact Bridget's mobile phone, with no answer.

95. Constable Slaney also reported that, on 1 December 2020, he sought the view of Sergeant Shane Ginters (**Sergeant Ginters**), who was acting as section sergeant at Melbourne North Police Station, on whether Bridget's phone should be triangulated. Sergeant Ginters reportedly responded *'[b]ased on what you have told me, I doubt it would be authorised*'.[65]

[65] Statement of Constable Slaney, CB pp.11.

Sergeant Ginters noted in his statement that he considered the reporting person may have been intoxicated '*and that it didn't sound like there was much in it*'.[66]

96. Sergeant Ginters stated that he urged Constable Slaney to call Mx Leigh back to determine why Bridget was considered to be suicidal and to allow a suitable risk assessment and a missing persons report to be progressed. Sergeant Ginters stated that Constable Slaney informed him that he had attempted to call Mx Leigh back, but there was no answer.[67]

97. Later that afternoon, Constable Slaney received a call from Senior Constable Tara Supple (**SC Supple**) from Flemington Police Station, who informed him that she had also taken a call from Mx Leigh in relation to Bridget being missing, and had received more information (including photographs) and would therefore progress the missing person investigation. As a result of Mx Leigh's contact with Flemington Police Station, a job was put through to Police Communications at 3:22pm for a welfare check at Bridget's Flemington address.[68] A welfare check was conducted and it was ascertained that nobody was at home.[69]

98. SC Supple contacted Mx Leigh after 4:40pm to obtain further details about the risk posed to Bridget, including their concerns about Bridget and her threats of suicide. SC Supple noted that she '*had concerns for FLACK'S welfare and so I gathered as much information as I could from LEIGH in order to complete a Missing Persons Report*'.[70] SC Supple contacted local hospitals to assist in locating Bridget, and attempted to contact Bridget's mobile phone.

99. However, the Flemington Police Station section sergeant subsequently stated to SC Supple that Melbourne North Police Station should have carriage of the investigation, as Bridget had been residing with Mx Leigh, rather than her usual home address in Flemington. As such, SC Supple emailed Constable Slaney at 7:14pm stating that he should handle the missing person reports.[71] SC Supple emailed Constable Slaney a copy of her notes and

[66] Statement of Sergeant Ginters, CB, p. 132.
[67] Statement of Sergeant Ginters, CB, pp. 132-133. This occurrence is not recorded in Constable Slaney's statement.
[68] Statement of Constable Slaney, CB pp. 9-12; Statement of SC Supple, CB, p. 135.
[69] Victoria Police Operational Safety Committee Incident Review (**OSCIR**) report, CB p. 493.
[70] Statement of SC Supple, CB, p. 136.
[71] Statement of FC Slaney, CB pp.11.

photographs of Bridget. After some back and forth as to who should have carriage, Melbourne North Police Station agreed to take carriage of the investigation.

100. The Missing Person Report in relation to Bridget (**Missing Person Report**)[72] was submitted on 1 December 2020 at 8:19pm by Sergeant Ginters, having been sent to him for approval by Constable Slaney at 5:41pm.[73] The narrative in the Missing Person Report, included, amongst other things, that the Missing Person (**MP**) was a transgender female known by the name of Bridget Flack, and that the RP (**Reporting Person**) had concerns for the MP, namely that the RP stated they believed the MP to be suicidal, and that the MP had her mobile phone on but was not answering.[74]

Investigation that ensued at North Melbourne Police Station (1-3 December 2020)

101. The Victoria Police Operational Safety Committee Incident review (**OSCIR**) in relation to Bridget's missing persons investigation notes that the day after Bridget was reported missing, on 2 December 2020, further enquiries were made in relation to the missing persons investigation, such as contacting the Waratah Clinic at IWAMHS for clinical information about Bridget, including as to any suicide risk assessment conducted.[75]

102. A triangulation request for Bridget's mobile telephone was also submitted by a Senior Sergeant at Melbourne North Police Station on 2 December 2020. This was refused by a Duty Inspector on the basis that, on the information at hand, Bridget's threat to life was not imminent, opining that the threat to life was a 'veiled' one and was over 48 hours ago.[76] It is noted that Bridget was described as being a 'high risk MP' in the triangulation request.

103. On this date, Angela was also contacted by police for the first time, following contact being made with her father. Angela noted that Bridget had been facing significant mental health issues and had been trying to access an inpatient admission to a mental health facility. Angela recalled phoning multiple police officers during this initial period of the investigation for

[72] LEDR Mk2 Summary Report, AM2-372 to AM2-374.
[73] OSCIR, CB p. 493.
[74] AM2-372 – AM2-373.
[75] OSCIR, CB p. 493.
[76] Statement of Deputy Commissioner Neil Paterson, CB p. 153; Email correspondence of Victoria Police members, AM9-1.

answers in relation to Bridget, noting that '*over the next 36 hours I spoke to more than seven different police officers at four different locations, trying to highlight the risk [to Bridget]*.'[77]

104. On 3 December 2020, a suite of further actions was taken in relation to the missing persons search. A police media release was issued through a variety of media channels and a 'keep a look out for' (**KALOF**) was broadcast over a number of police channels.[78]

105. On 3 December 2020, Mx Leigh was also contacted by police to clarify the precise nature of Bridget's self-harm and suicide threats. Mx Leigh stated that during their last phone call Bridget had sounded upset and said she was drinking by the river, and had made threats of suicide in the past.[79]

106. A second request to triangulate Bridget's phone, following rejection of the first request the day prior, was forwarded to Inspector Scott Johnson (then-Melbourne West Local Area Commander) and approved. In a statement to the Court, Inspector Johnson stated that *'[g]iven the evidence presented to me [by the Senior Sergeant in the triangulation request], it was evident that the missing person was in considerable risk of harm, and that all that could be done to locate her should be*'.[80]

107. However, while the second triangulation request was approved, no phone activity was reported as a result.[81] SC Garside clarified by way of supplementary statement that Bridget's mobile phone records indicated her phone was no longer showing data as of 8:45am on 3 December 2020.[82]

108. On 3 December 2020, a decision was made that the investigation was too complex for Melbourne North Police Station, which did not have the available resources or expertise to conduct the intensive investigation required, and the investigation was handed over to the detectives at Melbourne Crime Investigation Unit.[83]

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[77] Evidence of A. Pucci-Love, T-72 lines 27-30.
[78] Statement of Senior Constable Fielding, CB pp. 128-129; Evidence of DSC Garside, T-101 lines 6-11.
[79] OSCIR, CB p. 493.
[80] Statement of Inspector S. Johnson, AM10-1.
[81] Statement of Inspector S. Johnson, AM10-1.
[82] Statement of DSC Garside, AM 2-11.
[83] OSCIR, CB, p. 494.

Investigation that ensued by Melbourne Crime Investigation Unit (3-11 December 2020)

109. On 4 December 2020, the investigation was formally handed over to the Melbourne Crime Investigation Unit, and coordinated by DSC Daniel Garside, who liaised closely with Angela and '*was in constant dialogue with her*',[84] along with other police members such as Senior Constable Fielding and Detective Senior Constable Aaron Magnuson.

110. Investigators conducted a check of Bridget's incoming/outgoing calls records, SMS records and data usage, and were able to identify that the last phone activity was 'pinging' off fixed phone towers located in Alphington and Kew.[85]

111. Investigators also confirmed Bridget's last bank transaction was at a Dan Murphy's store in Collingwood on 30 November 2020, though received conflicting information from her bank in relation to transaction timings, which caused Angela significant frustration and some delays in identifying where and when Bridget may have last used her bank card.[86]

112. Multiple further enquiries were conducted over the ensuing days, including reviewing Bridget's Myki accounts, calling her phone, investigating reported sightings of Bridget, conducting social media checks, checking hospital admissions, and making enquiries with domestic airline carriers. Police members attended particular locations where members of the public had reported sightings of Bridget through Crimestoppers, with nil results.[87]

113. On 5 December 2020, Angela reported that she had been carrying out an extensive search around the location that Bridget's phone last 'pinged'. In ensuing days, a number of searches were conducted for Bridget by her friends and broader members of the LGBTIQA+ community, which resulted in items being located that were thought to have belonged to Bridget.

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[84] Statement of DSC Garside, CB, p. 105.
[85] Statement of DSC Garside, CB p. 97. Evidence at Inquest indicated that the information available from 'call charge records' provides only a rough indication of location and is far less precise than the information available through triangulation.
[86] Evidence of A. Pucci-Love, T89, lines 1-24. Angela attended the Collingwood branch of the bank in order to ask why conflicting information had been provided and to ascertain the last known transactions. *See also* evidence of DSC Garside, T-114, line 9 to T-116 line 3.
[87] Evidence of DSC Garside, T-102 lines 13-17.

114. These searches were referred to and coordinated via a Facebook group called '*Have You Seen Bridget Flack*', which, along with a series of posters, had been created by members of the LGBTIQA+ community in order to coordinate searches and share information such as maps and reports of found items thought to have belonged to Bridget.[88] This Facebook group was monitored daily by members of Victoria Police and '*aided as a platform where all police information provided to PUCCI-LOVE could further be passed onto the 6000-plus members [of the Facebook group]*'.[89]

115. Angela gave evidence that one of the searches coordinated through the Facebook group was on 8 December 2020 at Dight Falls in Abbotsford. Police were not present, though some attended in a personal capacity.[90] During this search, Angela reported encountering a large Victoria State Emergency Service (**SES**) crew and asked them if they were looking for Bridget. She was informed that they were actually running a training exercise that day, but would '*keep an eye out*' for Bridget during the course of the day.[91]

116. DSC Garside also made contact with the then-Victoria Police LGBTIQ Portfolio Manager in the Priority and Safer Communities Division (**PSCD**), Jen Dixon, via his office's Gay and Lesbian Liaison Officer (**GLLO**),[92] who provided advice and liaised with the LGBTIQA+ Commissioner and Missing Persons Unit, in an effort to extend a culturally-safe bridge between police and the LGBTIQA+ community.[93]

117. On 8 December 2020, the Manager of Dan Murphy's at Collingwood provided closed-circuit television (**CCTV**) stills of the person he believed to be Bridget via email to police investigators to assist in the search for Bridget, depicting her last known banking transaction on the morning of 30 November 2020.[94]

[88] Statement of C. Noone, CB pp. 512-513.
[89] Statement of DSC Garside, CB p. 98.
[90] Evidence of A. Pucci-Love, T-76 line 16 to T-77 line 3; evidence of DSC Garside, T-119, lines 6-7.
[91] Evidence of A. Pucci-Love, p. 88 lines 2-19.
[92] Now referred to by the acronym **'LLOs'** to refer more inclusively to LGBTIQA+ Liaison Officers**.**
[93] Evidence of DSC Garside, T-122, lines 10-21.
[94] Statement of DSC Garside, CB p. 97.

118. On 9 December 2020, investigators arranged for Water Police to conduct a search of the Yarra River by boat, which yielded nil results. A request for police drone assistance was made and refused as it was deemed not appropriate in the circumstances.[95]

119. On 9 December 2020, Angela completed a draft press release and supplied police with an up-to-date photograph of Bridget. Authority was provided for the CCTV stills from Dan Murphy's to be used in a media stand-up, which was conducted the following day, 10 December 2020, with Angela and DSC Garside.

120. On 10 December 2020, the Police Air Wing also conducted a search of Yarra Bend Park, Kew Golf Club and surrounding bushland, with nil results.

121. On 11 December 2020 at 5:05pm, DSC Garside attended Bridget's apartment to search her computer for additional clues that might lead to discovery of her whereabouts and contacted the Victoria Police Mounted Branch to enquire about a further location search.[96]

122. Prior to any such search being deployed, Bridget was found deceased at the Kew Billabong by two members of the LGBTIQA+ community, who called '000'. Emergency services attended and confirmed she was deceased.

Analysis

Missing Person Report and early investigation

123. In the course of my investigation and during Inquest, certain issues were identified with the Victoria Police Missing Person Report and steps taken early in the investigation.

124. Based on documents provided on behalf of the Chief Commissioner of Police after Inquest, the Missing Person Report was filed under Bridget's former (registered) name[97] utilising a

[95] Statement of DSC Garside, CB p. 99. DSC Garside indicated at Inquest that this was due to '*a few factors, one being resources in having a drone, two being the density of that area and three being the ability to choose Air Wing over the drone as they'd have usage of a heat map which they could use in their search along the Yarra which they wouldn't if they were to use a drone*'. – T-117 lines 6-11.
[96] Statement of DSC Garside, AM2-14.
[97] AM8-2.

photo that appears to have been sourced from the Law Enforcement Assistance Program (**LEAP**) prior to Bridget affirming her gender.[98]

125. In addition, the report did not include identification of any of the 22 risk factors listed in the *pro forma* risk assessment form, despite the fact that several listed factors may have been relevant in Bridget's circumstances, including: '*likely to cause self harm or attempt suicide*'; '*suffering from a physical illness, disability or mental health problems*'; and '*vulnerable due to age or infirmity or any other similar factor*'.[99] The only box ticked under 'Risk factors' was '*other*', with the risk level was ultimately recorded as 'medium'.

126. Evidence was heard at Inquest as to how this risk level was recorded as 'medium'.[100] Deputy Commissioner Paterson agreed that, given the risk factors in the form were left blank, it was possible that no risk assessment was conducted at all.[101] This is consistent with the statement of Sergeant Ginters that, as of when he left his shift on 1 December 2020, there was insufficient information to assess the risk posed to Bridget and that further information was required to inform a comprehensive risk assessment.[102]

127. I consider that there was a failure to appropriately identify and record the risks posed to Bridget in the initial Missing Person Report filed on 1 December 2020 that infected the time-critical steps in the investigation that were subsequently open to be taken by police.

128. The Missing Person Report, which identified no risk factors for Bridget apart from an unspecified '*other*' box being checked failed to adequately capture the risk factors known to police, including: (i) Bridget's transgender status, which carried with it an increased vulnerability to violence and risk of suicide (not as an inherent vulnerability or factor of being transgender, but as a product of being part of a group that has a higher incidence of discrimination, violence and suicidality compared with the population as a whole, which I

[98] AM8-3. This photograph was from a period in time prior to Bridget's gender affirmation process.
[99] Missing Person Risk Assessment; AM6-2 – as listed on L18A Form. The equivalent factors on the LEDR Mk II online missing persons report appear to be: '*vulnerable re age/infirmity*'; '*illness or health problems*'; '*likely to cause self-harm*'.
[100] Evidence of Deputy Commissioner Paterson, T-189, line 14 to T-191 line 16.
[101] Evidence of Deputy Commissioner Paterson, T-139, lines 9-20.
[102] Statement of Sergeant Ginters, CB, p. 134.

will refer to further below); and (ii) Mx Leigh's report that they believed Bridget was suicidal.

129. Given the narrative outlined by Mx Leigh to police, it is concerning that none of the risk factors were 'selected' in the form.[103] Indeed, it was submitted to me in closing submissions by Counsel appearing for the Chief Commissioner of Police (**CCP**) that there were two to three boxes in the risk assessment that could have or should have been ticked,[104] and that failure to do so amounted to an error. I will make a pertinent recommendation on this point later in this Finding.

130. As a result of this error, Bridget's risk status was listed on 1 December 2020 as 'medium' when it ought to have been 'high'.

131. The Section Sergeant noted in his statement that he had not received sufficient information about Bridget so was unable to adequately assess her level of risk in order to accurately provide this to a supervisor, and that a further risk assessment was required to be conducted.[105] However, an updated risk assessment does not appear to have been conducted after the Missing Person Report was submitted, even when further information was provided to police by Angela in relation to Bridget seeking an in-patient admission to a mental health facility in the lead-up to her going missing, which would have fulfilled a further risk criterion in the Victoria Police missing persons risk assessment.

132. Having so noted, I do not make any adverse comments in relation to the individual police members involved in filing the Missing Person Report, and whose conduct has been reviewed in granular detail with the great benefit of hindsight. Significantly, at the time

[103] Missing Persons Report workflow, AM8-3. It was initially unclear at Inquest whether the online LEDR Mk II digital Missing Persons Report was the sole means used to record and calculate risk by the reporting member, which includes 22 risk factors to select from, or whether a L18A hard copy Missing Person & Risk Assessment form had also been used, which includes 22 differently-worded risk factors. I consider that Bridget's missing persons report was made solely via the LEDR Mk II online missing persons report, rather than the L18A form, given the absence of the latter in the evidence before the Court.

[104] Closing Submissions of Counsel for the CCP, T-83 of Submissions Hearing Transcript, lines 21-30. Indeed, Deputy Commissioner Paterson gave evidence that there were '*no risk factors identified. If risk factors were identified in 1 to 8, then it would be high; in 7 to 10 then it would also require other considerations*'. He observed that '*risk 3, likely to cause self-harm or attempt suicide, is not crossed or risk 10, suffering from a physical illness, disability or mental health problem, is not crossed*'- Evidence of Deputy Commissioner Paterson, T-189 line 28 to T-190 line 4; T-190 lines 18-20; T-191, lines 5-9.

[105] Statement of Sergeant Ginters, CB, p. 134.

police submitted the Missing Person Report in relation to Bridget, there was no guidance on which particular risk factors might impact a missing person's overall risk rating. Evidence received after Inquest demonstrates that changes were made to the online form in February 2021 (referred to at Inquest as the 'LEDR Mk II form') to the effect that, if a reporting member selects a risk factor that is coded 'high risk' (such as 'illness or health problems'), they will now be prompted by a message in **red**, informing them that the missing person is 'high risk', and providing guidance on initial action to be taken.[106]

133. I consider this to be a positive development in assisting everyday police members in the task of assessing risk posed to missing persons, given that it provides enhanced and automated guidance on what the highest risk factors are, and, in the evidence of Deputy Commissioner Paterson, the concomitant need for time-critical investigative steps such as triangulation requests.[107]

134. However, I note that even if this had been place at the time Bridget went missing, it would not have assisted where no risk factors were identified by police. It is therefore crucial that police members completing Missing Person Reports appropriately record all applicable risk factors when filling in the report and are supported with appropriate training and guidance to do so.

135. To this end, the Victoria Police OSCIR into the missing person investigation for Bridget, included three recommendations to assist in enhancing the risk assessment process for police members in missing persons cases.

136. **Recommendation 1** was to '*develop a prompt sheet to guide members through the compilation of a missing persons report, including when to seek expert advice when the missing person is vulnerable or a member of a priority community*'.[108] I consider that provision of such a prompt sheet (as opposed to the Victoria Police Manual (**VPM**) on Missing Persons, which came into being in September 2023 and is not intended to function

[106] *See* Missing Persons Report Workflow, AM8-10.
[107] *See in this connection* evidence of Deputy Commissioner Paterson, T-159 lines 3-8.
[108] Operational Safety Committee Incident Review, Missing Person Investigation, Flemington, 1 December to 11 December 2020, prepared by Inspector Scott Brennan, dated 1 December 2021 (**OSCIR)**, CB, p. 490.

as a prompt sheet)[109] is critical step to ensuring that busy police members performing multiple types of duties have specific, concise guidance on what to do when persons are reported missing, including the specific steps that ought to be adverted to and risk factors considered.[110]

137. **Recommendation 2** was to '*review the missing person risk assessment to strengthen identification of risks specific to priority communities and vulnerable people*' (for example, listing LGBTIQA+ and/or specifically TGD status as factors to take into account in assessing risk in the context of a missing persons report).[111] I also consider this to be a critical step in recognising that members of these communities present a higher level of risk in terms of being victims of crime, suicidality and discrimination, and therefore present an elevated level of risk when reported as missing. The elevated risk is now acknowledged in the VPM[112] and should be explicitly listed as a risk factor on the online and hard copy missing persons risk assessment forms.

138. Critically, while LGBTIQA+ and/or TGD status may be listed as a 'risk factor' on the tick-box risk assessment for conciseness, Mr Elliot McMahon of Drummond Street Services gave evidence at Inquest that '*<u>discrimination</u> on the basis of trans and gender diversity would be more appropriate*',[113] in recognition that factors underpinning this risk are external rather than inherent, a proposition supported by Ms Michelle McNamara of Transgender Victoria.[114] I consider that this critical context should be included in police training on this topic, which will be the subject of a separate coronial recommendation.

139. **Recommendation 3** of the OSCIR was premised on the fact that the online and hard copy Victoria Police forms pertaining to the missing persons risk assessments include differently-

[109] Evidence of Deputy Commissioner Paterson, T-192, lines 21-23.
[110] The evidence of DSC Garside in this regard was that he took the same steps in a missing persons investigation as when investigating a serious crime – *see* T-111, lines 8-17.
[111] Evidence of Deputy Commissioner Paterson, T-140, lines 9-12.
[112] Victoria Police Manual on Missing Persons Investigations, 28 September 2023, AM5-6.
[113] Evidence of Elliot McMahon, T-506 lines 8-10, my emphasis. This was endorsed by Ms M. McNamara of Transgender Victoria – *see in this regard* T-514, lines 6-17.
[114] *'[…] what needs to be remembered and made clear in any risk factors for applying our risk assessment to trans and gender diverse population, is that those adverse risk factors in terms of mental health arise from the discrimination abuse ridicule that we've experienced over centuries, basically. And that is the key factor from my point of view'* – Evidence of M. McNamara, T-514 lines 11-17.

worded risk factors and should be reviewed '*to achieve consistency between the two methods available to compile missing person reports'*.[115] I consider consistency between the two forms to be a basic proposition that ought to be prioritised to ensure that the same risk factors are considered regardless of the method through which the assessment is conducted.

140. Given that no OSCIR recommendations have yet been implemented, pertinent coronial recommendations will follow.

Decision not to approve first triangulation request in relation to Bridget's phone

141. I consider the decision not to approve triangulation of Bridget's phone until it was too late to obtain any data from it, to be a significant lost opportunity to locate Bridget with precision and in a timely manner.

142. Evidence was heard at Inquest that, in order to be successful in determining Bridget's precise location, triangulation of her phone was required to be conducted as a matter of urgency. DSC Garside noted that triangulating a mobile phone is useful in a missing persons investigation as it allows a person's location to be identified when a telephone is switched on. DSC Garside noted '*I can't comment on how specific, to the actual metre of where that person is, but it's pretty good'*.[116] The urgency resides in the fact that triangulation must occur when the phone is switched on and prior to the battery becoming flat.

143. Requests for triangulation of phones are governed by federal legislation, namely the *Telecommunications Act 1997* (Cth) (**Telecommunications Act**). The test in section 287 of the Telecommunications Act, in force at the time of Bridget going missing, required that authorising officers needed to form a belief that triangulation was reasonably necessary to prevent or lessen a serious and imminent threat to the life or health of a person in order to approve the request. On 12 April 2023, in response to coronial recommendations in another

[115] OSCIR, CB p. 490.
[116] T-104, lines 9-13.

matter in NSW, the Telecommunications Act was amended to remove the requirement for the threat to be 'imminent'.[117]

144. The first triangulation request made in relation to Bridget's phone on 2 December 2020 was rejected on the basis that, according to the information at hand, Bridget's threat to life was not considered to be imminent (with the police member opining that the threat to life was a 'veiled' one and was over 48 hours ago).[118]

145. The same information in the first request was sent the following day to a different police member for authorisation, and was authorised on the basis that, in the view of the second decision-maker, '*it was evident that the missing person was in considerable risk of harm, and that all that could be done to locate her should be*'.[119]

146. However, by the time the request was authorised on 3 December 2020, it was four days since Bridget had been last heard from, and her phone was no longer able to be triangulated.[120] While the second request was approved, no triangulation data resulted, as at this point that Bridget's phone was switched off and likely out of battery.[121]

147. The evidence given at Inquest that triangulation '*was done*' is countered by more specific evidence received following Inquest, including police members' contemporaneous notes, that the second triangulation request, while approved, was of '*nil value'*.

148. As a result, investigators had to rely on the information extrapolated from the far less precise 'call charge records' information obtained in relation to Bridget's phone, which allowed

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[117] *See in this regard* '*Findings into the death of Thomas James Hunt',* 4 September 2020, State Coroner Magistrate Teresa O'Sullivan; Explanatory Memorandum, Telecommunications Legislation Amendment (Information Disclosure, National Interest and other Measures) Bill 2022 (Cth) 3(a).

[118] Statement of Deputy Commissioner Neil Paterson, CB p. 153. I note that this decision was arrived at despite the fact that the police member requesting triangulation described Bridget as a 'high-risk missing person'. It is not clear upon what basis this designation was arrived at – see mail correspondence of Victoria Police members, AM9-1.

[119] Statement of Inspector S. Johnson, AM10-1.

[120] Statement of Inspector S. Johnson, AM10-1-2. DSC Garside noted that, mobile phone records obtained retrospectively showed no data from Bridget's phone after 8:45am on 3 December 2020 – AM 2-11.

[121] Evidence of DSC Garside, T-108 lines 24-26. I note that the evidence at Inquest of Deputy Commissioner Paterson was that he understood that a '*triangulation request was made the following day and approved by a different inspector and that triangulation was done*' – T-144, lines 8-10. Counsel for the Chief Commissioner of Police acknowledged in closing submissions that '*We were unable to locate information that may come from such a triangulation request*' – T-87, lines 19-20. *See to the contrary*, Police Notes dated 3 December 2020 at 15:34 at AM9-10.

them to determine that her phone had last been in contact with (or in common parlance, '*pinged*') the Kew Golf Course cell phone tower and a tower in Alphington. Investigators therefore had a rough idea of where Bridget's last known location might be from this 'pinged' location, and this was shared with Angela with the knowledge that it would be shared with the broader LGBTQIA+ community, which I will turn to further below.

149. It was submitted to me by Counsel for the Chief Commissioner of Police, based on the evidence of Deputy Commissioner Paterson, that the first request for triangulation of Bridget's phone was not approved due to the legislative test at the time requiring the threat to her life or health to be 'serious and imminent' (my emphasis), and that '*if that request was made now in the current form, it would be granted and that is because of the legislative change removing the requirement for there to be an imminent threat and it was the imminence that caused the issue*'.[122]

150. I do not accept that proposition. I consider that, as submitted to me by Counsel Assisting, the information known to police members requesting and authorising the second triangulation request was essentially the same as in relation to the first triangulation request, which had been rejected. A different officer simply reached a different conclusion. Neither officer, it seemed, had ready access to a set of criteria or clear guidance in applying the legislative test,[123] which was acknowledged in the OSCIR to be '*subjective*'.

151. I note that **Recommendation 5** of the OSCIR was '*develop a risk assessment matrix in line with risk status/factors, to provide greater clarity in determining the serious and imminent threat to life of a missing person, to assist informing the mobile phone triangulation decision making process*'[124] to combat the perceived subjectivity of this decision-making process.

152. While this recommendation was perceived as partly redundant in light of the removal of the 'imminence' requirement by legislative change,[125] Deputy Commissioner Paterson acknowledged that an assessment of the seriousness of the threat (or risk) still requires the

[122] Closing submissions of Counsel for the Chief Commissioner of Police, T-86 line 26 to T-87 line 1.
[123] It is noted that brief guidance is provided in the VPM - *Telecommunications interceptions*, CB, p. 368-9, but there is no evidence that this was adverted to.
[124] OSCIR, CB, pp. 501-502.
[125] Evidence of N. Paterson, T-158 line 8 to T-159 line 8.

subjective assessment of the risk of the officer undertaking that assessment, regardless of the removal of the 'imminence' criterion. I therefore consider the recommendation is by no means redundant and in fact remains necessary to ensure that officers have appropriate guidance in this time-critical decision-making process as to the 'seriousness' of threat to life or safety. A pertinent recommendation will follow.

153. It was also submitted to me, based on the evidence of Deputy Commissioner Paterson, that an 'actual threat of suicide' would have been required to meet the imminence threshold of the Telecommunications Act as then applied, in order for a phone to be lawfully triangulated, rather than '*the expression of suicidality in the past*'.[126]

154. I was, and remain, troubled by this proposition, even in being strictly vigilant in avoiding hindsight bias. The evidence before me points to the fact that Mx Leigh reported on 1 December 2020 that they '*believed the MP is suicidal*' and that first triangulation request noted that upon last being seen, Bridget made '*veiled comments to suicide, possibly by hanging*'. It was not until 3 December 2020 that Mx Leigh was contacted by police to '*clarify the exact nature of [Bridget's] self-harm and suicide threats*'.[127]

155. In any event, by the time the first request for triangulation was made, the information police had was that Bridget had tried to gain admission to three private hospitals and had been refused treatment due to being self-funded. The applicant for the triangulation check had spoken to three of Bridget's friends as well as her employer/manager and noted that '*all hold concerns that MP will or has harmed herself*'.[128]

156. In light of the information known to police, it is unclear why an 'actual threat' of suicide or act of self-harm was perceived as a requirement to underpin the 'imminence' threshold of phone triangulation, and perplexing that this view was maintained at Inquest. As noted by Ms Bernasochi of Switchboard Victoria, '*not everyone discloses their suicidal thinking in such clear terms*'.[129] Police were apprised of the fears Bridget's loved ones had for her safety, of the fact that she was a member of a vulnerable community, and that she had been seeking

[126] Closing submissions of Counsel for the Chief Commissioner of Police, T-86, line 7.
[127] OSCIR, CB p. 493.
[128] AM9-2.
[129] Evidence of Ms A. Bernasochi, T-484 lines 28-29.

inpatient mental health treatment. Further, the second triangulation request was approved a day later based on the same information.

157. This reinforces to me that, even with the legislative test having changed to remove the 'imminence' requirement, which I consider to be positive, further guidance is still required for police members to assist in the subjective nature of the triangulation request decision-making process and determining the seriousness of the threat to life or safety to persons, as per OSCIR Recommendation 5.

158. For completeness, I do not consider the decision not to authorise the first triangulation request was causal or contributory in any way to Bridget's death. The evidence before me is that Bridget appears to have taken her own life soon after she went missing, noting that her last outgoing phone activity was at 11:04am on 30 November 2020[130] and last Facebook messages were sent to Mx Leigh at 1:46pm that same day.[131]

159. However, the decision not to authorise triangulation of her phone on the first request led to the physical search for Bridget being based on the much-less reliable data provided by the last 'pinged' location of her mobile phone, which dramatically increased the geographic area in which she could be located, and which led to a significant delay in her body being found. This led to considerable distress for her sister and for Mx Leigh. It also led to significant disquiet, fear, and outrage in the LGBTIQA+ community, a sentiment that unfurled and swelled in the days that followed and during which Bridget remained missing.

Adequacy of the Victoria Police missing persons search for Bridget, including methods deployed

160. I consider that the decision to transfer the missing persons investigation to the Melbourne Crime Investigation Unit (**CIU**) on 4 December 2020, due to the uniform branch not having sufficient resources or expertise to conduct the intensive investigation required, was appropriate. While there were police members who made considerable efforts in the missing

[130] Statement of DSC Garside, AM 2-11.
[131] Statement of H. Leigh, CB p. 48.

persons search during 1-3 December 2020, Bridget's sister Angela describes the difference between the two as being '*night and day*'.[132]

161. Indeed, Angela described that having a central point of contact at Victoria Police during this period made a significant difference, with a police member proactively contacting her with updates being greatly beneficial.[133] Prior to the transfer of the investigation to DSC Garside, she reports being told by police that '*there was nothing further that could be done*', which DSC Garside acknowledged at Inquest, in a most sincere manner, was '*tough to hear*', opining that '*I don't think you ever reach a point where there's nothing more that can be done*'.[134]

162. The evidence pointed to significantly increased investigative efforts being deployed by Victoria Police once DSC Garside took carriage of the investigation of 4 December 2020, consistent with the greater capacity of the CIU. This included police responding to numerous Crimestoppers reports of sightings of Bridget, investigating Bridget's last bank account activity, conducting a water search of the Yarra, an Air Wing search of the area in which Bridget's phone had last 'pinged', a media stand-up in which Angela participated alongside DSC Garside, and requests for use of police drones, stored communications, and the Police Mounted Branch.

163. Significantly, DSC Garside also sought the advice of the then-Victoria Police LGBTIQ Portfolio Manager in the Priority and Safer Communities Division via his office's GLLO (as they were then called), who provided advice and liaised with the LGBTIQA+ Commissioner and Missing Persons Unit.[135] DSC Garside's approach was considered, competent, and compassionate, and these actions are to be commended. He provided his personal mobile telephone number to Angela and communicated with Angela and Mx Leigh in relation to the

[132] Evidence of A. Pucci-Love, T-93, line 4.
[133] Evidence of A. Pucci-Love, T-92 line 28 to T-93 line 11.
[134] Evidence of DSC Garside, T-103, lines 11-15. Angela also gave evidence that an officer from Flemington police station told her to call the fire brigade in order to access Bridget's apartment – Evidence of A. Pucci-Love, T-78 line 28 to T-79 line 13.
[135] Evidence of DSC Garside, T-122, lines 10-21. I note that the OSCIR considers that this contact ought to have occurred earlier, though this issue was not explored at Inquest.

progress of the investigation, which, while contrary to Victoria Police policy,[136] was a demonstration of his personal dedication to the investigation.

164. However, the broader Victoria Police approach to the search for Bridget had concerning gaps. As submitted to me in closing submissions by Counsel Assisting, no ground searches were conducted for Bridget in the last 'pinged' location by Victoria Police members acting in their professional capacity. This task was undertaken by members of the LGBTIQA+ community who mobilised and coordinated their search activity through social media. Police did not attend or support the searches of community members looking for Bridget, though they had knowledge they were occurring through monitoring of the Facebook page with 6000+ members.

165. DSC Garside agreed that when information was passed to Angela it was likely to be passed on to the public and that the community were likely to go searching for Bridget.[137] Indeed, it was two community members, not police, who found Bridget deceased on 11 December 2020.

166. This runs counter to the approach specified in Victoria Police Practice Guide on Spontaneous Volunteers that was in place at the time Bridget went missing,[138] which is concerned with, amongst other things, ensuring the management and coordination of spontaneous volunteers and, critically, '*the safety and welfare of all searchers*'.[139] While police were not required to follow the Spontaneous Volunteers Practice Guide as a mandatory practice, there is no evidence it was ever referred to or that police members were even aware of its existence.

167. When it was put to Deputy Commissioner Paterson by Counsel Assisting that '*the LGBTIQA+ community felt that police left a very vulnerable community to search for one of their own in the knowledge that they might find Bridget deceased*', he acknowledged that this was '*certainly a valid perception*'.[140]

[136] *See in this regard* Statement of Deputy Commissioner Paterson, CB, p. 509.
[137] Evidence of DSC Garside, T-118, lines 9-29.
[138] *See* CB, pp. 353-356.
[139] *See* CB, p. 354.
[140] Evidence of Deputy Commissioner Paterson, T-149 line 21 to T-150 line 2.

168. By Victoria Police failing to engage with community members in search activity they knew was being carried out, they failed to consider the safety and wellbeing of the community members searching for Bridget.

169. The resulting scenario in which community members led searches with no oversight or coordination from Victoria Police also raised significant concerns as to amplified suicide contagion within the community, '*an observable phenomenon that happens following a suicide death where people who are exposed to that suicide or bereaved by that suicide become a greater likelihood of experiencing suicidal distress themselves or going on to die by suicide*'.[141] For the LGBTIQA+ community, suicide contagion can be experienced in different ways, including heightened fears around suicide based on being part of an at-risk population.

170. Mr Joe Ball of Switchboard stated at Inquest that had police appropriately assessed the level of risk Bridget faced as a missing person, this may have avoided a scenario whereby '*community members found her body and … we had potentially 6000 people who were impacted by suicide contagion'*.

171. The Commissioner for LGBTIQA+ Communities made lengthy submissions on the impact on the community of this occurring, noting that the group searching for Bridget '*had self-funded not just their searching activities, but also privately sourced counselling and support to debrief their endeavours'*.[142] As described by Ms Anna Bernasochi of Switchboard, community organisations such as Switchboard had to swiftly pivot and liaise with organisations such as the Office of the Commissioner for LGBTIQA+ Communities, Drummond Street Services, Thorne Harbour Health, and others. Switchboard offered postvention support to a massive group of impacted people who, despite not knowing Bridget personally, deeply felt the broader impact of her passing on the community.[143] Some feared she had been murdered.[144]

[141] Evidence of A. Bernasochi, T-496, lines 19-24. Ms Bernasochi also noted the term 'suicide contagion' to be problematic (see T-496 lines 10-11), which will be addressed later in this finding.
[142] Collated brief, p. 132.
[143] Evidence of Mr J. Ball and Ms A. Bernasochi, T-488, line 19 to T-493 line 16.
[144] Evidence of Mr J. Ball, T-522, line 16.

172. Counsel for DSC Garside drew my attention to **Recommendation 4** of the OSCIR, which recommended a review of the *Crime Investigative Guidelines – Missing Persons and Missing Persons Squad – Initial Action Guide* to address the internal incident management system and concomitant issues faced in the investigation for Bridget in an urban setting, namely: (i) management of public information; (ii) search coordination; and (iii) spontaneous volunteer management.[145] While it remains somewhat unclear to me as to why there is a dearth of guidance for police on missing persons searches conducted in an urban environment, to the extent that Victoria Police has itself identified this as a practice improvement that will enhance the coordination of urban missing persons searches in the future, I consider this recommendation ought to be implemented.

173. Given that this OSCIR recommendation has also not yet been implemented, a pertinent coronial recommendation will be made in this respect.

Guidance and support for Victoria Police members conducting missing persons investigations

174. I consider the issues in the Victoria Police missing persons investigation for Bridget, that have been identified in hindsight, prevailed at an organisational rather than at an individual level. I do not intend to make any adverse findings against the individual police members involved in the investigation, the vast majority of whom were not required to give evidence at Inquest, and who were undertaking their investigative duties alongside multiple other operational duties.

175. In particular, I consider that the actions of DSC Garside in the missing persons investigation relating to Bridget were dedicated, compassionate, and culturally-sensitive. However, he had assumed carriage of an investigation that was already compromised given the lack of triangulation data and lack of comprehensive risk assessment conducted in the earliest days of the investigation. To this end, I consider that individual police members were not adequately supported by Victoria Police with readily-accessible guidance as to the time-critical steps they were required to take.

[145] Submissions of Counsel for DSC Garside, T-77, line 2 to line 8.

176. At the time Bridget went missing, there was no Victoria Police Manual (**VPM**) on missing persons investigations. This was first introduced in September 2023.[146] This VPM steps out police members' responsibilities and procedures, amongst other things, in missing persons searches, including initial action to be taken. Compliance with the VPM is mandatory.

177. What existed in December 2020 was a Victoria Police Manual – Procedures and Guidelines **(VPMG**) on missing persons investigations that contained a number of mandatory and non-mandatory actions to be taken in relation to such investigations.[147] Actions that were considered mandatory and non-mandatory are not clearly differentiated. However, Deputy Commissioner Paterson gave evidence at Inquest that the following steps in the former VPMG were mandatory:

- Police members are to immediately investigate any report of a missing person;
- A missing person report must be taken in person;
- A Missing Persons Report and Risk Assessment Form must be completed.[148]

178. Deputy Commissioner Paterson also noted that phone triangulation requests constituted a mandatory step when the member believes there is a serious and, at the time, imminent threat to life or health of a person.

179. Also available to police by way of guidance, in December 2020, were the Crime Investigative Guidelines on Missing Persons, a document of some 140 pages, and the more concise Missing Persons Squad Initial Action Guide, being a basic checklist of initial enquiries to be considered at uniform level when a person goes missing, though which does not explicitly address any process for risk assessment.[149] A suite of other miscellaneous

[146] AM-5, dated 28 September 2023.
[147] VPMG – Missing Persons Investigations, CB, pp. 157-164. This has since been replaced by the Missing Persons VPM.
[148] Victoria Police Manual – Procedures and Guidelines, CB p. 158; Evidence of Deputy Commissioner Paterson, T-134, lines 6-10.
[149] *See* CB pp. 196-337; pp. 338-351.

documents was also available, including those specific to crime attendance and investigation.[150]

180. However, any evidence that these documents were referred to by frontline investigators in Bridget's search – even at the stage it reached the Crime Investigation Unit (**CIU**) – is absent.[151] Indeed, evidence of DSC Garside in this regard was that, even at a CIU level, he took the same steps to progress a missing person investigation as when investigating a serious crime.[152]

181. Thus, while a patchwork of guidance documents was in existence at the relevant time, this does not appear to have been amenable to provision of time-critical, concise, guidance for police members on steps to undertake in Bridget's missing persons investigation. Key Finding 4 in the OSCIR also identified the deficiencies in existing guidance in the sense that there was no Missing Person prompt or guide sheet available to assist the reporting member in what information is critical to garner at the time of first report.[153]

182. It was the evidence of Deputy Commissioner Paterson, by way of his first statement, that:

- A new Practice Guide 'Missing Persons – Initial Actions to locate' will soon be published to provide further guidance for members and the steps to be undertaken following a missing person's report, informed by consideration related to Bridget's missing person investigation;[154]

- The VMPG on missing persons investigations and Investigative Guidelines will also be updated to reflect current practice and expectations.[155]

[150] *See* Statement of Deputy Commissioner Paterson, CB, p. 146 at [19].
[151] *See* in this regard evidence of DSC Garside, T-127, line 11 to T-128 line 16.
[152] T-111, lines 8-17.
[153] OSCIR, CB p. 498.
[154] Statement of Deputy commissioner Paterson, CB p. 146.
[155] Statement of Deputy commissioner Paterson, CB p. 146. It is not clear to me why the VPMG is being updated in circumstances in which the VPM states that it is being published to, amongst other things, replace the VPMG – *see* update history at AM5-10.

183. At Inquest, Deputy Commissioner Paterson noted that the work has not yet been completed and remained in draft form.[156]

184. In conjunction with the implementation of OSCIR Recommendations, I consider that further guidance on risk assessment and initial investigative steps in missing persons investigations, including by way of a prompt sheet, should be developed as a priority, and as already identified by Victoria Police.

185. The need for clear guidance resides in the fact that filing a missing person report, is sadly, not an uncommon task for uniform police members. Deputy Commissioner Paterson indicated in his first statement that '*receiving and responding to missing persons reports is a core function of front-line policing, in particular for general duties uniform members. Victoria Police investigates approximately 20000 missing persons reports each year*'.[157]

186. I consider that a consolidation of the current patchwork of guidance is urgently required to allow police to do their job and appropriately address the risks posed to the many Victorians who go missing every day, particularly where missing persons investigations are tasked to uniform members in the first instance rather than a centralised Missing Persons unit that investigates all reports of missing persons (as in, for example, New South Wales).[158]

The evidence of Deputy Commissioner Paterson and implementation of the OSCIR recommendations

187. I note for completeness that I found Deputy Commissioner Paterson to be a sincere witness who displayed a deep commitment to his position and to enhancing the wellbeing of the LGBTIQA+ community, as demonstrated through various roles held at Victoria Police, such as the executive sponsor and champion of the Victoria Police Pride Network, amongst many others. It was Deputy Commissioner Paterson (in consultation with Jen Dixon, then-LGBTIQ Portfolio Manager and Acting Detective Inspector Tony Combridge of the Missing

[156] *See for example* Evidence of Deputy Commissioner Paterson, T-193 line 18 to T-194 line 6.
[157] Statement of Deputy Commissioner Paterson, CB p. 145.
[158] *See in this regard* https://www.police.nsw.gov.au/can_you_help_us/missing_persons

Persons Unit)[159] who commissioned the OSCIR above and beyond the stipulated requirements for this type of review, in an effort to ensure that, following concerns regarding the missing persons investigation for Bridget, opportunities for organisational learning and improvement could be appropriately harnessed and acted upon.[160]

188. Further, the provision of the OSCIR to the Court on behalf of the Chief Commissioner of Police to aid my inquiry was of great assistance and demonstrated the thoroughness of the internal scrutiny that attended upon Victoria Police's own actions, which is to be commended.[161]

189. Given the quality of the review conducted, which I considered was generally very high,[162] it is therefore deeply concerning – and almost inexplicable – that none of the five OSCIR recommendations, made in December 2021 following an incident that occurred in December 2020, have yet to be implemented by Victoria Police, and, per the evidence of Deputy Commissioner Paterson, there is no concrete timeframe in which to do so.[163]

190. At Inquest, Deputy Commissioner Paterson noted the barriers to implementation of the recommendations were technological (in this case, in relation to Recommendation 2, though the same issue appeared to apply to all), noting '*the system changes that are required to our LEAP system which is a system from the 1990s are considerable to add a new risk category*

[159] Statement of J. Dixon, CB, p. 126. I note that the Missing Person Squad in Victoria Police sits in Crime Command and '*investigates missing person cases aligned to their level of risk or who have disappeared under suspicious circumstances*' – see 'Missing Persons' *Victoria Police* (Web Page 30 July 2024) https://www.police.vic.gov.au/missing-persons.
[160] Evidence of Deputy Commissioner Paterson, T-177 lines 10-18.
[161] I note the evidence of Mr McMahon of Drummond Street Services and Mr Ball of Switchboard in this regard (*see* T-486 line 6 to T-487 line 30) that the OSCIR had limitations given it was an internal review process; notwithstanding, I consider that the provision of the OSCIR to the Court for the purposes of the present investigation represented a willingness on Victoria Police's part to have its own internal processes subject to independent scrutiny.
[162] I note in this regard that questions were put by Counsel Assisting to Deputy Commissioner Paterson on the conclusion of the OSCIR that there was no evidence of overt or unconscious bias in the course of the missing person search for Bridget, and of the methodology used to reach this conclusion. The evidence as to this was equivocal, and as a matter of fairness, I do not propose to make any formal finding on this issue, having refrained from calling the author of the OSCIR to give evidence. However, it may be considered that the question of whether or not overt or unconscious bias is present is a proposition distinct to whether or not policy has been followed in a general sense. *See in this regard* T-151 lines 29-30 to T-152 line 26.
[163] *See for example* evidence of Deputy Commissioner Paterson, T-153 line 22 to T-154 line 7.

into it. It's in a schedule of works that should be completed shortly and we can't change a manual form until the systems underlying that are changed so that it marries up'.[164]

191. Deputy Commissioner Paterson assured the Court that implementation of the recommendations was not outstanding due to any philosophical barriers, but confirmed this was due to '*very old legacy IT systems, and they are quite cumbersome to change'*.[165]

192. While appreciating the difficulties presented by existing IT infrastructure, and in particular LEAP, I consider this troubling. The OSCIR recommendations are geared towards not only making the LGBTIQA+ community safer but also to helping individual police members do their jobs well. In that respect the OSCIR recommendations offer both a pathway for frontline police conducting missing persons searches in relation to vulnerable communities to ensure they can discharge their duties appropriately and in line with their functions under the *Victoria Police Act 2013*.

193. Over and above this, implementation of the OSCIR recommendations is of critical importance to the LGBTIQA+ community, and in particular to the TGD community, to promote cultural safety in interactions with police through, at a minimum, implementing the lessons learned from Bridget's missing persons investigation in a timely manner.

194. It is therefore troubling that no recommendations have been implemented several years on due to what is ostensibly an IT issue. To use the somewhat pithier words of Dr Vivienne of Transgender Victoria about their community, '*in 2023, it is not acceptable to say, "Computer says no, we don't understand who you are and what you need." We need a timeline and a budget for [Victoria Police] actually doing the work'*.[166] A pertinent coronial recommendation will follow.

[164] Evidence of Deputy Commissioner Paterson, T-153, lines 22-29.
[165] Evidence of Deputy Commissioner Paterson, T-155, lines 18-20.
[166] Evidence of Dr Vivienne, T-482, lines 14-29.

2 – Victoria Police and the trans and gender diverse community

195. The second item in the scope is the '*Victoria Police policies, procedures, training, and initiatives relating to the transgender and gender diverse (TGD) community'.*

Capturing additional gender identities in Victoria Police systems

196. Extensive evidence was heard at Inquest in relation to the need for Victoria Police systems to be able to capture additional gender identities (and potentially LGBTIQA+ status more broadly) beyond binary 'male' and 'female' in its forms and systems. This was held to be important in a coronial context for reasons noted by Commissioner Fernando, insofar as '*knowledge of LGBTIQA+ status is important I think for a comprehensive coronial investigation which may be undertaken by the court or may be considered as a factor relevant to suicide*'.[167] Improved data collection was also held to be necessary from the perspective in accurately identifying LGBTIQA+ suicide rates and concomitant prevention initiatives,[168] a sentiment that was strongly endorsed by Ms Bernasochi from Switchboard.[169]

197. At Inquest, Deputy Commissioner Paterson gave evidence that Key Finding 10 from the OSCIR, which relates to enhancing the ability of Victoria Police systems to capture additional gender identities, has yet to be progressed. The OSCIR refers to the Australian Government Guidelines on the Recognition of Sex and Gender, which commenced in July 2013, and which note that individuals may identify as a gender other than the sex they were assigned at birth, or may not identify as exclusively male or female, and that this should be reflected in records held by the government.

198. In relation to the amendments required to police systems to capture additional gender identities, Deputy Commissioner Paterson gave evidence that a whole-of-government approach was required before this could occur and that responsibility for leading the whole-

[167] Evidence of Commissioner Fernando, T-410, lines 14-17.
[168] Evidence of Commissioner Fernando, T-410, line 27 to T-411 line 4.
[169] Evidence of A. Bernasochi, T-413, lie 11 to T-415 line 6.

of-government approach resided with the Commissioner for LGBTIQA+ communities (**Commissioner Fernando**).[170]

199. Conversely, Commissioner Fernando gave evidence at Inquest that this approach already exists through Victoria's first whole-of-government LGBTIQA+ strategy for 2022-2032, *Pride in our future*, via 'Priority area 3: Visibility to inform decision making' which is geared towards enhancing the dataset in relation to the LGBTIQA+ populations across government to ensure the accuracy of the evidence base informing government decision-making in relation to these populations.[171]

200. Indeed, it appears that the implementation of the whole-of-government approach is already underway in other Victorian government departments and entities. Information received following the hearing of closing submissions at Inquest revealed that the Department of Health, also an Interested Party to these proceedings, had already initiated work to capture additional identities which as of the date of this Finding, has now been completed, as per the following:

- *'The Department of Health endorsed the new requirement for health services to report on 'sex at birth' and 'gender' as part of its annual changes process for key health services data collections, following receipt of submissions from and consultation with health services and community.*

- *The change was informed by the whole-of-government LGBTIQA+ strategy, Pride in our future: Victoria's LGBTIQA+ strategy 2022-32, and in particular Priority area 3: Visibility to inform decision making.*

- *To support health services to more safely implement this change, the Department consulted with health services and community to develop guidance on the inclusive collection and reporting of sex and gender data.*

[170] Evidence of Deputy Commissioner Paterson,T-178 line 21 to T-179 line 22.
[171] Evidence of Commissioner Fernando, T-409, lines 17-26.

- *The Department of Health guidance complements the refreshed Victorian Public Sector's LGBTIQA+ Inclusive Language Guide.*

- *Health services are required to implement these changes from 1 July 2024*'.[172]

Engagement with the LGBTIQA+ Community

201. The statement of Deputy Commissioner Paterson indicates that there has a been a shift over the last 10 years in the way in which Victoria Police engages with the LGBTIQA+ community. His statement comprehensively outlines a number of initiatives that relate to police engagement with the LGBTIQA+ community, including, amongst others, the LGBTIQA+ Inclusion Action Plan 2023-2024, the *Keeping You Safe* Strategy 2023-8, the whole-of-government LGBTIQA+ Strategy *Pride in our Future 2022-32*, as well as a number of policies of general application that also provide guidance of engagement with the LGBTIQA+ community, such as the VPM on Community Policing.[173]

202. Deputy Commissioner Paterson also reflected on what is being done following critical incidents (such as the missing persons investigation relating to Bridget) to engage with the community, noting that there are no specific mechanisms in place to govern the way in which Victoria Police engages with LGBTIQA+ community organisations following critical incidents beyond its existing policies and procedures. Deputy Commissioner Paterson noted there are forums in which police have important opportunities for proactive engagement with the community, such as the LGBTIQA+ Portfolio Reference Group (**PRG**), comprising a range of peak bodies and interest groups and the LGBTIQA+ Community Portfolio Manager.[174]

Training of Victoria Police members on issues relating to the LGBTIQA+ Community

203. In his statement to the Court, Deputy Commissioner Paterson helpfully outlined the various LGBTIQA+ awareness and sensitivity initiatives offered through Victoria Police, including, *inter alia*, (i) having LGBTIQA+ community members participate in the 'Community

[172] Additional Materials 11, Correspondence from Department of Health to the Coroners Court dated 5 March 2024.
[173] Statement of Deputy Commissioner Paterson, CB pp. 147-151.
[174] Statement of Deputy Commissioner Paterson, CB p. 149 and p. 151.

Encounters Program' at the Police Academy, to educate new recruits, along with general LGBTIQA+ Awareness training which was revised and updated in 2022; (ii) general LGBTIQA+ awareness and sensitivity training for Victoria Police staff; and (iii) holding regular LGTBIQA+ awareness training sessions facilitated by 'Pride in Diversity', including TGD training sessions.[175]

204. At Inquest, Deputy Commissioner Paterson endorsed the need for police to be culturally competent in dealing with members of the LGBTIQA+ community, and noted that in the absence of providing LGBTIQA+-specific training not just to new recruits but to **all** police members (which was not a strategy he endorsed), the 'failsafe' in his view is ensuring that policies and procedures can appropriately allow for risks to such priority communities to be assessed and actioned, such as in a missing persons context.[176]

205. Ms Elisabeth Lane (**Ms Lane**), the Court's lived experience expert and a proud transgender woman, gave evidence of her own role in the provision of such training for Victoria Police as part of her role with Pride in Diversity, and of the response of Victoria Police, opining, '*is it perfect? No. But are they continually trying to improve and improving? Yes. I've done training there to large groups and … last year, I did trans awareness training left totally open to anyone who wanted to turn up and almost 200 police officers did'*.[177]

206. In its submissions to the Court, Transgender Victoria agreed that overall, '*parts of the Police would genuinely like to improve relations with the LGBTIQ+ community in general and the TGD community in particular and notes the efforts described in the Police Submission. TGV particularly acknowledges the Police LGBTIQ+ Reference Group (**PRG**) of which it has been an active member since its inception in 2014'*. Transgender Victoria opined that, however, *'the Police have often been slow to deliver meaningful actions in response to issues raised with the PRG. The Police have also been reluctant to communicate these publicly to the LGBTIQ+ community […].*[178]

[175] Statement of Deputy Commissioner Paterson, CB p. 149.
[176] Evidence of Deputy Commissioner Paterson, T-169, lines 5-21.
[177] Evidence of E. Lane, T-38, lines 19-24.
[178] Submissions of Transgender Victoria, Collated Brief, pp. 332-338.

207. Referring to a Victoria Pride Lobby survey conducted in 2020,[179] Transgender Victoria noted that the TGD community has historically had low levels of trust in the Police, opining that in recent years, following certain events impacting the safety of members of the LGBTIQA+ community, '*Police relations with the broader LGBTIQ+ community and the TGD community in particular have deteriorated*'.[180] In addition to a suite of recommended changes and also advocating for Victoria Police to apologise to the TGD community for its policing of these events, Transgender Victoria submits that '*at a minimum, LGBTIQ+ awareness training should be mandatory for all existing and new staff, and the process of community encounters with TGD people should be made mandatory for all serving Police officers and new recruits*'.[181]

Analysis

Capturing additional gender identities in Victoria Police systems

208. Deputy Commissioner Paterson confirmed at Inquest that the current inability of Victoria Police systems to capture additional gender identities is '*not about Victoria Police lack of desire to change, it's about following a whole-of-government process so that we're not counting something that other government agencies aren't also counting or indeed that we may do it wrong, we may create a category that's not [one of] the accepted whole-of-government categories*'.[182]

209. I consider that the evidence heard at Inquest has usefully clarified that such a whole-of-government response is already in place via Priority Area 3 of the LGBTIQA+ Strategy *Pride in our Future 2022-32*, under the banner of which the Department of Health has already scoped and initiated its own changes to the way in which data is collected to capture information on gender and sex more comprehensively, along with detailed guidance for

[179] Victoria pride Lobby, Upholding our rights *LGBTIQA+ attitudes towards and experiences of policing in Victoria*, available: https://www.vicpridelobby.org/download/upholding-our-rights-lgbtiqa-attitudes-towards-and-experiences-with-police/.
[180] Submissions of Transgender Victoria, Collated Brief, pp. 333-4.
[181] Submissions of Transgender Victoria, Collated Brief, pp. 335-6.
[182] Evidence of Deputy Commissioner Paterson, T-178 line 29 to T-179 line 6.

service providers to assist in respectfully and accurately capturing that data. The Department of Health is to be commended for its proactive approach and for its work on this front.

210. Commissioner Fernando noted at Inquest that, while he strongly advocated for Victoria Police systems to be changed to accommodate gender identities beyond 'male' and 'female', and while his office took the lead in development of the overarching LGBTIQA+ Strategy *Pride in our Future 2022-32*, the operationalisation of action items thereunder is a matter for individual government entities. He opined, very respectfully, '*in regards to Form 83 or in regards to updates to Victoria Police's systems, I think it's unlikely or inappropriate for my office to walk into that agency to demand or suggest*'.[183]

211. While recognising that work will be required to be done in conjunction with other government entities to implement any changes in collection of data via LEAP, I consider it is untenable that Victoria Police maintains a position that its own systems cannot be updated to capture additional gender identities due to the need to await that whole-of-government response. Two years into the 10-year strategy, I consider that Victoria Police must undertake the work required to capture additional gender identities as a matter of priority with any liaison that is required with other Victorian departments and other entities (for example, Corrections Victoria) to ensure consistency in the way such questions are framed to capture the data.

212. A pertinent recommendation will follow.

Engagement with the LGBTIQA+ Community

213. The current Victoria Police initiatives to engage with community are multifaceted and are to be commended.

214. However, it is clear from the evidence heard at Inquest that there is an enduring perception amongst some LGBTIQA+ community members and organisations that the cultural

[183] Evidence of Commissioner Fernando, T-411, lines 17-20. In relation to the 10-year strategy, he noted '*while I have strategic responsibilities over the implementation of that strategy, it is a shared responsibility right across every government and every agency of the State government to implement the necessary changes underneath that strategy for it to be effective at year 10*' - T-519, line 28 to T-520, line 7.

competence of police, as it relates to the LGBTIQA+ community, still requires strengthening, and in fact remains fragile due to incidents in recent years in which community trust was damaged by police actions (such as the incident in which photographs of Danielle Laidley were unlawfully shared by Victoria Police members).[184] Deputy Commissioner Paterson acknowledged that such incidents do indeed '*damage trust with the broader LGBTIQA+ community and in particular the trans and gender diverse community*'.[185]

215. Having so stated, I do note the evidence of Ms Lane, the Court's lived experience expert, and of Deputy Commissioner Paterson, was that police are now better equipped to decisively respond to such incidents in ways that strive to ensure that LGBTIQA+ community safety is prioritised and relationships with the community can be maintained. Ms Lane opined:

> *If I may, the Danielle Laidley issue, that should never have happened, but it did. Now what was the police response to that? There was one – 20, 30 years ago they would have closed ranks. They did not. The perpetrators were held to account and they all – they basically received basically fines or demotions or punishment representing the nature of what they'd done. So – and the one thing I often say, I've said to the police themselves, I said, that's one example of good policing. You cannot stop any bad action coming, you can only do so much, but what do you do after it? And what they did was they made it very clear that that will not be accepted in the police force. The community will be protected first and foremost*.[186]

216. I found the evidence from Ms Lane and the Deputy Commissioner to be compelling in this regard. Deputy Commissioner Paterson acknowledged the importance of all community members being able to trust police and was cognisant of the historical and systemic barriers of certain communities in doing so, noting that '*possibly for LGBTQIA+ communities as*

[184] *See in this regard* the written outline of closing submissions of Transgender Victoria, p. 4 at [21-22]. Such incidents are summarised in the question of Counsel for Transgender Victoria to Deputy Commissioner Paterson at T-181 line 15 to T-182 line 3.
[185] Evidence of Deputy Commissioner Paterson, T-184, lines 22-24.
[186] Evidence of E. Lane, T-43, lines 14-27.

other priority communities, it becomes a greater leap in terms of the level of trust that's required and that comes about the history of policing with various priority communities'.[187]

217. Notwithstanding, as submitted to me by Counsel Assisting and Counsel for Transgender Victoria, ensuring that the LGBTIQA+ community has a baseline level of trust in police is an ever-evolving endeavour. The missing persons search for Bridget was a further example of an incident in which that level of trust was impacted because the LGBTIQA+ community felt that police had left vulnerable community members to search for one of its own. Deputy Commissioner Paterson appreciated this was '*certainly a valid perception*'.[188] Indeed, as I have already noted, Victoria Police were not involved in the search efforts for Bridget and those from the community who coordinated those searches felt '*deeply angry*'.[189]

218. It is perhaps therefore unsurprising that the statement of one of the community members who found Bridget who noted, '*I was not personally known to Bridget but I felt the need to help look for her because I didn't feel that police had done a thorough enough search for her'*, concludes with the words '*I want to make it known that trans lives matter*'.[190]

219. The need to assert this - that *trans lives matter* – is both deeply poignant and reflective of the broader sentiment amongst the LGBTIQA+ community that the missing persons investigation for Bridget was not taken seriously by Victoria Police because Bridget was transgender.[191] Having carefully considered the issue, I am not of the view that this is supported by the available evidence. While there were serious deficiencies in the Victoria Police missing persons investigation for Bridget, there is no evidence that the investigation was not taken seriously because she was transgender. Rather, police failed to recognise the actual risk of suicide that Bridget presented, and also failed to recognise the heightened risk Bridget faced of experiencing suicidality as a transgender woman. The deficiencies in the investigation emanated, in part, from this failure.

[187] Evidence of Deputy Commissioner Paterson, lines 7-11.
[188] Evidence of Deputy Commissioner Paterson, T-149 line 21 to T-150 line 2.
[189] Submissions of Commissioner for LGBTIQA+ Communities, Collated Brief, p. 140.
[190] Statement of M. Knight, CB, pp. 19-21.
[191] *See in this regard* Submissions of the Commissioner for LGTIQA+ Communities, Collated Brief, p. 121.

220. Victoria Police must therefore acknowledge that the task of building trust with the LGBTIQA+ community, and in particular, the TGD community, is an ongoing one. Real change, such as committing to and taking the lead on capturing additional gender identities in police systems and implementing OSCIR recommendations after having commissioned such a robust internal review, is required to underpin and engender an ongoing sense of trust. This is necessary even where there are stated to be no philosophical barriers to these things occurring; the proof is very much in the pudding.[192]

221. I note in this regard that, DSC Garside, in responding to a question from Counsel for Transgender Victoria on the extent to which Victoria Police's culture in relation to understanding and meeting the needs of TGD community has improved since the time of the missing person investigation in relation to Bridget, noted '*I'd like to hope so. But I'd like to hope that that just extends past Victoria Police and that the community are more accepting and understanding of transgender people in the community'*.[193]

Training of Victoria Police members

222. I consider the improvements made to LGBTIQA+-specific training by Victoria Police over recent years, outlined in the statement of Deputy Commissioner Paterson, to be encouraging. In particular, noting what Counsel Assisting described as the '*broad church*' of the LGBTIQA+ community, with unique issues to each denomination thereunder, I consider it commendable that such training includes modules targeted at improved awareness of TGD-specific issues. Indeed, the evidence provided by Ms Lane was that her training on TGD issues was well-attended by Victoria Police members, and she spoke positively of their engagement.

223. Notwithstanding, I accept the submission of Counsel Assisting in relation to Victoria Police training that Deputy Commissioner Paterson was unable to say at Inquest what proportion of the force has received LGBTIQA+ training of some kind, nor what the specifics of the

[192] *See in this regard – and again* - the evidence of Dr Vivienne of TGV - *'In 2023, it is not acceptable to say, "Computer says no, we don't understand who you are and what you need." We need a timeline and a budget for them [Victoria Police] actually doing the work'* - T-482, lines 14-29.
[193] Evidence of DSC Garside, p. 125, lines 24-30.

training are, including whether such training addresses the incidence of suicide in the TGD community specifically.[194]

224. The need for such specific awareness was demonstrated through the evidence of the then-Chief Psychiatrist of Victoria, Dr Neil Coventry, who supported the need for police to be trained alongside clinicians as frequent 'first responders' to incidents of suicide and self-harm. This includes where police are required to transport persons under the *Mental Health and Wellbeing Act 2022*, despite the health-led approach that this new Act strives for.[195] This is consistent with the evidence of Dr Vivienne of Transgender Victoria, who opined '*I think that all first responders need to have a minimum level of understanding and expertise in trans and gender diverse complexity including non-binary recognition alongside a trauma informed and impacted understanding of what suicide and suicidality is likely to look like*'.[196]

225. I also note that, the particular risks to Bridget that attended upon her being from a community vulnerable to suicide were not well-recognised (insofar as this was not considered a factor impacting her risk level) by the police members receiving and filing the Missing Person Report. Accordingly, I consider that the training regime of Victoria Police could be further strengthened and that Victoria Police should make LGBTIQA+ awareness training mandatory for all police members and staff. Such training should include a TGD-specific component, addressing factors that can contribute to the risk of suicide in LGBTIQA+ and TGD communities, and the ways in which police members can appropriately assess and respond to such risks. A pertinent recommendation will follow.

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[194] *See in this regard* the evidence at T-168 lines 14-18: Counsel Assisting: '*Are you able to say at present what proportion of the force has received LGBTIQA+ awareness and sensitivity training of some kind?*' Deputy Commissioner Paterson: '*I'm not able to give you that statistic off the top of my head; however, I would guess that it would be quite high*'.

[195] Evidence of Chief Psychiatrist Coventry, T-348, line 16 to T-349, line 4. This corresponds with the evidence of Dr Vivienne of TGV, who noted '*I think that all first responders need to have a minimum level of understanding and expertise in trans and gender diverse complexity including non-binary recognition alongside a trauma informed and impacted understanding of what suicide and suicidality is likely to look like*' – T-517 lines 22-27.

[196] Evidence of Dr S. Vivienne, Transgender Victoria, T-517, lines 18-27.

3 - Mental ill health and suicidality in the trans and gender diverse (TGD) community

226. The third item in the scope of inquest is '*[t]he evidence base concerning the incidence of mental ill health and suicidality in the TGD community, including the reasons for this'*.

227. I heard evidence in these proceedings that TGD people face disproportionate rates of mental ill health and suicidality compared to the population as a whole, as well as a higher rate of completed suicide.[197] While there is some variation in specific findings and datasets (particularly where studies are drawn from clinical populations, as opposed to the TGD population more broadly), there is clear evidence that the TGD community reports and experiences higher rates of depression, anxiety, suicidality and self-harm than the population as a whole,[198] with Dr Kalra of the Monash Health Gender Clinic stating that 50-75% of TGD people report having a mental health issue.[199]

228. At Inquest, Professor Zajac of Austin Health noted that, in his experience of treating TGD patients (through a clinic treating approximately 600 TGD individuals), '*virtually all […] report some kind of mental health problem. So it's almost universal*.'[200] Bailey Nation-Ingle of the Victorian Department of Health (**Department of Health**) stated that TGD people are one of the most at-risk populations globally for suicidal ideation, suicide attempts and also death by suicide, with Carolyn Gillespie of Thorne Harbour Health noting that TGD people are also reported to experience the highest rates of distress out of the LGBTIQA+ population

[197] Evidence of Dr P. Jenkins, RANZCP, T-211 line 28 to T-212 line 9.
[198] *See* evidence of Dr P. Jenkins, RANZCP, T-212 lines 4-9.
[199] *See* evidence of Dr G. Kalra, Monash Health Gender Clinic (**MHGC**), T-212 line 21 to T-213 line 6, referring to Ingrid Bretherton et al ''The Health and Well-Being of Transgender Australians: A National Community Survey' (2021) 8(1) *LGBT Health* 42 (**Bretherton Survey**). DOI: https://doi.org/10.1089/lgbt.2020.017 (**Bretherton Survey**) (I note that the transcript at T-212 line 27 refers to this as being authored by 'Weatherton' but the reference to 'Bretherton' is confirmed at T-214, line 10). The precise rate of mental ill health and suicidality in the TGD population varies according to the study cited and the specific mental illness being referred to – *see for example* T-213 lines 9-29. The Bretherton Survey involved 928 participants who reported high rates of co-occurring mental health issues, such as lifetime diagnoses of anxiety (67%) and depression (73%), as well as high rates of self-reported self-harm (63%) and attempted suicide (43%). In contrast, self-reported rates of depression, anxiety and suicide attempts for the general population are indicated at 11.6%, 26.3%, and 3.2% respectively – *see* LGBTIQ+ Health Australia, *Snapshot of Mental Health and Suicide Prevention Statistics for LGBTIQ+ People. Sydney, Australia: LGBTIQ+ Health Australia* (2021). Available at: https://www.lgbtiqhealth.org.au/statistics.
[200] *See* evidence of Professor J. Zajac, Austin Health Gender Clinic (Endocrinology) (**AHGC**), T-214, lines 16-21.

as a whole, with double or higher the rate of suicide attempts than cis-gendered participants.[201]

229. Despite this, both expert panels at Inquest emphasised that there is nothing inherent in being TGD that comprises or causes mental ill health or suicidality.[202] The Chief Psychiatrist (as he then was), Dr Neil Coventry, noted in particular that contemporary approaches in the provision of healthcare to TGD people have moved away from pathologisation of gender identity, a phenomenon Ms Gillespie described as where '*identity is seen as unwell or needing fixing or that there's something wrong in you*'.[203]

230. Dr Coventry emphasised that '*pathologising gender identity really neglects the impact of complex psychosocial structural factors, the discrimination, trauma, marginalisation, family issues and also this can impede people getting access to care, certainly access to appropriate mental health specialist care'*.[204] In a similar vein, the Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) noted in its submission to the Court that '*the discrimination and marginalisation experienced by LGBTIQ+ people increases the risk of developing mental health conditions and creates barriers to accessing supportive services'*.[205]

Factors contributing to levels of distress, mental ill health, and suicidality in the TGD population

231. At Inquest, witnesses on both expert panels, as well as the Court's lived experience expert, Ms Lane, gave evidence regarding the factors contributing to levels of distress, mental ill health and suicidality in the TGD population. These factors include TGD peoples' experiences of family violence and rejection, social exclusion, discrimination and experience of violence, as well as the negative impacts of societal 'debate' on TGD issues and on the

[201] *See* evidence of Mrs B. Nation-Ingle, Department of Health, T-216 line 28 to T-217 line 1 and Ms C. Gillespie, Thorne Harbour Health, T-214, line 24 to T-215, line 7. *See further in this regard* Adam Hill et al, 'Private Lives 3: The Health and Wellbeing of LGBTIQ People in Australia' (Research Paper, Monograph Series No. 122, ARCSHS, La Trobe University, 2020) 50-53 (**Private Lives 3**). 'Cisgendered' is used for someone whose gender identity aligns with their sex assigned at birth.
[202] *See for example* the evidence of C. Gillespie, Thorne Harbour Health, T-222, lines 1-3.
[203] Evidence of C. Gillespie, T-325, lines 1-3.
[204] Evidence of Dr N. Coventry, Chief Psychiatrist, T-228 lines 14-23.
[205] *See* Collated Brief, p. 100.

very right of TGD people to exist.[206] The expert evidence demonstrates that the individual and cumulative impacts of these factors, which I will outline in further detail below, raise the risk of suicidality amongst the TGD population.

Discrimination

232. At Inquest, Dr Kalra of the Monash Health Gender Clinic (**MHGC**) cited an Amnesty International article which noted that TGD people face up to 50-60 instances of 'microaggressions' or incidents of casual discrimination per day.[207] Examples of discrimination faced by TGD people were given by Dr Nguyen of the Royal Children's Hospital Gender Service (**RCH Gender Service**) to include overt bullying, name-calling, physical assault, sexual assault, and not being accepted in schools or jobs, which can result in a sense of rejection that ultimately impacts mental health. Referring to a minority stress framework, Dr Nguyen stated that '*when you have [discrimination of these kinds] and it is ongoing there is a sense of anxiety, there's a sense of hypervigilance, there's poor self-esteem, a sense of self-shame. These all impact on a person's mental health… those who experience discrimination have increased rates of depression, anxiety, suicidality, and self-harm*'.[208]

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[206] *See in this regard* the evidence of Dr J. Morandini, RACGP, T-230 line 17 to T-231 line 17 and T-307 line 20 to T-308 line 9; C. Gillespie, Thorne Harbour Health, T-254 line 15 to T-255 line 17 and T-309 line 28 to T-312 line 2; Dr T. Nguyen, RCH Gender Clinic, T-308 line 25 to T-309 line 18; Professor J. Zajac, AHGC, T-309 lines 20-26; Mr Ball of Switchboard, T-424 line 15 to T-426 line 6; Ms M. McNamara of TGV, T-426 line 30 to T-427 line 30; Commissioner Fernando, T-428 line 2 to T-429 line 9; Ms A. Bernasochi of Switchboard, T-430 lines 2-14; Mr E. McMahon, Drummond Street Services, T-445 line 11 to T-447 line 9.

[207] Evidence of Dr G. Kalra, T-308 lines 11-14. *See in this regard* Mill O' Sull 'Transgender People Face Casual Discrimination Up To 60 Times A Day' *Amnesty International* (Web Page, 29 March 2017) <https://www.amnesty.org.au/transgender-people-face-casual-discrimination-up-to-60-times-a-day/#:~:text='Transgender%20people%20face%20casual%20discrimination%20up%20to%2060%20times%20a%20day',Mill%20'O'Sull&text=Transgender%20rights%20have%20come%20under,Jennings%20and%20actress%20Laverne%20Cox>.

[208] Evidence of Dr T. Nguyen, T-308 line 25 to T-309 line 12. Dr Nguyen's evidence at Inquest echoes the written submissions of the RCH Gender Service, in which it was stated that the external factors faced by TGD people that lead to poorer mental health outcomes can be understood using a 'minority stress framework'. A 2012 study described the 'minority stress model' in transgender people as '*the stressors related to being a marginalised minority group, which in turn can lead to negative physical and psychosocial outcomes. External stressors or distal factors occur across a spectrum of severity, such as misgendering, social exclusion, bullying, discrimination, verbal harassment, physical and sexual assault. These can lead to proximal stressors or internal factors, such as concealment of transgender identity, hypervigilance, internalised transphobia and fear of rejection. Minority stressors may be chronic or acute and over time can lead to negative health outcomes and health disparities such as increased substance use (including smoking and alcohol), depressed mood, anxiety, self-harm and suicidality.*' – *see* Submission of RCH

233. Transgender Victoria highlighted in its submissions that, at times, the fear of experiencing discrimination can also cause TGD people to delay taking steps towards affirming their gender '*until living in their birth gender becomes intolerable*'.[209] The point of gender affirmation can therefore be a period of particular vulnerability for TGD people, which MHGC noted in its submissions as a period that has been associated with an increase in suicide risk.[210]

234. Commissioner Fernando and Mr Elliot McMahon of Drummond Street Services also gave evidence about the compounding impacts of intersectionality on the experience of discrimination (for example, a person who is both transgender and Aboriginal may face heightened discrimination and a lower sense of wellbeing due to intersecting experiences of both transphobia and racism).[211]

Family violence and rejection

235. Mr McMahon gave evidence that, in a survey and subsequent report commissioned by Equality Australia in conjunction with Drummond Street Services, TGD respondents were found to be 2.7 times more likely to experience family violence over their lifetime than the population as a whole.[212] Mr McMahon stated that Australian research into LGBTIQA+

Gender Service, Collated Brief p. 286, referring to Michael Hendricks and Rylan Testa 'A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the Minority Stress Model' (2012) *Professional Psychology: Research and Practice* 43(5) 460. DOI: https://doi.org/10.1037/a0029597.

[209] Submissions of Transgender Victoria, Collated Brief, p. 258. In this vein, Dr Kalra drew a comparison with Dr Abraham Twerski's description of the way in which a lobster grows, and its period of vulnerability in discarding an outer shell that has grown restrictively around it (which requires it to shelter from prey), to a TGD person's experience of affirming their gender and the vulnerability and stress that this can entail in the face of anti-trans sentiment - Evidence of Dr G. Kalra, T-315, line 18 to T-316 line 6. *See also in this regard*: JINSIDER, 'Rabbi Dr. Abraham Twerski on Responding to Stress' (YouTube, 26 February 2009) <https://www.youtube.com/watch?v=3aDXM5H-Fuw>.

[210] Submission of Dr J. Erasmus, Collated brief, p. 90. *See further in this regard* Greta Bauer et al, 'Suicidality among trans people in Ontario: Implications for social work and social justice' (translated from original Québécoise French), *Revue Service Sociale* (2013) 59(1) 35. DOI: https://doi.org/10.7202/1017478ar. Cf evidence of Mr Elliot McMahon, T-437, lines 14-21: '*For many transgender women it's not the point of affirmation that is the most dangerous. I think that that danger often follows transgender women throughout their lives and of course that's true for some non-binary people and trans men as well, but I really do want to acknowledge that trans women and transfeminine people tend to bear the brunt of that*'.

[211] Evidence of Commissioner Fernando and Mr E. McMahon of Drummond Street Services, T-417, line 5 to T-418, line 6.

[212] Evidence of Mr E. McMahon, T-446 lines 2-7. *See in this regard* Madeline Gibson et al 'There's No Safe Place at Home: Domestic and family violence affecting LGBTIQ+ people' (Research Paper, Equality Australia: Sydney and Melbourne, Centre for Family Research and Evaluation and Drummond Street Services, 2020) 24.

experiences of family violence has found that recent experiences of suicidal ideation, suicide attempts, and high or very high psychological distress were associated with experiences of both family of origin violence and intimate partner violence.[213]

236. Mr McMahon also gave evidence in relation to the incidence of family rejection experienced by TGD people by virtue of their TGD status, which can include '*increased arguments and conflicts, abuse and neglect, silence and avoidance, control and isolation and revoking housing. Familial exclusion in any of those categories to any degree is potentially psychologically damaging*'.[214]

237. Ms Gillespie of Thorne Harbour Health noted that experience of violence or rejection from the family can '*escalate at points of outwardly affirming gender*'.[215] Indeed, Ms Lane, the Court's lived experience expert, noted that, in deciding to undergo her own gender affirmation process later in life, and in the lead-up to telling family, colleagues and friends, she '*made the expectation to lose everyone*'.[216]

Experience of violence in the community

238. Mr Joe Ball of Switchboard gave evidence that, through provision of its helpline services, Switchboard has become apprised of the unique experience by members of the TGD community (particularly transwomen) of violence who '*fear going outside, fear going on public transport, fear basic things that people can do'*. This can be heightened when one may be perceived as transgender in public, and be impacted by the degree to which one is seen to '*pass*' in one's affirmed gender.[217]

239. The submissions of Equinox outlined that experiencing physical assault correlated most highly with attempted suicide in the TGD community, referring to a study in which violence

[213] Evidence of Mr E. McMahon, T-446 lines 8-19.
[214] Evidence of Mr E. McMahon, T-445, lines 11-23.
[215] Evidence of C. Gillespie, Thorne Harbour Health, T-282 lines 3-7.
[216] Evidence of Ms E. Lane, T-25 lines 27-28.
[217] Evidence of Mr J. Ball, Switchboard, T-425, lines 13-25. *See also* evidence of Ms M. McNamara, T-426 line 23 to T-427 line 30. The notion of 'passing' was acknowledged by Mr Ball to be problematic, and the discussion of 'passing' was noted by Dr Vivienne to hinge on a '*binary construct that we're folded back into… the experiences of being not fitting are manifest from moment to moment on an ongoing basis when there's not a bathroom door that you can walk through safely or there's not a form that you can identify yourself in*'.

experienced due to being TGD was reported by 21% of participants, and which doubled the probability of a lifetime suicide attempt.[218]

Social exclusion

240. Mr McMahon of Drummond Street Services gave evidence of the impacts of social exclusion faced by TGD people, noting that '*social exclusion for trans and gender diverse people impinges on our fundamental rights, among the types of social exclusion our community experiences are exclusion from income and protection. Exclusion from education. Poor work conditions including workplace discrimination. Lack of access to affordable healthcare of decent quality and lack of access to housing and basic amenities. [These are] some of the key social determinants of health and exclusion from access to them has long lasting material impacts on physical and mental health and well-being'.*[219]

241. The effects of discrimination and social exclusion on TGD people were noted to be potentially long-lasting, with Dr Coventry, then-Chief Psychiatrist, giving evidence that '*I think it runs the significant risk that people lose the protective factors that are very helpful for mental health and wellbeing, particularly if we're talking about children and young people that, with withdrawal from many other domains of their life, so thinking about young people that are already somewhat dislocated from education who drop out of education, they lose the opportunities for vocational training, tertiary education, all the other social impacts through this*'.[220]

'Debate' on TGD issues in the media

242. The Commissioner for LGBTIQA+ Communities, Commissioner Fernando (as he then was), noted in his submissions to the Court the deleterious impact on TGD people of '*criticisms, hate speech and attacks upon trans people in the media and on social media*',[221] an issue spoken to at Inquest by many witnesses, including those on the Medical Panel, such as Dr

[218] Submissions of Equinox, Collated Brief, p. 78. *See in this regard* Sav Zwickl et al, 'Factors associated with suicide attempts among Australian transgender adults' (2021) 21 *BMC Psychiatry* 81. DOI: https://doi.org/10.1186/s12888-021-03084-7.
[219] Evidence of Mr E. McMahon, T-446 line 20 to T-447 line 2.
[220] Evidence of Dr N. Coventry, Chief Psychiatrist, T-318 line 20 to T-319 line 2.
[221] Submissions of the Commissioner for LGBTIQA+ Communities, Collated Brief, p. 122.

Nguyen of the RCH Gender Service[222] and Professor Zajac of Austin Health.[223] Significantly, Bailey Nation-Ingle of the Department of Health gave evidence that, following an 'anti-trans rally' held in March 2023 in Melbourne, the Department received many calls from service providers indicating a significant increase in the numbers of referrals to their services, including those supporting LGBTIQA+ people following a suicide attempt, suicidal ideation or self-harm. Mind Australia also reported a significant increase of referrals from TGD people at that time.[224]

The right to exist

243. At Inquest, Ms Gillespie described the '*philosophical, ideological, religious objections to the existence of trans and gender diverse people*' that underpin the experience of discrimination and social exclusion of TGD people.[225] Dr Mark Dalgleish gave evidence of the deleterious impact of such attitudes, insofar as the very existence, welfare and wellbeing of TGD people, which ought to be non-negotiable, are shifted '*into spheres that are seen as being debatable or optional*'.[226] Dr Dalgleish opined that the questioning of gender identity necessarily entails questioning an intrinsic quality that underpins one's very existence, noting that '*gender, and to a large degree sexuality is embodied, it is deeply personal in their fullest sense because it is not just how we are operating in the world, it's how we are in our very existence*'.[227]

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[222] T-317 lines 13-26, referring to the stated impact on a young TGD patient of a former Prime Minister's comments on 'gender whispering'. This point was also raised by Ms M. McNamara of Transgender Victoria at T-434 lines 4-27.
[223] T-317 line 28 to T-318 line 16, referring the impact of media commentary on sporting events in which TGD athletes are competing or seeking to compete.
[224] Evidence of Mrs B. Nation-Ingle, T-313 lines 12-23.
[225] Evidence of C. Gillespie, Thorne Harbour Health, T-315 lines 9-12.
[226] Evidence of Dr M. Dalgleish, T-319, lines 21-22. These words were echoed at Inquest by Dr Vivienne of Transgender Victoria, who noted that the provision of care and services to the TGD community should not require one to have to first establish that '*we exist and we have the right to be well*'; this should be a given. *See* evidence of Dr S. Vivienne, T-519 lines 2-5.
[227] Evidence of Dr M. Dalgleish, T-250, lines 6-10. *See also* Submissions of Transgender Victoria, Collated Brief, p. 253. Ms M. McNamara of Transgender Victoria also spoke to this issue at Inquest at T-435, lines 4-15: '*When the leadership of this country and the media apparently unite in opposition to our very identity and we had Mark Dalgleish speak about the centrality of our identity to our whole being and our whole existence in this planet, in this world, in these unceded lands, it really shakes you to the core and it shakes me to the core when I'm challenged by media articles and leadership that denies my identity and um for a population of the characteristics that we've heard who have such fragile mental health and who are exposed to such shocking rates of suicidality and suicide attempts, it can only have a deleterious effect on their mental health*'.

244. While the weight of the evidence suggests that the burden of stigma, discrimination and exclusion is heavy for the adult TGD community, evidence at Inquest was heard that the inverse may exist for children and young people who are supported to identify as TGD or to explore a TGD identity and who exhibit no mental health issues, distress and experience of suicidal ideation. Dr Tram Nguyen of the Royal Children's Hospital Gender Service stated:

> *'Can I make the obvious statement that being trans and gender diverse is a wonderful part of human diversity, to be celebrated, and it's not a mental health condition and not all trans and gender diverse people will experience gender dysphoria or have mental health diagnoses. I have the luxury and the absolute joy of working with young people, particularly those who are under eight and who are supported and affirmed by their parents and their community, and they do not have a mental health condition and they live and thrive'*.[228]

Classifications

245. The Coroners Prevention Unit (**CPU**), in providing advice to the Court on the cluster investigation, also emphasised that, while there are increased risks of suicidality, distress and mental ill health amongst TGD people, not conforming with a birth-assigned gender expectation is not itself a mental health 'condition'.[229]

International Classification of Diseases and Related Health Problems

246. The CPU referred to the World Health Organization (**WHO**) International Classification of Diseases and Related Health Problems (**ICD**), which is used in Australia for classification of health-related conditions. According to the WHO, the 11th Edition of the ICD (**ICD-11**) which came into effect from 1 January 2022, redefined and replaced outdated diagnostic categories, including 'transsexualism' and 'gender identity disorder in children', with

[228] Evidence of Dr T. Nguyen, T-229 lines 16-26. Dr Kalra of the MHGC also provided a unique perspective of his work with the Indian Hijira community, a cultural group in India whose members do not align with a gender binary. Dr Kalra noted that the sense of dysphoria and mental ill health in this community is not as prevalent as seen in the Western context, which he posits is due to the increased cultural acceptance for the Hijira community in India - Evidence of Dr G. Kalra, T-234 line 25 to T-235 line 10.

[229] *See in this regard* Coroners Prevention Unit Cluster Report (**CPU Cluster Report**), Collated Brief, pp. 10-11. *See also in this regard* the Submissions of Transgender Victoria, Collated brief, pp. 256-258.

'gender incongruence of adolescence and adulthood' and 'gender incongruence of childhood' respectively. Gender incongruence is defined in the ICD-11 as '*characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex. Gender variant behaviour and preferences alone are not a basis for assigning the diagnoses in this group*'.[230]

247. In the ICD-11, gender incongruence has been moved from the 'Mental and behavioural disorders' chapter and into the new 'Conditions related to sexual health' chapter, to reflect current knowledge that TGD identities are not conditions of mental ill health, and that classifying them as such can cause enormous stigma. Transgender Victoria noted that this revision was of great importance to TGD people '*as it depathologises being transgender and more closely accords with TGD peoples' understanding of themselve*s'.[231]

Diagnostic Statistical Manual

248. The CPU also noted that in 2013, the Diagnostic Statistical Manual (**DSM-5**), which is published by the American Psychiatric Association and is used by some clinicians as a classification of mental disorders in Australia, the diagnostic category of '*gender identity disorder*' was changed to '*gender dysphoria in adolescents and adults*' and '*gender dysphoria in children*'. The change is reflected in the revision published in March 2022 (**DSM-5-TR**) which focuses on the gender-related distress experienced by an individual, rather than the individual's gender itself. Gender dysphoria in this context is defined as a '*clinically significant distress or impairment related to gender incongruence, which may*

[230] *See* CPU Cluster Report, Collated Brief, pp. 10-11, referring to WHO, Gender incongruence and transgender health in the ICD, Available: https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd#:~:text=ICD%2D11%20has%20redefined%20gender,gender%20incongruence%20of%20childhood%E2%80%9D%20. Extended definitions are included for gender incongruence in childhood and in adolescence/adulthood, with the latter described thusly: '*Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual's body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis''*.

[231] Submissions of Transgender Victoria, Collated brief, pp. 255-258. In this connection, Transgender Victoria emphasised the need to avoid pathologisation of TGD identities through use of words such as 'comorbidities' to describe co-occurring mental health conditions in TGD people.

include desire to change primary and/or secondary sex characteristics'.[232] I note that the DSM-5-TR and definitions therein are not used by all clinicians in providing gender-affirming treatment.[233]

249. As will be discussed in the next section, not all individuals who identify as TGD will experience psychological distress or meet the criteria for gender dysphoria, and some people can experience gender-related distress without identifying as TGD. In Australia, it is important to note that the presence of gender dysphoria is not required to access gender-affirming treatments. In its submissions to the Court, the RANZCP stated '*gender dysphoria emerges in many different ways and is associated with significant distress for those who experience it. However, gender incongruence is not inherently pathological*'.[234] Dr Peter Jenkins on behalf of the RANZCP emphasised at Inquest that the RANZCP does not believe that being TGD is a mental health condition.[235]

250. Notwithstanding these changes to the DSM and ICD, their effect may still be somewhat '*pathologising'*.[236] Dr Coventry noted the ongoing challenge that gender-related issues are still viewed through the prism of disease. He stated that *'[t]he incongruence is actually from how our culture might be responding, so I find these labels very unhelpful because they are very unsophisticated, they focus on the individual… so I think while the World Health Organization as my colleague Peter Jenkins was mentioning is an improvement, I think it's still talking about disease entities which creates barriers, I think, for people to be able to*

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[232] 'What is Gender Dysphoria', *American Psychiatric Association* (Web Page, August 2022) <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria>. An extended definition is included to guide diagnoses of gender dysphoria.

[233] The classification of gender dysphoria under the DSM-5 is strongly resisted by some health care practitioners who are of the view that this continues to pathologise gender identity – *see for example* the approach of the MHGC outlined at 'Frequently Asked Questions', *Monash Health* (Web Page) <https://monashhealth.org/services/gender-clinic/questions/#assessments>; and Dr T. Nguyen, RCH Gender Clinic, T-230, lines 2-12 – '*I would also like to add to the comment around the DSM-5 classification that it is pathologising, it doesn't speak to the trans experience, and it perpetuates binary gender stereotypes in terms of preferences and behaviours but in addition to this the real problem with it, it's the perpetuation of its use. It's used in spaces where it is required for medical affirmation, or it is required for surgical affirmation so there needs to be systemic changes not just within the DSM-5 and moving on to DSM-6 but within systems that continue to uphold it as a requirement*'.

[234] Royal Australian and New Zealand College of Psychiatrists submission, Collated Brief, p. 99. It is noted that this part of the RANZCP's submissions referenced Position Statement 103 which relates to the RANZCP's position in working with TGD people in Australia and New Zealand and the role of psychiatrists in responding to their mental health needs. However, this aspect of the position statement remains unchanged.

[235] Evidence of Dr P. Jenkins, RANZCP, T-231, lines 19-21.

[236] Evidence of Dr T. Nguyen, RCH Gender Clinic, T-230, lines 2-12.

access care and it also creates barriers in terms of cultural sensitivity in terms of looking at the impact of stigma and discrimination on someone's health and well-being rather than internally what's going on'.[237]

Analysis

Levels of distress, mental ill health and suicidality in the TGD population

251. I consider that the evidence at Inquest established unequivocally that those in the TGD community face disproportionate rates of distress, mental ill health, and suicidality compared to the population as a whole. The reasons for this are multifactorial, intersecting, and linked to extrinsic factors associated with the broader community's responses to TGD people, which can include experience of discrimination, violence and exclusion that erode the TGD community's wellbeing and contributes to mental ill health.

252. I have considered this evidence in light of the reported experience of the five deceased persons whose deaths I am investigating as part of the cluster. In respect of the issue of discrimination, I note that Natalie's fear of being discriminated against as a transgender person was described by her psychologist as something that deeply affected her mental health and led her to equivocate in relation to engaging with a gender clinic to affirm her identity as female, believing she would be '*severely discriminated against by others due to being transgender*'. This was described as a major barrier in her being able to overcome her fear of being in public and contributed to her increasing isolation.[238]

253. The experience of social isolation was also demonstrated in the evidence related to all five deaths in this cluster, and was amplified by COVID-19 lockdown conditions. For example, in the years after she finished high school, Matt was described as rarely leaving her bedroom due to anxiety and depression. Matt was also never able to secure a job, despite continuing to look and apply for work.[239] I also heard evidence that AS and Matt lived isolated lives, often confining themselves to their bedrooms, and while Bridget was supported by Mx Leigh

[237] Evidence of Dr N. Coventry, Chief Psychiatrist, T-232 line 26 to T-233 line T-234 line 19.
[238] Statement of R. Berthelsen, CB in the matter of Natalie Wilson, p. 55.
[239] Statement of J. Byrne, CB in the matter of Matt Byrne, p. 23; Statement of R. Byrne, CB in the matter of Matt Byrne, p. 18.

and her sister Angela following the COVID-19 lockdowns, she too reported becoming increasingly isolated in her small Flemington apartment, where she lived alone.[240]

254. The experience of family rejection was also evident amongst certain of the deceased whose deaths I am investigating as part of the cluster. For example, while she enjoyed support from other members of her family, including her father, AS's mother told her on her sixteenth birthday that if she wished to pursue gender affirmation, she would not be welcome in the family home.[241] This led AS to leave the family home which she described as an '*involuntary*' act. Indeed, AS noted that she needed this understanding and support, and her experience of family rejection made her feel '*more alone and vulnerable*'.[242]

255. Finally, heightened fears of violence against TGD people were also reflected in evidence that, following Bridget going missing on 30 November 2020, many LGBTIQA+ community members feared she had been attacked, kidnapped, or murdered.[243]

Impact of gender-affirming care on distress, mental ill health and suicidality

256. The evidence of Professor Zajac of Austin Health was that in general, mental health issues and distress experienced by TGD individuals is significantly reduced after commencing gender affirming treatment.[244] This was echoed by Dr Kalra of MHGC,[245] Dr James Morandini of the Australian Psychological Society,[246] and Dr Tram Nguyen of the RCH Gender Service.[247] Dr Mark Dalgleish also opined that the overall health of TGD people can improve when receiving gender-affirming care.[248]

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[240] Statement of H. Leigh, CB in the matter of Bridget Flack, p. 45.
[241] Statement of S.T, CB in the matter of AS, p. 7 and also CB in the matter of AS, p. 54.
[242] *See* CB in the matter of AS, p. 54.
[243] Submissions of the Commissioner of LGBTIQA+ Communities, Collated Brief, pp. 122, 124, 130 and 136.
[244] Statement of Dr J. Zajac, Collated Brief, p. 51, referring to Lucas Foster et al 'Short-Term Effects of Gender-Affirming Hormone Therapy on Dysphoria and Quality of Life in Transgender Individuals: A Prospective Controlled Study' (2021) 29(12) *Front Endocrinal (Lausanne).* DOI: 10.3389/fendo.2021.717766.
[245] Evidence of Dr G. Kalra, T-252 line 24 to T-253 line 5.
[246] Evidence of Dr J. Morandini, T-256 line 12 to T0257 line 4.
[247] Evidence of Dr T. Nguyen, T-259 line 27 to T-260, line 20.
[248] Evidence of Dr M. Dalgleish, T-255, line 19 to T-256, line 6. I will return to this further below in analysing the evidence in relation to provision of culturally-appropriate gender-affirming care; its relevance to the present scope item is that for TGD people, affirming one's gender may in fact reduce suicidal ideation and distress and lead to significantly improved mental health outcomes.

The need for improved data regarding the TGD community

257. While noting that there is clear evidence of disproportionate mental ill health, distress and suicidality amongst the TGD population, the data on this issue is widely considered to be incomplete, including in relation to the incidence of completed suicides in the TGD community.

258. In Victoria, this has been attributed to '*systemic issues around data collection*',[249] insofar as entities such as Victoria Police, and until recently, the Coroners Court of Victoria and the Department of Health, have not had a comprehensive system for capturing and recording all gender identities (including transgender and non-binary identities), instead relying on the so-called traditional binary male/female designations.[250]

259. This is compounded by the fact that there is no population level data on the number of TGD people nationally or in Victoria.[251] In a 2019 study, it was estimated that 0.1% - 2% of the population identify as TGD[252] and that this cohort represents a sizeable and increasing proportion of the general population,[253] with significant and growing numbers of people who are willing to publicly identify as TGD.[254] However, the current data is likely to be a significant under-count of the numbers of TGD people in Australia.[255]

260. A report issued by the Coroners Court in 2022 entitled 'Suicide among LGBTIQ+ people' acknowledged the limitations in the available dataset on suicides amongst the LGBTIQA+ population in Victoria.[256] Indeed, the report did not include data on deaths of TGD people as a discrete part of the LGBTIQA+ community due to concerns it may represent a

[249] Evidence of Mrs Nation-Ingle, Department of Health, T-219, line 15.
[250] This gives rise to the risk not only of failing to accurately record transgender identities but, as specifically noted by Dr Mark Dalgleish, it also gives rise to a risk that non-binary identities will not be recognised and recorded – *see evidence* of Dr M. Dalgleish, T-223 lines 13-16.
[251] Evidence of Commissioner Fernando, T-397, lines 13-15. *See also* evidence of Mr Ball, Switchboard, T-397 line 24 to T-398 line 5.
[252] *See* Ada Cheung et al 'Position statement on the hormonal management of adult transgender and gender diverse individuals' (2019) 211(3) *Medical Journal of Australia* 127. DOI: 10.5694/mja2.50259.
[253] *See* Qi Zhang et al 'Epidemiological considerations in transgender health: A systematic review with focus on higher quality' (2020) 21(2) *International Journal on Transgender Health* (**Zhang et al**). DOI: 10.1080/26895269.2020.1753136.
[254] Submissions of Transgender Victoria, Collated Brief, p. 254.
[255] *See* evidence of Mr J. Ball, Switchboard, T-398 lines 27-29.
[256] Evidence of Mrs Nation-Ingle, Department of Health, T-218 line 25 to T-219 line 2.

significant undercount of the suicides in this cohort, and following concerns from community organisations on the impact of this. The report further recognised that *'[i]ncomplete or inaccurate data may only offer limited insight into suicide among LGBTIQ+ communities and could potentially be unhelpful (and even damaging) to prevention efforts*'.[257]

261. As noted in the above report, the lack of systems agility to accurately capture data has significant practical and policy implications. It is evident that accurate estimates of the proportion, distribution, and composition of the TGD population, as well as projections of resources required to adequately support health needs of TGD people, will ultimately depend on the availability of systematically collected high-quality data,[258] such as via the Australian census.[259]

262. In the context of accurately recording the rate of suicides in the TGD community in Victoria, I note that the Coroners Court has recently updated its own database to be capable of capturing all gender identities, which I will return to later in this Finding,

263. However, coroners investigating suicides may not be aware the subject of their investigation was a member of the TGD community unless this is documented in the coronial material: for example, by members of Victoria Police who submit the initial report of death (**Form 83**) or by the coroner's investigator, also a member of Victoria Police, who gathers witness statements and evidence.

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[257] *See* 'Suicide among LGBTIQ+ people' (Report, *Coroners Court of Victoria*, 14 October 2022) <https://www.coronerscourt.vic.gov.au/sites/default/files/2022-10/Coroners%20Court%20of%20Victoria%20-%20Suicide%20among%20LGBTIQ%2B%20people.pdf>.

[258] *See* Zhang et al . This ought to include a disaggregation, as noted by Commissioner Fernando, of those identifying as gender diverse or gender non-conforming as well as those identifying as transgender (*see in this regard* evidence of Commissioner Fernando, T-395 line 29 to T-396 line 6 and Mr J. Ball, Switchboard, T-400 lines 9-26) Mr Ball also gave evidence that TGD people might identify in different ways at different times of their lives – *see in this regard* T-397 lines 24-26.

[259] *See in this regard* '2026 Census topic review: Phase two directions' *Australian Bureau of Statistics* (Web Page, 12 December 2023) <https://www.abs.gov.au/statistics/research/2026-census-topic-review-phase-two-directions> and evidence of Ms M. McNamara, T-399 lines 12-22. However, as of 26 August 2024, the ABS has indicated that this will not occur in the 2026 census – 'Changes to 2024 Census Testing Plans' *Australian Bureau of Statistics* (Web Page, 26 August 2024) <https://www.abs.gov.au/media-centre/media-statements/changes-2024-census-testing-plans>.

264. While there is a myriad of reasons why a person's LGBTIQA+ status, or more specifically, TGD status, might not be immediately apparent to Victoria Police members tasked with reporting a suicide,[260] I consider that improved data collection systems at every step of the investigation process is required to capture this information as and when it may become known. Accordingly, Victoria Police should turn its attention, as a priority, to updating its LEAP systems and associated forms (such as the Form 83) to allow for all gender identities to be captured in line with the Australian Bureau of Statistics Standard[261] and consistent with the commitment under Priority Area 3 of 'Pride in our future: Victoria's LGBTIQA+ strategy 2022-32'.[262] A pertinent recommendation will follow.

4 – Provision of culturally-appropriate gender-affirming care

265. The fourth item in the scope of inquest is '*[t]he availability of and issues concerning provision of culturally-appropriate gender-affirming care to TGD people in Victoria, including where there are intersecting mental health issues and diagnoses'*.

Terminology

266. Prior to analysing the evidence received on the provision of culturally-appropriate gender-affirming care to TGD people in Victoria, I consider that it is worth briefly outlining the applicable terminology. Dr Mark Dalgleish gave evidence at Inquest of the importance of language to capture the breadth of experiences within the TGD community, stating that '*when it comes to providing gender affirming healthcare we also want to be affirming in every aspect of what we are doing, and that means that we have to recognise a diverse – a diverse expression of identities, sexuality identities, gender identities, other identities that form the wholeness of who we are as humanity*'.[263] I have approached this task with Dr

[260] For a list of these, *see* Suicide among LGBTIQ+ people' (Report, *Coroners Court of Victoria*, 14 October 2022) p 4 <https://www.coronerscourt.vic.gov.au/sites/default/files/2022-10/Coroners%20Court%20of%20Victoria%20-%20Suicide%20among%20LGBTIQ%2B%20people.pdf>.
See also in this regard the evidence of Commissioner Fernando, T-412 lines 16-23 – '*I do note that there may be some sensitivities around police officers being able to ask the question of gender identity and/or sexuality on Form 83 to any parent or senior next of kin who may be at the scene, but nonetheless I think it is an important exercise for Victoria Police to do in regard to a cultural safety framework that the organisation should adopt*'.
[261] *See in this regard* the evidence of C. Gillespie, Thorne Harbour Health, T-225 line 18 to T-226 line 9.
[262] *See in this regard* evidence of Commissioner Fernando, T-411, lines 24-28.
[263] Evidence of Dr M. Dalgleish, T-244 line 26 to T-245 line 8.

Dalgleish's words in mind, noting that in relation to certain terminology, there are several available definitions.

267. As a broad starting point, I note that '**gender**' is used to refer to the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men, and gender diverse people. The World Health Organization (**WHO**), which is the agency of the United Nations responsible for, *inter alia*, providing leadership on global health matters, notes that gender interacts with but is different from '**sex**', which refers to the different biological and physiological characteristics of females, males and intersex people, such as chromosomes, hormones, and reproductive organs.

268. Gender and sex are related to but different from '**gender identity**', which is described by the WHO as a person's internal and individual experience of gender, which may or may not correspond to their sex at birth.[264] Gender identity has also been described as 'a *person's innermost concept of self as male, female, a blend of both or neither'*.[265]

269. The term '**TGD people**' is commonly used, including in the World Professional Association for Transgender Health (**WPATH**) 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' (**WPATH Standards**) to be '*as broad and comprehensive as possible in describing members of the many varied communities that exist globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth*'.[266]

- Within the acronym 'TGD', a '**transgender person**' is a person whose gender identity or expression is different from that assigned at birth or who sits outside the gender binary.

[264] 'Gender', *Worth Health Organisation* (Web Page) <https://www.who.int/europe/health-topics/gender#tab=tab_1>.
[265] CPU Cluster Report, Collated Brief, p. 4. *See further in this regard* Charles Roselli 'Neurobiology of gender identity and sexual orientation' (2018) 30(7) *Journal of Neuroendocrinology*. DOI: 10.1111/jne.12562.
[266] Eli Coleman et al 'Standards of Care for the Health and Transgender and Gender Diverse People, Version 8' (2022) 6(23) *Journal of Transgender Health*. (**WPATH Standards 8**). DOI: 10.1080/26895269.2022.2100644. Conversely, the term '**cisgender**' is used for someone whose gender identity aligns with their sex assigned at birth. I have also used the acronym '**LGBTIQA+'** in this Finding to refer to Lesbian, Gay, Bisexual, Trans and Gender diverse, Intersex, Queer, Questioning, and Asexual communities, being an inclusive umbrella abbreviation of diverse sexualities, genders, and sex characteristics (including TGD people). These definitions are used in the Victorian Government LGBTIQA+ Inclusive Language Guide, October 2023 (Web Page) <https://www.vic.gov.au/sites/default/files/2023-10/LGBTIQA%2B-inclusive-language-guide.pdf>.

The terms male-to-female and female-to-male may be used to refer to individuals who are undergoing or have undergone a process of gender affirmation.

- '**Gender diverse**' is a broad term that encompasses a diversity of gender identities and gender expressions including: bigender, trans, transgender, genderqueer, gender fluid, gender questioning, gender diverse, agender, and non-binary. Gender diverse refers to identities and expressions that reject the belief that gender is determined by the sex someone is assigned at birth.

- The term '**non-binary**' is used to describe one whose gender is not exclusively male or female. Non-binary is both an identity and an umbrella term describing a range of people who exist outside societal expectations that gender is only a binary of male and female.[267]

270. The process of '**gender affirmation'** (also known as 'transitioning', though this is often not preferred terminology)[268] will be outlined further below, and is described simply as '*the personal process or processes a trans person determines is right for them in order to live as their defined gender and so society recognises this. This may involve social, medical, and/or legal steps that affirm a person's gender'.*[269]

271. Finally, as noted by Transgender Victoria, the WHO describes '**gender-affirmative healthcare**' as including '*any single or combination of a number of social, psychological, behavioural or medical (including hormonal treatment or surgery) interventions designed to support and affirm an individual's gender identity*'.[270]

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[267] *See in this regard* the Submissions of Equinox, Collated Brief, p. 72.
[268] *See in this regard* Submissions of Equinox, Collated Brief, pp. 72-73: '***Transitioning*** *describes a TGD individual's progress towards living their gender identity, either privately and/or publicly, when that identity is other than the gender identity presumed at birth. Transitioning in many cases (but by no means all) will involve some gender affirming medical or health care, however in nearly all cases the gender affirmation process will have begun well before this occurs. Throughout this response we refer to 'affirmation' rather than 'transitioning' as a truer representation of what TGD people experience*'.
[269] *See* CPU Cluster Report, Collated brief, p. 5, referring to 'LGBTQIA+ glossary of common terms, *Australian Institute of Family Studies* (Web Page, February 2022) < https://aifs.gov.au/resources/resource-sheets/lgbtiqa-glossary-common-terms>.
[270] *See* Submission of Transgender Victoria, Collated Brief, p. 256, referring to 'Gender Incongruence and transgender health in the ICD'. *World Health Organization* (Web Page) <Gender incongruence and transgender health in the ICD (who.int)>.

272. I will explore further below what the term '**culturally-appropriate**' means in the context of care and services provided to the TGD community. However, as a basic proposition and as noted by the CPU, referring to the submissions of Thorne Harbour Health, culturally-appropriate care of TGD people is that which is safe, accessible and welcoming insofar as it avoids the medicalisation or pathologisation of gender identity, avoids discrimination, is trauma-informed and holistic, and often involves peer workers and/or is peer-led; *'if you can see yourself in a service, you can attend a service'*.[271]

273. In the preceding section of this Finding, I have already noted basic definitions of '**gender incongruence**' (a marked and persistent incongruence between an individual's experienced gender and the assigned sex) and '**gender dysphoria**' (clinically significant distress or impairment related to gender incongruence, which may include desire to change primary and/or secondary sex characteristics). In relation to these definitions, I acknowledge that some organisations do not use or support use of the definition and classification of 'gender dysphoria' under the DSM-5, and adopt the advice of the WHO's ICD-11 which instead recommends using the term '**gender incongruence**', including in a diagnostic context.[272]

The process of gender affirmation

274. I heard evidence at Inquest that gender affirmation can involve social, legal, and medical affirmation.[273] Dr Nguyen of the RCH Gender Service noted that gender affirmation is '*not a linear process*'.[274] A gender affirmation journey is unique to the individual – '*there is no requirement for transgender people to undertake any form of affirmation; there is no*

[271] CPU Cluster Report, Collated brief, p. 16, referring to Equinox Submissions. Collated Brief. Ms M. McNamara of Transgender Victoria provided a helpful definition at Inquest of the related concept of '*cultural safety',* noting *'my simple definition would be that a cultural safety exists when a marginalised person for whom the cultural safety is being established, walks into a service and feels instantly at home and comfortable that they can - all their needs can be met … as a full person within that* service' – *see* T-525 lines 11-16.

[272] *See in this regard* 'Frequently Asked Questions', *Monash Health* (Web Page) <https://monashhealth.org/services/gender-clinic/questions/#assessments>. In this connection, Professor Zajac appeared to comment that the distinction may not be meaningful to some: '*the surgeons usually insist on one or two psychiatrists or psychologists or somebody like me writing – writing, saying that the person has general incongruence or gender dysphoria, or whatever it is we're calling it that day'* – T-243 lines 7-11.

[273] I note that I received evidence of further forms of affirmation within these categories, to include familial affirmation as well as affirmation of gender in the workplace, professional associations, unions, and educational institutions – *see in this regard* the submissions of Transgender Victoria, Collated Brief, p. 258.

[274] Evidence of Dr T. Nguyen, T-236, lines 11-12; reflected in submissions of Equinox, Collated Brief, p. 75.

prescribed order and there are as many trans-narratives as there are trans people'.[275] Further, a gender affirmation process is not restricted to any particular timeframe and may be a lifelong process even where certain elements of affirmation are ceased, such as hormone treatment.[276]

275. **Social affirmation** may include use of chosen names, pronouns, online profiles, clothes, hair-style, grooming (hair removal, make-up), and clothing. **Legal affirmation** involves a formal change of name and gender markers on legal documents such as a birth certificate, passport, or Medicare card. **Medical affirmation** may include processes by which a person changes their physical sex characteristics via hormonal intervention and/or surgery (including chest reconstructive surgery, breast augmentation, or genital surgery),[277] and while this is the focus on many policy discussions in this space, medical affirmation is not the goal of all TGD people.

276. Dr Coventry, Chief Psychiatrist, noted the importance of gender-affirming care being individual-led and that it should not be assumed, for example, that '*everyone wants medical affirmation in terms of your physical appearance matching your gender identity*'. Culturally-appropriate gender-affirming care means '*not challenging one's sense of identity, showing shared respect, dignity, shared understanding and really intense listening and working together for people to be making appropriate decisions about their own health and their future. That's the respect everyone is entitled to*'.[278]

Standards, guidelines, assessment and access to care

277. The Australian Professional Association for Transgender Health (**AusPATH**) is Australia's peak body for professionals involved in the health, rights and well-being of TGD people.[279]

[275] Submissions of RCH Gender Service, Collated Brief, p. 279.
[276] Evidence of Dr T. Nguyen, T-236, lines 20-23. *See also* T-244 lines 9-16 per Dr Nguyen – '*just because someone stops hormones doesn't mean that they have stopped their gender affirmation. An example of this is someone who might be happy with the permanent effects of testosterone and don't feel they need to have it ongoing. That doesn't mean their gender has changed, it just means that they feel affirmed in who they are in their body and don't feel the ongoing requirement for hormone treatment*'.
[277] Submissions of RCH Gender Service, Collated Brief, p. 279. Gender affirming surgeries are currently not available in Victoria to people under 18 years of age.
[278] Evidence of Dr N. Coventry, T-238 lines 15-20.
[279] See in this regard the Submissions of Transgender Victoria, Collated Brief, p. 264.

AusPATH has endorsed the WPATH Standards[280] to guide healthcare professionals on the process of medical gender affirmation in Australia, in conjunction with position statements and standards released separately by AusPATH.[281] These standards include those addressing initiation of gender-affirming hormone therapy via the 'informed consent' model (**AusPATH Informed Consent Standards**), which build upon those previously developed and issued by Equinox Gender Diverse Health Centre (**Equinox**),[282] which are also endorsed by AusPATH.

Two potential models for medical affirmation

278. Different gender clinics and health practitioners offering gender-affirming care operate using different models. The first is the WPATH model. The Monash Health Gender Clinic (**MHGC**), which is publicly funded, operates using the WPATH model and requires a comprehensive mental health assessment to be conducted prior to any gender-affirming medical treatment commencing. While there have been significant changes made to the standards contained in WPATH-7 (issued in 2012) and WPATH-8 (issued in 2022), under these standards of care, a mental health assessment is still required to be conducted prior to gender-affirming medical treatment commencing,[283] with any mental health symptoms that interfere with a person's capacity to consent to gender-affirming treatment to be addressed before treatment is initiated.[284] MHGC also assesses suicide risk as part of the mental health assessment and factors this into any treatment plan.[285]

279. The WPATH model is used at MHGC for the delivery of all gender-affirming care, including commencement of hormone treatment and surgeries, some of which are offered through

[280] WPATH Standards 8.
[281] AusPATH notes on its website that it '*recommends judicious use of the [WPATH] SOC 8 together with the Position Statements that AusPATH has released*' - 'Standards of Care for the Health of Transgender and Gender Diverse People, Version 8' *AusPATH* (Web Page, 1 September 2011 and updated in 2022) <https://auspath.org.au/2011/09/01/world-professional-association-for-transgender-health-standards-of-care-version-7/>.
[282] *See* AusPATH (2024). Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy. Australia: Australian Professional Association for Trans Health. Version 1.1. (Web Page) ,https://auspath.org.au/wp-content/uploads/2024/06/AusPATH_Informed-Consent-Guidelines_DIGI_2024_RLv01.pdf>.
[283] *See* summary of requirements at S256 - WPATH Standards 8.
[284] Statement of Dr G. Kalra, Collated Brief, p. 327, referring to WPATH Standards 8 S172.
[285] Statement of Dr J. Erasmus, Collated Brief, p. 92 (noting this statement was provided when WPATH-7 was still in place) 'Frequently Asked Questions', *Monash Health* (Web Page) <https://monashhealth.org/services/gender-clinic/questions/#assessments>.

MHGC or in partnership with private surgeons. The WPATH Standards require letter(s) of support from a mental health professional as a pre-condition for gender-affirming surgery,[286] including to ensure the patient fulfils the WPATH criteria such as capacity to consent to the surgery, gender incongruence being marked and sustained, and assessment of any health conditions.[287]

280. The WPATH Standards are viewed by some as perpetuating a form of gatekeeping that limits access to gender-affirming care. However, proponents such as MHGC note that the WPATH Standards are applied flexibly, in a person-centred manner, and underscore the importance of a cautious approach to gender-affirming care.[288]

281. The second model for providing gender-affirming medical care is the '<u>informed consent' model</u> or '<u>shared decision-making pathway</u>', adopted by Austin Health Gender Clinic, Equinox,[289] and other gender clinics, as well as individual GPs providing gender-affirming care outside of a gender clinic setting (usually at a patient's own expense). Rather than being predicated on a mental health assessment, consent models of hormone-prescribing resist the notion that a doctor can determine the validity of a person's gender, and instead centre the TGD person in the decision-making process, whilst ensuring that the patient understands and can consent to the potential impacts that gender-affirming hormone therapy may have on their body and life.[290]

282. Professor Zajac of Austin Health noted that, for his patients, first contact is made by a peer navigator, followed by a GP or endocrinologist to assess a patient for gender-affirming

[286] *See* WPATH Standards 8 S256.
[287] *See in this regard*: https://www.healthdirect.gov.au/gender-affirming-surgery#what-is
[288] *See in this regard* Homewood et al 'Urological focus on gender affirmation surgery' (2024) 53(5) *Australian Journal of General Practice* DOI: 10.31128/AJGP-11-23-7044; 'Frequently Asked Questions', *Monash Health* (Web Page) <https://monashhealth.org/services/gender-clinic/questions/#starting-at-clinic>.
[289] Carolyn Gillespie of Thorne Harbour Health (which Equinox forms a part of), gave evidence at Inquest that '*the premise of the work of Equinox is an informed consent model which assumes that clients of the service know themselves and without any evidence otherwise we assume that they are in a position to make decisions in relation to their own body and their lives. So that's directly to address some of the gatekeeping issues that people have in terms of historically having to get psychiatric assessments and psychological reports and whatnot in order to access gender affirming care*' - Evidence of Carolyn Gillespie, T-264, lines 8-16.
[290] AusPATH Informed Consent Standards.

hormone therapy, with a psychiatrist also available if needed.[291] Professor Zajac noted that, while a mental health assessment is not a precondition for delivery of gender-affirming treatment, he recommends all patients have ongoing mental health support when affirming their gender identity.[292]

283. Professor Zajac gave evidence at Inquest that '*in terms of the models used, the WPATH - what you might call the mental health model – is gradually being replaced by the informed consent model*', opining however that those with significant mental health problems are '*better off'* with the WPATH model.[293] Dr Kalra of MHGC concurred that the WPATH model is more appropriate for those '*with complex mental health issues or perhaps more than two or three mental health issues',* noting that those within this cohort '*end up coming to the Monash Health Gender Clinic*'.[294] For MHGC, existence of serious mental illnesses is not a barrier to gender-affirming care *per se*, but the presence of illnesses such as schizophrenia and other major mental illnesses may warrant a longer period of assessment prior to any gender-related treatments commencing.[295]

The importance of gender-affirming care being culturally-appropriate for TGD people

284. Ms Gillespie gave evidence that Equinox, established in 2016, was the first service of its kind, designed to allow TGD people to '*access a really culturally affirming general practice service, so what we offer is all aspects of GP care including hormone initiation, sexual health, mental health, vaccination, endocrinology, nursing support, secondary consultation to prison services…*'.[296]

285. Equinox employs TGD-identifying nursing staff and peer workers as well as GPs who identify as members of the LGBTIQA+ community. Ms Gillespie described: '*our community*

[291] Submissions of Professor J. Zajac, Collated Brief, p. 53. Professor Zajac also noted that the gender-affirming services that Austin Health provides are delivered through the state-funded Trans and Gender Diverse in Community Health Initiative (**TGDiCH**), a consortium of Austin Health, Your Community Health (at PANCH in Preston), Ballarat Community Health and Thorne Harbour Health and includes endocrinologists, psychiatrists, GPs, peer workers and other support personnel – *see* Collated Brief p. 52.
[292] Submissions of Professor J. Zajac, Austin Health Gender Clinic, pp. 51-53.
[293] Evidence of Professor J. Zajac, Austin Health Gender Clinic, T-269, lines 17-26.
[294] Evidence of Dr G. Kalra, T-271, lines 11-17.
[295] 'Frequently Asked Questions', *Monash Health* (Web Page) <https://monashhealth.org/services/gender-clinic/questions/#starting-at-clinic>.
[296] Evidence of Ms C. Gillespie, Thorne Harbour Health, T-210 line 26 to T-211 line 15.

holds our community',[297] noting that TGD people are best-placed to determine what culturally-appropriate care looks like for them.

286. Ms Gillespie stated that, in terms of the relationship between Equinox and the TGD community, there is '*genuine and meaningful inclusion around processes and decisions that get made. So when services and systems are built like Equinox was truly in partnership and led not just in partnership but led by trans and gender diverse people, it meant that we have a service that now sees thousands of people and supports them because it's actually structured to meet those needs*'.[298]

287. The benefit is that TGD people feel genuinely able to access the service and have their health needs met. This may also avoid the significant health risks which can arise where TGD people report delaying or avoiding needed medical treatment to avoid the risk of discrimination.[299]

The importance of multidisciplinary care

288. During my investigation, I received evidence that the importance of a multidisciplinary approach to gender-affirming care for TGD communities is underscored in both the WPATH and 'informed consent' models of care. WPATH promotes care from a multidisciplinary team as vital to the wellbeing of TGD people and considers this to be a key part of any assessment or treatment plan, with regular reviews between service providers, including importantly when there are indicators of risk.[300] This approach is exemplified by gender clinics such as MHGC, which is staffed by a multidisciplinary team comprising consultant

[297] Evidence of Ms C. Gillespie, Thorne Harbour Health, T-284, lines 14-15.
[298] Ms Gillespie also noted in this regard the Inquest process demonstrated cultural safety for TGD people through visible signs of inclusion, as well as consultation with people with lived experience prior to the convening of the hearing '*to talk about how we could best make these structures and processes culturally safe for our trans and gender diverse community*' – *See* evidence of Ms C. Gillespie, Thorne Harbour Health, T-320, line 15 to T-321 line 7. To this end, Ms Lane noted, in assessing whether a space was safe for her to access as a transgender woman, and in referring to the courtroom, '*Now, what I do is, I look for any signs of inclusion. Things like the flag you have here, or the flags here, show support and this is a really important thing for the community*' – T-32, lines 18-21.
[299] Submissions of Equinox, Collated Brief, p. 84, referring to Lucille Kerr, Christopher Fisher and Tiffany Jones 'TRANScending discrimination in health & cancer care: a study of trans & gender diverse Australians' 2019 117 *Australian Research Centre in Sex Health* (**Kerr et. al., 2019**). DOI: 10.26181/5d3e1cc21a99c. This study found in relation to TGD people high levels of unmet healthcare needs, discomfort discussing their needs, feeling misunderstood, emergency department avoidance, barriers to care, numerous instances of poor treatment in the healthcare system and hesitancy to disclose their gender – see p. 6.
[300] WPATH Standards 8.

psychiatrists, clinical psychologists, a social worker, endocrinologists, peer support workers, a project worker, research assistant and administrative workers along with external private consultants in speech pathology and plastic surgery.[301]

289. Ms Gillespie of Equinox highlighted the importance of a multidisciplinary approach for those receiving gender-affirming medical care through an informed consent model, stating '*I think from our perspective, having holistic integrated care is just good healthcare and it doesn't matter who it is that's sitting in front of you but particularly for trans and gender diverse folk, when you provide a holistic integrated model, you can attend to all of the things that impact on someone's mental health and their wellbeing. So for us we work within an organisation that can really be often a one stop shop*'.[302] This may include additional services such as culturally-safe alcohol and other drug support, support for family violence and other issues that may be faced by TGD persons seeking access to care, as well as providing a pathway to receipt of acute mental healthcare where needed.[303]

290. Professor Zajac of Austin Health lamented the deficiency in private practice in providing multidisciplinary gender-affirming care, where it is usually '*just me and the GP, it's hard to find at - for me to get access to the wide range of supports that are available at a place like Thorne Harbour and some of the other general practices who have an interest in this area*'.[304] Professor Zajac considered this was less than ideal where the potential mental health effects of gender-affirming hormones are required to be monitored, and in light of his recommended approach that all TGD persons undergoing gender-affirming hormone therapy have access to mental health support.[305]

291. This fragmentation of care can also be exacerbated where, as noted by Dr Nguyen in relation to care in the private sector, Medicare does not provide a billing item for case-conferencing in many circumstances, and different practitioners who liaise with each other in relation to a patient will often do so based on duty of care alone.[306]

[301] *See* Statement of Dr G. Kalra, Collated Brief, p. 324.
[302] Evidence of C. Gillespie, T-281, lines 19-26.
[303] Evidence of C. Gillespie, T-286, lines 2-7.
[304] Evidence of Professor J. Zajac, T-286 lines 11-17.
[305] Submissions of Austin Health Gender Clinic, pp. 51-53.
[306] Evidence of Dr T. Nguyen, T-287 line18 – T-288 line 2.

Access to gender-affirming medical care and impact on wellbeing of TGD adults, including those with co-existing mental health conditions

292. As noted earlier in this Finding, the evidence of Professor Zajac of Austin Health was that, generally, mental health issues and distress experienced by TGD individuals is reduced after commencing gender-affirming hormone treatment.[307]

293. Professor Zajac referred to a recent controlled study in which one group of TGD participants was taken off the waiting list at a gender clinic and provided gender-affirming hormone treatment (testosterone) immediately, while a second group of TGD participants at the gender clinic remained on the waitlist without hormone treatment (the waitlist being three months). A range of responses was sought from both groups during this period in relation to measures of wellbeing, mental health, and suicidality, with the study concluding that '*immediate testosterone compared with no treatment significantly reduced gender dysphoria, depression, and suicidality in transgender and gender-diverse individuals desiring testosterone therapy*'. Professor Zajac remarked that there is '*clear evidence from this controlled study that even as short a period as three months can improve the wellbeing of individuals*'.[308]

294. The improved mental wellbeing and reduced suicidality of TGD persons upon commencing gender-affirming treatment was echoed by Dr Kalra of MHGC, who gave evidence at Inquest that '*we do see people who have embarked on the medical affirmation pathway and we follow up people who have started on hormones or have undergone surgery for one year, starting perhaps three months after their first appointment after they've started on hormones or undergone surgery and we do see that positive effect in the reduction of their distress, in almost disappearance of the suicidal thoughts that they were experiencing. So we do see that happening over a period of time once they have embarked on the pathway'*.[309]

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[307] Statement of Dr J. Zajac, Collated Brief, p. 51, referring to Lucas Foster et al 'Short-Term Effects of Gender-Affirming Hormone Therapy on Dysphoria and Quality of Life in Transgender Individuals: A Prospective Controlled Study' (2021) 29(12) *Front Endocrinal (Lausanne)*, DOI: 10.3389/fendo.2021.717766.
[308] Evidence of Professor J. Zajac, T-262 line 10 to T-263, line 16. *See further in this regard* Brendan Nolan 'Early Access to Testosterone Therapy in Transgender and Gender-Diverse Adults Seeking Masculinisation: A Randomised Clinical Trial' (2023) 6(9) *JAMA Network Open*, DOI: 10.1001/jamanetworkopen.2023.31919.
[309] Evidence of Dr G. Kalra, T-252 line 24 to T-253 line 5.

295. Indeed, the benefit of improved mental wellbeing upon commencing of gender-affirming hormone therapy was noted in a number of the submissions provided to the Court, including those of the Royal Australian College of General Practitioners (**RACGP**),[310] Equinox,[311] and the Australian Psychological Society.[312] While observing some limitations to the 2021 study he referred to, Dr Erasmus, formerly of MHGC, also noted that hormone therapy may improve quality of life and decrease depression and anxiety.[313]

296. Dr James Morandini of the Australian Psychological Society referred to a number of studies noting '*modest improvements*' in psychological functioning following commencement of gender-affirming hormone treatments, with certain studies noting an improvement to wellbeing that is slightly stronger than most anti-depressant treatments would yield. Dr Morandini noted that '*the standard of evidence is still needing to build, but certainly there is no evidence that suggests that these treatments on average have harmful effects for people'*.[314]

297. In this connection, it is noted that each of the submitting organisations, prior to Inquest, was asked by CPU to address the existence of any risks or harmful effects associated with feminising and masculinising gender-affirming medical treatments. The known risks and side effects reported by these organisations were predominantly related to physical health (e.g. lower bone mineral density in transwomen following commencement of gender-affirming hormone therapy),[315] but also included those that may also impact on TGD peoples' mental health and wellbeing, such as the risk of mood swings or behavioural disturbance from hormone treatment (e.g. estrogen,[316] progesterone,[317] or cyproterone)[318]

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[310] *See* submissions of RACGP, Collated Brief, p. 109.
[311] *See* submissions of Equinox, Collated Brief, pp. 77-78.
[312] *See* submissions of Australian Psychological Society, Collated Brief, p. 58.
[313] *See* submissions of Dr J. Erasmus, Collated Brief, p. 90, referring to Kellan Baker et al 'Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review' (2021) 5(4) *Journal of the Endocrine Society*. DOI: 10.1210/jendso/bvab011. Therein, it was noted that no studies had been found where quality of life scores decrease or depression and anxiety increase following commencement of gender-affirming hormone therapy. The authors found there was insufficient evidence to draw a conclusion about the effect of hormone therapy on death by suicide (*see* Collated Brief, p. 78).
[314] Evidence of Dr J. Morandini, T-256 line 12 to T-257 line 4.
[315] Submission of Dr J. Erasmus, MHGC, Collated Brief, p. 91.
[316] Submission of Dr J. Erasmus, MHGC, Collated Brief, p. 92.
[317] Evidence of Professor J. Zajac, T-372 line 27 to T-373 line 2.
[318] Submissions of RCH, Collated Brief, p. 282.

with RACGP noting in this context a risk of emotional lability and risk of depression/anxiety for those affirming male-to-female, and increased aggression and emotional lability for those affirming female-to-male.[319]

298. The implications are that those with a mental illness who are affirming their gender should have a comprehensive mental state examination where indicated, and be monitored for changes in mood, appropriateness of medication regimes, consideration of potential drug-to-drug interactions, and assessment of any increased risk of suicidality,[320] as is already provided for in both the WPATH Standards and informed consent model.[321] The MHGC submission notes, for example, that given that estrogen can trigger mood swings, it is important that a person who has borderline personality disorder or a mood disorder has adequate control of their condition before commencing gender-affirming hormone treatment.[322]

299. Evidence was heard at Inquest that further long-term studies are needed to assess certain of the health impacts of gender-affirming care on the TGD population (an example given was an increased risk of heart disease or stroke in transwomen).[323] However, Professor Zajac opined that, in the short-term '*we know quite a lot*' and that these risks are explained in detail as a precondition to those seeking to commence gender-affirming hormone treatment.[324]

300. He also noted in response to questioning from Counsel for Transgender Victoria that his experience was that the proportion of people de-transitioning (namely, the act of stopping or reversing the social, medical, and/or legal changes achieved during a gender affirmation process) is very small, opining that '*the material in some of the press about how common this is not based on any factual data'*.[325]

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[319] Submissions of RAGCP, Collated Brief, p. 105.
[320] Submissions of RAGCP, Collated Brief, p. 105.
[321] *See in this regard* Australian Informed Consent Standards, p. 11 – '*Complex mental health issues should be addressed, and the patient supported, prior to commencing hormone therapy*'.
[322] Submission of Dr J. Erasmus, MHGC, Collated Brief, p. 92.
[323] Submission of Dr J. Erasmus, MHGC, Collated Brief, p. 91. See further the evidence of Professor J. Zajac, T-372 line 15 to T-373 line 12.
[324] Evidence of Professor Zajac, T-372 lines 27-28.
[325] Evidence of Professor Zajac, T-372 lines 8-15. This is consistent with studies noting the need for improved data on so-called 'detransitioning' to better-inform health responses - *see for example* Pablo Espósito-Campos et al 'Gender detransition: A critical review of the literature' (2023) 51(3) *Actas Esp Psiquitar.* PMID: 37489555.

301. Notwithstanding the gap in data on long-term physical health outcomes for TGD people undergoing gender-affirming treatment, I heard extensive evidence at Inquest, detailed in this section, supporting general outcomes of improved mental wellbeing and reduced suicidality amongst TGD people when they access gender-affirming medical treatment.

302. Further, Mrs Nation-Ingle, State Suicide Prevention and Response Adviser within the Department of Health, noted that '*delayed or denied access to treatment among trans people pursuing medical transition was linked to a greater likelihood of suicidality compared to those whose treatment was timely and comprehensive*'.[326] This is supported by the previously-noted submission of MHGC, in which it was stated that the time between making a decision and then being able to access gender affirming care can be a particularly vulnerable period and has been associated with an increase in suicide risk, hence reinforcing the need to minimise barriers to accessing gender affirming care once a decision to affirm one's gender has been made.[327]

303. The importance of timely access to gender-affirming care as a means to improved wellbeing for TGD people was also emphasised by those beyond the Medical Panel. Transgender Victoria stated that, while the decision to affirm one's gender requires courage and may be delayed by the individual, access to gender-affirming care once the decision to affirm has been made is critical to reducing lack of congruence between gender identity and gender assumed at birth, and often '*will ameliorate the ridicule, vilification, psychological and physical abuse and serious violence that TGD people suffer from*'.[328]

[326] Evidence of Mrs B. Nation-Ingle, T-259, lines 3-8, referring to Private Lives 3. It is noted that this was not expressly stated in Private Lives 3 but in a journal article subsequently produced by the Private Lives 3 Research team, namely Adam Hill et al, 'Demographic and psychosocial factors associated with recent suicidal ideation and suicide attempts among trans and gender diverse people in Australia' (2023) 53(2) *Suicide and Life-Threatening Behaviour* (**Hill *et al.* 2023**), DOI: https://doi.org/10.1111/sltb.12946

[327] Submission of Dr J. Erasmus, Collated brief, p. 90. See further in this regard Greta Bauer et al, 'Suicidality among trans people in Ontario: Implications for social work and social justice' (translated from original Québécoise French), *Revue Service Sociale* (2013) 59(1) 35. DOI: https://doi.org/10.7202/1017478ar.

[328] Submissions of Transgender Victoria, Collated brief, p. 248 and p. 260, referring to Hill *et al*. 2023 and 'AusPATH: Public Statement of Gender Affirming Healthcare, including for Trans Youth' *AusPATH* (Web Page, 26 June 2021) <https://auspath.org.au/2021/06/26/auspath-public-statement-on-gender-affirming-healthcare-including-for-trans-youth/>.

Barriers to accessing gender-affirming care

Waitlists and moral distress

304. Long waiting lists to access gender clinics were described at Inquest by Dr Nguyen as a great source of '*moral distress*' for clinicians, who have substantially *'more demand than we have capacity to see*'.[329] As of July 2024, MHGC's wait-list was over **two years**, with MHGC currently booking appointments for clients whose referrals were received in June 2022.[330] Austin Heath's Gender Clinic waiting list was closed as of March 2024.[331] Equinox's waitlist, at the time of Inquest in November 2023, had been closed since April 2022, with some 1,500 clients already being treated at the clinic.[332]

305. Dr Morandini noted that the waitlists for gender-affirming surgeries can be '*terrible*' and are '*causing significant distress to folks in the community*'. Dr Morandini noted that there are delays of up to two years to access surgeries such as vaginoplasty for transwomen.[333]

306. Dr Nguyen of RCH Gender Services gave evidence of an upward trend in demands for gender-affirming medical care, opining that in the future, she '*would expect that we will then have more demand and increased waitlists. This is not something that will be ending soon*'.[334]

307. In the context of extremely long waiting lists, choosing the right pathway may have critical impacts on the timing in which gender-affirming treatment is able to be received. The pathways for accessing gender-affirming care are quite different; one starts with a psychiatrist or psychologist (in the case of clinicians following the WPATH Standards of

[329] *See* evidence of Dr T. Nguyen, T-297, lines 23-24. Dr Nguyen noted that, as of November 2023 at RCH Gender Clinic, '*our current waiting list for the initial appointment is somewhere between four to six months and then after that into the full multidisciplinary team can be another six months to 18 months and at times people age out of the service. […]. We would like to provide more care and we would like to improve access' – see* T-297 line 26 to T-298 line 3.
[330] 'Frequently Asked Questions', *Monash Health* (Web Page) <https://monashhealth.org/services/gender-clinic/questions/#assessments>.
[331] https://www.austin.org.au/gender-clinic/ 'Gender Clinic (Endocrinology)' *Austin Health, Clinics & Services* (Web Page) <https://www.austin.org.au/gender-clinic/>.
[332] Evidence of C. Gillespie, T-294 lines 22-24. It is noted that at the time of issuing this Finding, this may have changed.
[333] Evidence of Dr J. Morandini, T-290, lines 21-29.
[334] Evidence of Dr T. Nguyen, T-300 lines 15-21 and T-303 lines 231-23.

Care, as at MHGC); the other starts with an endocrinologist or GP (in the case of clinicians following the informed consent model, as at Austin Health, Equinox or private GPs). Those seeking to affirm their gender must therefore have some idea as to which pathway they might be more suitable for and identify the appropriate waiting list to 'join'. This may not always be clear for would-be clients.

308. Dr Kalra gave an example of where someone may be waitlisted for an informed consent pathway of medical affirmation, and the service provider eventually assesses them as being more appropriate for a WPATH pathway (due to the complexity of mental health issues, for example) and they are referred to MHGC for another 18-month wait. Evidence also indicates that Matt, for example, had appointments at multiple clinics for the purposes of being prescribed gender-affirming hormone therapy,[335] and was later referred to Monash Health for assessment in relation to gender-affirming surgery.

309. This raises the critical issue as to how the wellbeing of TGD people on waiting lists for gender-affirming care is managed. Dr Kalra of MHGC noted that a social worker from MHGC will telephone those on the MHGC waitlist within a two-month period to do an intake assessment, assess their needs, and inform them of the alternative informed consent model as '*many folks are not aware of the pathway*'.[336] During this '*vulnerable period*', MHGC depends upon grassroots organisations such as Thorne Harbour Health to assist in providing social and emotional wellbeing supports to those on the MHGC waitlists.[337] Ms Gillespie noted that, at Equinox (which is part of Thorne Harbour Health), for those on the waiting list, there is '*a really robust peer network of support available for people which people may or may not choose to tap into […] the role of peers can't be underestimated in supporting people's wellbeing or even affirming how rubbish it is actually to have to wait*'.[338]

[335] *See* statement of A. Brownhill, CB in the matter of Matt Byrne, p. 49.
[336] Evidence of Dr G. Kalra, T-292 lines 10-16.
[337] Evidence of Dr G. Kalra, T-299 line 22 to T-300 line 11. However, MHGC will shortly trial a peer-run engagement group, namely a 5-week online program for people on its waitlist, as well as one-on-one peer support – *see* T-292 line 24 to T-293 line 13.
[338] Evidence of C. Gillespie, T-301 lines 10-15 and 27-29.

310. Dr Dalgleish noted that for individual GPs providing gender-affirming treatment, there can be difficulties accessing psychologists for patients through the federally-funded Mental Health Care Plan system.[339]

Evidence of strategies to reduce waitlists

311. Professor Zajac made a suggestion in his submissions to the Court, endorsed by Dr Kalra, that to address the issue of long waitlists and the existence of two separate medical affirmation pathways, there should be a '*central intake point, managed by peer navigators or gender clinic nurses responsible for triaging clients and referring them to either pathway. [This] could be a means by which significant wait lists are reduced as well as limiting client distress. […] If this proposal was implemented, persons with gender incongruence seeking gender affirmation could be waitlisted to the most appropriate pathway dependent on their complexity of need. In this circumstance MHGC would be allocated clients who would likely, in accordance with the WPATH model, require psychiatric assessment*'.[340] This was described at Inquest by Dr Kalra as '*a* ***funnel model*** *I would call it, wherein everybody joins one waitlist in the neck of the funnel*'.[341]

312. Dr Kalra also emphasised the importance of availability for delivery of gender-affirming care to regional and rural patients, which was endorsed by Dr Coventry[342] and Professor Zajac,[343] and of the need to ensure a better process to manage waitlists.

313. While there was significant support for addressing waitlist issues and consolidating available options for TGD patients, other witnesses took a different view of the proposed 'funnel model'. Ms Gillespie of Thorne Harbour Health expressed a concern that a central intake point would inadvertently replicate 'gatekeeping' of gender-affirming care and emphasised the importance of TGD people being involved in scoping any proposals to reduce waitlists. Ms Gillespie opined that '*the ultimate goal here is that it doesn't matter what the touchpoint*

[339] Evidence of Dr M. Dalgleish, T-302, lines 9-21.
[340] Submissions of Dr G. Kalra, Collated brief, p. 327, referring to submissions of Professor Zajac, Collated Brief, p. 53.
[341] Evidence of Dr G. Kalra, T-338 line 26 to T-339 line 1 (my emphasis).
[342] Evidence of Dr N. Coventry, T-342 line15 to T-343 line 6.
[343] Evidence of Professor Zajac, T-344 lines 11-14.

is, a trans and gender diverse person should get good universal healthcare wherever they are, just like any other member of the Victorian community'.[344]

314. Dr Dalgleish recognised the value of a central intake point while avoiding so-called 'gatekeeping', and proposed a central referral system telephone line which could '*act almost as a centralised referral system without actually limiting direct community referrals, self-referrals to other services as well*'.[345] Dr Nguyen also recognised the attraction of a '*streamlined one stop shop*' though noted this may run counter to a vision in which gender-affirming care is '*everybody's business*' and could be delivered by GPs where a TGD person lives, and who is known to them longitudinally.[346]

315. Professor Zajac opined that whatever approach is adopted, it needs to be more streamlined, '*but I think we need to give the system a shake because, well, I think more of the same is not going to get us anywhere*'.[347]

Cost

316. Transgender Victoria, in its submissions to the Court, noted the cost, complexity and administrative burden on TGD people of affirming their gender, including **legal affirmation** (such as changing a name or record of sex on a birth certificate with Births, Deaths and Marriages Victoria, or doing so on a passport via the Australian Passport Office), for which Transgender Victoria provides funding (sourced from donations) to TGD Victorians seeking to legally affirm their gender so that cost is not a barrier to them doing so.[348] Ms Lane, the Court's lived experience expert, also noted at Inquest the costs to TGD people associated with **social affirmation** in changing wardrobe to clothing that affirms one's identity.[349]

[344] Evidence of C. Gillespie, T-340 line 16 to T-341 line 3.
[345] Evidence of Dr M. Dalgleish, T-341, lines 23-26. They made the comparison with termination of pregnancy services where '*the Royal Women's Hospital have a telephone number that anyone can phone up and access and that telephone number can refer to different services…so it can act… almost as a centralised referral system without actually limiting direct community referrals, self-referrals to other services as well*'.
[346] Evidence of Dr T. Nguyen, T-342, lines 5-13.
[347] Evidence of Professor J. Zajac, T-344 lines11-21.
[348] Submission of Transgender Victoria, Collated Brief, p. 262. See also in this regard the evidence of Dr T. Nguyen, T-237, lines 18-26.
[349] Evidence of Ms E. Lane, T-40 lines 28-30.

317. However, the biggest cost, for those TGD people going down that pathway, is usually that associated with **medical affirmation**. Unless one has access to a publicly-funded clinic such as MHGC (which currently has two-year wait times), Austin Health, or Equinox, which is funded through Medicare and other program funding (whose waitlist at the time of Inquest was closed), the costs of consultations for gender-affirming treatment are required to borne by the patient, or, as is the preferred terminology of Equinox, 'client'. As noted by Transgender Victoria, this can result in '*very large out of pocket costs for patients seeking treatment in private clinics which is often the only option available given the wait times and limited availability of public clinics*'.[350]

318. Professor Zajac gave evidence that he bulk-billed his TGD patients, but there are still costs associated with treatment. In particular, he noted there was a lack of consistency as to the way prescriptions are issued and costs meted out (for example, to access testosterone via the Pharmaceutical Benefits Scheme, there is a requirement for TGD people to have hormones prescribed by an endocrinologist rather than a GP).[351]

319. Dr Dalgleish noted that Medicare bulk-billing for GP consultations is increasingly unsustainable, and does not allow easily for remunerable multidisciplinary conferencing, which is critical to comprehensive holistic care for TGD people. Dr Nguyen agreed, noting that current issues with bulk-billing will likely place additional demands on the public system in the future.[352]

320. There are also costs associated with the requirement for psychological or psychiatric support. As Dr Dalgleish noted, even those with a mental healthcare plan are only entitled to a rebate from Medicare rather than the full cost of the session with a psychologist being covered.[353] This is significant in light of the fact that, while those affirming their gender via an informed consent model may not require a mental health assessment in order to commence treatment, most are recommended to maintain mental health support throughout the affirmation process. There is also the added burden on TGD people of researching whether the services

[350] Submission of Transgender Victoria, Collated Brief, p. 266.
[351] Evidence of Professor J. Zajac, T-240, lines10-13.
[352] Evidence of Dr M. Dalgleish, T-288, lines 5-12; Evidence of Dr T. Nguyen, T-303, lines 8-22.
[353] Evidence of Dr M. Dalgleish, T-302, lines 9-21.

they seek to access are likely to be culturally safe,[354] in a community that is already financially disadvantaged and often fearful of discrimination in healthcare settings.[355]

321. Finally, and significantly, the cost of gender-affirming surgery can be tens of thousands of dollars. Due to the lack of availability of certain surgeries in Australia, many TGD people are required to travel overseas to access such surgeries, which adds to the expense of the procedures themselves. Those without private health insurance will be further limited in available options.

322. Ms Lane, the Court's lived experience expert, spoke openly at Inquest of the costs of her own gender-affirming surgery, which included facial feminisation surgery in Spain at the cost of approximately $30,000, as well as a number of surgeries in Australia and Thailand, totalling approximately $100,000.[356] In her statement to the Court, Ms Lane noted that gender-affirming surgery '*has a lot of costs associated and for me I had to sell my investment property to pay for them. It means my dream to retire at 60 are just that, a dream and I will be working until I am 70. Not everyone has the financial support for this and there is very limited Medicare to assist with the cost*'.[357]

Workforce issues

323. A further barrier to accessing gender-affirming medical care is the fact that the pool of clinicians providing such care to the TGD population is relatively small, meaning that there is an insufficient number of gender-affirming clinicians to meet demand for their services.

[354] *See* Collated brief, p. 227; 'Understanding LGBTQA+SB suicidal behaviour and improving support: insight from intersectional lived experience' (Research Paper, RMIT University, 2023). DOI: https://doi.org/10.25439/rmt.23640978.v1

[355] Some examples of discrimination in a healthcare setting were provided at Inquest, including from Professor Zajac, who noted that he had '*a patient, a young transman getting acne from his testosterone who went to see a dermatologist. The dermatologist came out of his office and yelled at him and said, 'Get out of my waiting room', so if that's not discrimination what is? And that person was scarred for years*' – *see* T-309 lines 20-26.

[356] Evidence of Ms E. Lane, T-27, line 20 to T-28 line 26.

[357] Statement of Ms E. Lane, Collated Brief, p. 43.

324. Professor Zajac noted that there is inadequate access to endocrine services as *'it's only a small percentage of endocrinologists who will see trans individuals. … some people feel they haven't had enough training, which is true, and some people just refuse'*.[358]

325. Similarly, there are only a small number of GPs who deliver gender-affirming care outside of a gender clinic context,[359] with Professor Zajac highlighting his experience where '*one GP in a clinic is very enthusiastic and keen to treat trans individuals but the partners or the other GPs in that clinic are not, and that's often the problem for the patient'*.[360] This was affirmed by Dr Dalgleish who noted that in being a GP offering gender-affirming care outside a gender clinic context '*you're often on your own*', and others in the clinic may not be supportive.[361]

326. Dr Nguyen gave evidence that the workforce issues in delivering gender-affirming care are rooted in discrimination and '*hostility within the medical profession to the vision of gender affirming care amongst medical practitioners of all, of various sub-specialties, psychiatry in particular because that is my craft group, but also others….So what this means for trans people is that the access to care is limited because practitioners feel at risk*'.[362]

327. Drs Nguyen and Dalgleish noted a clear need for capacity-building in mainstream health providers, further gender diversity and cultural safety training for clinicians, and a non-discriminatory approach by medical indemnity insurers.[363] This was echoed by Mx Harden of Thorne Harbour Health, who delivers training to GPs on TGD health, and who stated that a significant barrier faced by GPs '*is that they don't feel supported by their colleges or by their medico-legal insurance, and places like that. So having leadership from those organisations I think would help clinicians feel that they have someone behind them, they*

[358] Evidence of Professor J. Zajac, T-241, lines 23-29.
[359] Evidence of Dr T. Nguyen, T-275 lines 15-16.
[360] Evidence of Professor J. Zajac, T-276 lines 5-11.
[361] Evidence of Dr M. Dalgleish, T-274, lines 4-5. Dr Dalgleish noted however that the RACGP has a special interest group for TGD health that offer GPs training through Thorne Harbour Health – *see* evidence of Dr M. Dalgleish, T-326, lines 6-13. Mx Harden of Thorne Harbour Health also noted that this new interest group '*sends a really clear signal that RACGP are invested in improving trans and gender diverse health…in the GP sphere*' – *see in this regard* T-459 lines 19-24.
[362] Evidence of Dr T. Nguyen, T-274 line 21 to T-275 line12.
[363] *See generally* T-274 line 21 to T-278 line 13.

have this organisation - you know, their college is supporting the work they're doing'.[364] They noted further that improved access to primary healthcare clinicians offering gender-affirming medical care would see a reduction in waitlist of gender clinics.[365]

328. There was extensive evidence at Inquest about additional mainstream GPs, sexual health physicians or private endocrinologists receiving training to be in a position to prescribe gender-affirming hormones to TGD persons,[366] including as a means to reduce waitlists. As noted earlier, Dr Nguyen's and others' vision is one in which delivering gender-affirming care is '*everybody's business*' and could be delivered by clinicians based where a TGD person lives.[367] This would also help address the issue highlighted by Dr Kalra of the lack of services for TGD people living in rural or regional areas, an issue also noted by Dr Coventry.[368] However, there may be fears of TGD people facing discrimination from accessing mainstream services[369] and fears on clinicians' part of backlash in providing health services to the TGD population,[370] which will be addressed further below.

Gender-affirming care for children and young people

329. In the course of my investigation, the Court received submissions from the Royal Children's Hospital Gender Service (**RCH Gender Service**), which provides gender-affirming care for children and young people who are referred prior to their 16th birthday and who reside in Victoria. Dr Tram Nguyen, consultant psychiatrist and a co-director of the RCH Gender Service also gave evidence at Inquest as part of the Medical Panel.

330. I have not addressed children and young persons' gender-affirming treatment pathway in detail in this Finding because, while there is evidence that AS received gender-affirming treatment as a young person in Queensland, the five deceased persons in this cluster inquest

[364] Evidence of Mx V. Harden, Thorne Harbour Health, T-521 lines 15-29.
[365] Evidence of Mx V. Harden, Thorne Harbour Health, T-524, lines 9-21 – '*My solution is to have primary healthcare clinicians be able to provide gender affirming or medical gender affirmation services. If a trans person can go to their regular GP and discuss their gender identity with them and know that they won't face discrimination, they won't be refused care, that will reduce the wait lists at all of the specialist services, trans and gender diverse healthcare, gender affirming healthcare. Medical affirmation is not specialist care, and it doesn't need to be held at specialist's services*'.
[366] *See for example* in relation to GPs the evidence of Dr M. Dalgleish, T-352 lines 13-26.
[367] Evidence of Dr T. Nguyen, T-342, lines 5-13.
[368] Evidence of Dr N. Coventry, T-342 line 15 to T-343 line 6.
[369] Evidence of Dr T. Nguyen, T-323 line 23 to T-324 line 8.
[370] *See in this regard* the evidence of Mx V. Harden, Thorne Harbour Health, T-457 lines 7-12.

were all adults when they died, and their pathways to gender-affirming medical care (with the exception of AS, who then resided outside this jurisdiction), commenced in adulthood. I am thus limited in part by the scope of Inquest and the principles in *Harmsworth*.[371]

331. However, in light of the prevention role of the Court and the evidence of Dr Nguyen, it would be remiss of me not to briefly address the issue of care being provided to children and young people. In this connection, referring to two recent studies, Dr Nguyen gave evidence at Inquest that young people who were commenced on gender-affirming medical care in early adolescence had associated reduced depression and suicidality compared to those who were commenced later and those who were commenced in adulthood.[372] She noted several hypotheses around this, including the greater congruence of physical appearance with experienced gender (based on not having developed secondary sex characteristics of the young person's sex at birth) leading to a greater internal sense embodiment and lower chance of being discriminated against, as well as the possibility that having a supportive family facilitating the young person's pathway was contributory to wellbeing outcomes.[373]

332. Dr Nguyen also gave evidence that for young people who are supported early in their gender identity pathway, such as through puberty suppression, their mental health outcomes are on par with their cisgendered peers, compared to those who have not had that early affirmation.[374]

333. The option of medical gender affirmation for children and young people therefore presents an opportunity for early intervention and prevention of distress, mental ill health, and suicidality that TGD people can face later in life.

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[371] *Harmsworth v The State Coroner* [1989] VR 989.
[372] Evidence of Dr T. Nguyen, T-259 line 27 to T-260, line 7. *See further in this regard* Diane Chen et al 'Psychosocial Functioning in Transgender Youth after 2 Years of Hormones' (2023) 388(3) *New England Journal of Medicine* 240-250. DOI: 10.1056/NEJMoa2206297 *This 2-year study involving transgender and nonbinary youth found that gender-affirming hormones (**GAH**) improved appearance congruence and psychosocial functioning*, and Jack Turban et al 'Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults' (2022) 17(1) *PLOS One.* DOI: https://doi.org/10.1371/journal.pone.0261039. *which found that access to GAH during adolescence and adulthood is associated with favourable mental health outcomes compared to desiring but not accessing GAH*.
[373] Evidence of Dr T. Nguyen, T-260, lines 8-20.
[374] Evidence of Dr T Nguyen, T-261 line 29 to T-262 line 6.

334. The submissions of the RCH Gender Service provide a detailed overview of the clinical care pathway for children and young people being treated by the service, and emphasise the multidisciplinary nature of this care, the comprehensive ways in which any mental health issues are addressed, and that care is provided with regard to the WPATH Standards 8 and the Australian Standards of Care and Treatment Guidelines for TGD children and Adolescents.[375] Dr Nguyen gave evidence that care is provided to children and young people presenting to the service through a family-focused, '*holistic person-centred model*', the end point of which is not necessarily medical prescribing.[376]

335. I acknowledge that a divergence of opinion exists in the community in relation to how to best address and treat distress related to gender identity, particularly in children and young people. In this connection, I received correspondence following the close of evidence from an organisation named 'Genspect' seeking further evidence to be called at Inquest from clinicians who support, *inter alia*, a different approach to providing care for children and young people facing gender-related distress,[377] and highlighting the outcomes of the final report authored by Dr Hilary Cass, which includes recommendations on ways in which to improve the United Kingdom's National Health Service (**NHS**) funded gender identity services, and which was published in April 2024 (**Cass Review**).[378]

336. While I gave careful consideration to Genspect's correspondence, I was conscious of the limits of the scope of the Inquest and considered that a detailed examination of the issues raised in Genspect's correspondence would stray beyond the confines of the settled scope. Further, at the time the correspondence from Genspect was received, the Inquest had already occurred, the coronial briefs had been tendered, and interested parties had already made

[375] *See* submissions of RCH Gender Service, Collated Brief, pages 276-289.
[376] Evidence of Dr T. Nguyen, T-268 lines 24-26.
[377] Correspondence received from Genspect dated 20 March 2024, Court File, referring, inter alia, to what Genspect described as '*mounting global concern amongst countless medical and allied health professionals about the efficacy and safety of GAC*' [gender-affirming care].
[378] Correspondence received from Genspect dated 11 May 2024, Court File, referring to, *inter alia*, 'Independent review of gender identity services for children and young people: Final report' (Research Paper, Cass Review, April 2024) Accessible at: <https://cass.independent-review.uk/wp-content/uploads/2024/04/CassReview_Final.pdf>. The Genspect correspondence highlights, *inter alia*, that *'[i]n her report, Cass concludes that there is no clear evidentiary basis for medical gender affirmation interventions in children and confirms that the evidence for puberty suppression and cross-sex hormone treatment is of such poor quality that no foundation exists for clinical decisions and informed consent*'.

closing submissions. It is also pertinent to note that Genspect had not sought to participate actively in the inquest by seeking standing as an interested party.[379]

337. Importantly, the Inquest did not identify any issues with the approach of RCH Gender Service or the gender-affirming care given to young TGD people, which is provided in accordance with national and international standards, that would warrant further evidence being called. While those standards may evolve over time (and do evolve, when one looks at the long history of WPATH), there was nothing to suggest from Dr Nguyen or from any witness from any organisation – which included a wide range of entities across the health services spectrum, including those providing gender-affirming care, the Victorian Department of Health, Victoria's Chief Psychiatrist, and representatives from peak professional bodies - that the approach to gender-affirming care for children and young people in Victoria warranted further examination in the manner urged upon me by Genspect. Conversely, the positive impacts in providing gender-affirming care to this cohort were highlighted by a number of witnesses, including Mrs Bailey Nation-Ingle from the Department of Health.[380]

338. For completeness, I note that I considered Dr Nguyen to be an impressive witness. Her evidence was articulate, reasoned, and spoke of a doctor who cares deeply for her young patients and their families. While health services in other jurisdictions might be evaluating service models aimed at addressing gender-related distress in children and young people, including the United Kingdom's NHS, the evidence at the Inquest demonstrates that the care provided by Dr Nguyen and her colleagues at the RCH Gender Service is multidisciplinary, holistic, individualised, and appropriately cautious. I consider that the relevance of any issues raised by the Cass Review will be a matter for the RCH Gender Service to consider in light of this existing approach.

339. In such circumstances, and having considered in detail the studies and reports referred to in correspondence by Genspect, I was not of the view that it was necessary or in the interests

[379] *See in this regard* sections 56 and 66 of the Act. Further, Further, section 64 specifies that the witnesses to be called at Inquest, and the determination of the relevant issues for the purposes of the Inquest, are matters for the Coroner.
[380] *See for example* Evidence of Mrs B. Nation-Ingle, T-259 lines 9-18.

of justice to call further evidence on this topic, and as a courtesy, the Court informed Genspect of the same earlier this month.

Analysis

340. Historically, TGD people have faced numerous barriers to accessing gender-affirming care. Certain of these barriers have been attributed to 'gatekeeping' of gender-affirming medical care by medical practitioners, who in the past could decide when, where, and how TGD people were able to medically affirm their gender identity.[381] The most recent WPATH Standards, while still viewed as a form of 'gatekeeping' by some, have lowered requirements for hormone treatment before surgical interventions, and removed requirements for living in desired gender role prior to receipt of gender-affirming care.[382] In a further step towards supporting the self-determination of TGD people, the 'informed consent' model, the second pathway to gender affirmation in Victoria, is premised on the TGD person being in control of their own health, and explicitly rejects the notion of medical practitioners as 'gatekeepers' of gender-affirming care.[383]

341. Despite this, significant barriers still exist for TGD people affirming their identities, particularly via a medical pathway, including due to issues of cost, access and long waitlists in the face of increasing demand for access to gender-affirming care.[384] Given the evidence I heard at Inquest that '*delayed or denied access to treatment among trans people pursuing medical transition was linked to a greater likelihood of suicidality compared to those whose treatment was timely and comprehensive*',[385] coupled with the evidence that trans and gender diverse people are already one of the most at-risk populations globally for suicidal ideation

[381] Submissions of Transgender Victoria, Collated Brief, p. 264.
[382] See examples contained in 'World Professional Association for Transgender Health Standards of Care for Transgender and Gender Diverse People, Version 8 Frequently Asked Questions (FAQs)' (Web Page, WPATH) <https://www.wpath.org/media/cms/Documents/SOC%20v8/SOC-8%20FAQs%20-%20WEBSITE2.pdf>.
[383] Ms C. Gillespie of Thorne Harbour Health (which Equinox forms a part of), gave evidence at Inquest that '*the premise of the work of Equinox is an informed consent model which assumes that clients of the service know themselves and without any evidence otherwise we assume that they are in a position to make decisions in relation to their own body and their lives. So that's directly to address some of the gatekeeping issues that people have in terms of historically having to get psychiatric assessments and psychological reports and whatnot in order to access gender affirming care*' – *see* T-264, lines 8-16.
[384] *See in this regard* evidence of Dr T. Nguyen, T-303 lines 21-22.
[385] Evidence of Mrs B. Nation-Ingle, T-259, lines 3-8, referring to Hill *et al*. 2023.

and attempts,[386] I consider these ongoing barriers to gender-affirming care to raise serious concerns in relation to the health and wellbeing of TGD Victorians.

342. Indeed, in terms of the five people whose deaths I have investigated as part of the cluster, I consider these access issues to be most clearly reflected in the experience of Matt, who, in October 2019, underwent a medical procedure for gender-affirming purposes (an attempted orchiectomy) that was attempted by an unlicensed non-medical person with resulting complications, including excessive bleeding. When Matt presented to the emergency department after the aborted procedure, she told doctors that she had opted to go to a non-medical person for the procedure as she had been '*unable to obtain orchiectomy via conventional means*'.[387] I refer to the link between this incident and Matt's suicide further in the Finding into her death; suffice to say here that I consider this to be a cogent – and deeply troubling – example of the need for improved accessibility of gender-affirming medical care for those assessed as suitable.

Strategies to improve access to gender-affirming care in Victoria

343. While there are three gender clinics that receive some form of public funding in Victoria for delivery of gender-affirming care to adults (MHGC, AHGC, and Equinox), these are the only publicly-funded options for those seeking access to gender-affirming care, and they simply cannot keep up with the demand for services.[388] The RCH Gender Service is similarly-stretched.[389]

344. Ms Gillespie gave evidence that, at Equinox (which, at the time of Inquest, had a closed waitlist since April 2022, and had approximately 1,500 existing clients), when the waitlist is opened, it is opened for 175 people. '*It takes us roughly two years to clear that waitlist and then we re-open it and it's full within about 10 days of re-opening*'.[390]

[386] *See* evidence of Mrs B. Nation-Ingle, Department of Health, T-216 line 28 to T-217 line 1.
[387] ED Discharge summary, Matt Byrne, p. 4/80, Court File. An orchiectomy or orchidectomy is the removal of testicles.
[388] *See* evidence of Ms C. Gillespie, Thorne Harbour Health, T-295 lines 19-23.
[389] *See* evidence of Dr T. Nguyen, T-297, line 23 to T-298 line 25.
[390] *See* evidence of Ms C. Gillespie, Thorne Harbour Health, T-294 line 22 to T-295 line 5.

345. The pattern of increasing demand for gender-affirming care that far outstrips supply is a feature across all of the publicly-funded gender clinics, and calls into question the wellbeing of the individuals on the waitlists, who may have limited options for mental health support in the interim, at a point where they are often most vulnerable. The long waitlists also create moral distress for clinicians providing gender-affirming care, exacerbated by existing workforce issues faced by those delivering such care in an environment that is often marked by hostility and burnout. This situation is clearly untenable for patients and healthcare providers alike.

346. I therefore intend to make a recommendation, as a matter connected with the deaths I am investigating, to the Department of Health to consider **immediately increasing resourcing** to meet the growing demand for publicly-funded gender clinics delivering critical culturally-appropriate gender-affirming care to TGD patients. While noting, *inter alia*, that allocation of funding to services is subject to Victorian Government budgetary decisions, the Department has indicated in closing submissions that it agrees in principle with this proposition.[391] Indeed, the Department's witness provided clear, useful and cogent evidence at Inquest, underpinning the need for greater access to gender-affirming care as a means to ameliorate levels of distress and suicidality amongst TGD Victorians.[392]

347. The evidence from this Inquest has demonstrated that best practice care at such gender clinics (exemplified by existing approaches at clinics such as Equinox) is multidisciplinary, individualised, and culturally-safe through, *inter alia*, use of peer navigators and co-design with those from the TGD community, based on the maxim '*nothing about us without us*'.[393]

348. The Department may consider, as advocated by Transgender Victoria, that any additional resourcing for gender-affirming medical care is paired with revision of the existing framework for delivery of gender-affirming care to TGD Victorians, noting that the existing framework is now over six years old, in order to ensure the framework can keep up with current levels of demand. Transgender Victoria submits that any new framework emphasises

[391] *See in this regard* Outline of Submissions of the Secretary to the Department of Health, 13 February 2024, Court File, pp. 1-2.
[392] *See in this regard*, the evidence of Mrs B. Nation-Ingle, T-259, lines 3-8, referring to Hill *et al*. 2023.
[393] See in this regard the evidence of Mx V. Harden, T-458, lines 18-26 – '*As a trans person myself, I won't trust a service or a program that's developed if there are no trans and gender diverse people involved*'.

the provision of services not only through publicly-funded gender clinics but also through primary healthcare networks.[394]

349. In this connection, I heard substantial evidence inquest advocating for GPs and other primary health providers being trained to provide gender-affirming care to TGD people on the basis that such care is not required to be provided through a specialist service. I consider that the evidence at Inquest has indeed demonstrated the need for **further training of healthcare professionals** who may come into contact with or provide gender-affirming healthcare to TGD patients. I agree, as urged upon me by Counsel Assisting, that the RACGP and RANZCP, under the guidance of TGD experts, should develop and offer training and support to all healthcare professionals under their remits, including those who provide or wish to provide care to TGD people, with the aim of ensuring cultural safety for TGD people accessing services in these settings.

350. While not every GP or psychiatrist might feel equipped to deliver gender-affirming care to those in the TGD community, the expansion of existing training will ensure that appropriate referrals can be made and all TGD patients be cared for in a culturally-safe manner.

A note about the 'funnel model'

351. In providing for any new framework or funding increase for delivery of gender-affirming care in Victoria, the Department may wish to consider methods to streamline access points to waitlists, including Dr Dalgleish's proposal of a telephone intake point that can provide information and referrals without limiting direct community referrals or self-referrals to other services[395] (particularly to health providers outside a gender clinic contact). While the idea of a 'funnel' as a central intake point for all gender-affirming care providers in Victoria

[394] See in this regard Outline of Submissions if Transgender Victoria, p. 1, referring to First Submission pf Professor Euan Wallace, Secretary to the Department of Health, itself referring to 'Development of trans and gender diverse services in Victoria', noting that the existing framework for providing health and social services to TGD Victorians was developed in response to a report commissioned by the Department of Health in 2018 by Australian Healthcare Associates (**AHA**). Available: https://www.health.vic.gov.au/publications/development-of-trans-and-gender-diverse-services-in-victoria-final-report. Transgender Victoria also emphasises that while a new framework is being delivered, urgent increases in funding are provided for existing and new public health clinics – *see* Outline of Submissions on behalf of Transgender Victoria, pp. 1-2, Court File and oral submissions of Mr C. Kaias on behalf of Transgender Victoria at Submissions Hearing T-52 line 11 to T-53 to T-54 line 14.
[395] Evidence of Dr T. Nguyen, T-342, lines 5-13.

was not broadly supported at Inquest, it is clear that, at a minimum, more information is required on the gender-affirming pathways available both for the benefit of the clinical community and for those who may seeking to join such a waiting list, which could be centrally available.[396]

5 – Provision of suicide prevention and postvention supports in the TGD community

352. The fifth item in the scope of inquest is '*[t]he availability of and issues concerning provision of culturally-appropriate suicide prevention and postvention supports to TGD people in Victoria'.*

353. Ms Bernasochi of Switchboard Victoria (**Switchboard**), which runs LGBTIQA+-specific suicide prevention, bereavement[397] and postvention[398] programs, gave evidence at Inquest that, in the past, there has been a lack of LGBTIQA+-specific, and in particular, TGD-specific, funding nationally for suicide prevention initiatives. While acknowledging that there are no reliable data on the number of TGD people in Victoria, Ms Bernasochi noted that '*we do have consistent data about rates of suicidal distress among trans and gender diverse people. This data alone should be enough for us to see significant investment in trans and gender diverse suicide prevention*'.[399]

354. Ms Bernasochi opined that, to be most effective, suicide prevention and postvention responses in the LGBTIQA+ communities need to be culturally-appropriate, community-centred and peer-driven. Such supports need to be '*particularly targeted for LGBTIQA+ people who have been bereaved or exposed to […] suicide. Unlike general postvention practices, these actions emphasise the cultural identities of those affected and seek to affirm,*

[396] Evidence of Dr G. Kalra, T-292 lines 10-16.
[397] Defined by Switchboard as *'[t]he period of grief, mourning, or sadness following deep loss, typically following the death of someone*' – *see* 'LGBTIQA+ Suicide Postvention Response Plan: Preliminary Findings', Collated brief, p. 172.
[398] Defined by Switchboard as '[a]*ctivities and intervention related to supporting and helping people bereaved by suicide. This may include counselling, support groups, support from medical professionals etc. This aims to reduce the heightened risk of those bereaved by suicide and promote healing. – see* 'LGBTIQA+ Suicide Postvention Response Plan: Preliminary Findings', Collated brief, p. 172.
[399] Evidence of Ms A. Bernasochi, T-420 lines 2-6.

celebrate and connect with the LGBTIQA+ identification and communities'.[400] The approach of Switchboard recognises that connectedness with the LGBTIQA+ community can moderate suicidality and that '*narratives of sexual and gender diversity are key sources of strength which can reduce feelings of burdensomeness*'.[401]

Addressing 'suicide contagion'

355. The need for a culturally-appropriate response to suicide prevention is particularly borne out in addressing the risk of so-called 'suicide contagion' in LGBTIQA+ communities, which Ms Bernasochi describes as '*an observable phenomenon that happens following a suicide death where people who are exposed to that suicide or bereaved by that suicide become a greater likelihood of experiencing suicidal distress themselves or going on to die by suicide*'.[402] Ms Bernasochi gave evidence at Inquest that suicide contagion is experienced differently in the LGBTIQA+ community to that of the population at large, due to the high rates of suicidal distress that exist '*pervasively*' in these communities, and in particular for TGD communities, a perception from the outside that '*a suicide is being blamed around identity for that person's death*', as well as a perception from within that '*being an at-risk population feeds into the perpetuation of contagion too*'.[403]

Available suicide prevention initiatives aimed at LGBTIQA+ communities in Victoria

356. Switchboard is a peer-led organisation working nationally to provide culturally-appropriate suicide prevention programs for the LGBTIQA+ community, funded in the most part by the Department of Health. Amongst multiple other initiatives, Switchboard operates two seven-day-a-week helplines, one as the Victorian partner of 'QLife', which is the national helpline for the LGBTIQA+ community, the second being the State-wide 'Rainbow Door' helpline,

[400] LGBTIQA+ Suicide Postvention Response Plan: Preliminary Findings, Switchboard, Collated brief, p. 178.
[401] Submission of Switchboard, Collated Brief, p. 159. Ms Bernasochi gave evidence at Inquest of what a culturally-appropriate postvention activity looks like, *'[s]o what we might consider a postvention activity that is a social intervention, might be providing education to a bereaved community, it might be providing debriefing support, it could be working with key people in the community who are writing messaging around a loss, it could be around getting support pathways known to people, it could be facilitating a memorial*' – *see* T-499 lines 7-13. *See further in this regard* the evidence of Mr J. Ball, T-509 lines 11-21.
[402] Evidence of Ms A. Bernasochi, Switchboard, T-496 lines 19-24. The term is, however, problematic when associated with LGBTIQA+ and more specifically, TGD identities, as it '*is actually associated with homophobia and transphobia, as if our lives are somehow infectious or problematic*' – *see* T-496 lines 12-19.
[403] Evidence of Ms A. Bernasochi, Switchboard, T-497 lines 13-19.

being a family violence, mental health, and suicide prevention helpline that was established following the Royal Commission into Victoria's Mental Health System (**Royal Commission**).[404] Switchboard also designed and maintains the first-ever LGBTIQA+ suicide prevention hub, 'CHARLEE', an online resource containing information and support details for those impacted by suicide.[405]

357. In addition to funding certain of the peer-led suicide prevention initiatives offered by Switchboard to the TGD and LGBTIQA+ communities more broadly, the Department has a number of programs aimed at reducing suicidality in LGBTIQA+ communities, including in response to the Royal Commission, which made recommendations on a number of LGBTIQA+-specific mental health and suicide prevention initiatives, including (but not limited to):

- The new *Victorian suicide prevention and response strategy (2024-2034)* and initial two-year implementation plan (yet to be publicly released at the time of this Finding being delivered), which are being developed in close consultation with whole-of-government partners and the Suicide Prevention and Response Expert Advisory Committee, which includes organisational representatives from Switchboard Victoria and Drummond Street Services, as well as lived and living experience representatives who identify as LGBTIQA+;

- The co-production of an LGBTIQA+-specific aftercare service, which is due for completion in 2024;[406]

- The expansion and enhancement of the Hospital Outreach Post-Suicidal Engagement (**HOPE**) program, through which Switchboard Victoria has been funded to deliver a LGBTIQA+ affirmative practice and suicide prevention training package to HOPE services in 2023-2024 to ensure HOPE staff have the most expansive learning

[404] See evidence of Mr J. Ball, T-381 line 28 to T-382 line 13.
[405] *See in this regard* 'Charlee' (Web Page) <https://www.charlee.org.au/>.
[406] 'Aftercare' referring the care received by people following a suicide attempt, planning and/or intent, in light of the fact that an attempt is known to be the most significant risk factor for further suicidal behaviour and compassionate aftercare can reduce further suicide attempts and suicide deaths) – AM-4.

opportunity to improve their practice supporting LGBTIQA+ people experiencing suicidal distress; and

- As part of the existing Memorandum of Understanding between the Coroners Court and the Department, the Suicide Prevention and Response Office receives notification of suspected suicides among high priority communities, including LGBTIQA+ people, working with Switchboard, the Coroners Court and Standby Support After Suicide to monitor suspected suicides of TGD Victorians, including working to ensure that culturally-appropriate postvention takes place.[407]

Analysis

358. The Department has an increasing number of initiatives aimed at addressing the high rates of suicide in TGD communities, and in the LGBTIQA+ community more broadly. These initiatives are to be commended, and underpinned by the broader work of the Department in endorsing a new requirement for health services to report on 'sex at birth' and 'gender' as part of its annual changes process for key health services data collections, as part of the whole-of-government LGBTIQA+ strategy, 'Pride in our future: Victoria's LGBTIQA+ strategy 2022-32'.[408] Such changes are paving the way for a clearer picture of the health needs and outcomes of the TGD community.

359. I consider that the evidence at Inquest demonstrates the critical importance of ensuring culturally-appropriate suicide prevention and postvention supports are available to the LGBTIQA+ community and in particular, the TGD community, given the high rates of self-harm, suicidality, and completed suicides in these communities. As noted earlier in this Finding, this need was clearly demonstrated in the enormous efforts of Switchboard and other community-based organisations to mobilise following Bridget's death, to provide supports to community members, some of who knew Bridget personally, and some of whom

[407] *See in this regard* the second Statement of Professor Euan Wallace, Secretary of the Department of Health dated 23 November 2023, AM-4.
[408] Correspondence from the Department to the Court dated 5 March 2024, AM-11.

were impacted as members of the TGD and broader LGBTIQA+ community.[409] The postvention supports that were required, and the risk of 'suicide contagion', was experienced in a way that was unique to the LGBTIQA+ community and required a culturally-appropriate response that was swift, tailored, community-specific and peer-led.[410]

360. I also consider that the evidence of 'suicide contagion' received during the coronial investigation demonstrates the importance of culturally-appropriate suicide prevention and postvention supports to the TGD community, and well as the need for early intervention. As detailed elsewhere in the Findings into these deaths, the available evidence indicates that at least three of the deceased persons (Matt, who died on 30 March 2021, AS who died on 9 May 2021, Heather who died two days later on 11 May 2021) knew directly at least one other person in the cluster. Given their means of suicide by way of ingesting sodium nitrite, it is likely that there was some discussion of this method of suicide amongst them (including with a fourth person in NSW, 'E', who died on 23 July 2021 after ingesting sodium nitrate).

361. Further to this point, the media coverage surrounding certain of the deaths, combined with online discussion about and deep concern regarding the deaths within local LGBTIQA+ communities, meant it was possible that some of the deceased persons knew about others' deaths even if they were not personally acquainted, and that these concerns crossed borders into the LGBTIQA+ community in other states and territories. In relation to Bridget going missing and her subsequent death, Mr Ball noted '*I think we still feel it today, that news – her going missing was shared in our major news outlets, this court case… when she was missing it was shared in Star Health, it was shared on Joy FM, it impacted so many people, 6000 plus*'.[411]

362. As I have noted in the Findings into the deaths of Matt, AS, and Heather, these connections - confirmed and possible - between the deceased persons, suggested that 'suicide contagion' played a role in the emergence of the cluster, which has implications for preventing further

[409] The evidence of Ms Bernasochi in this regard was: '*Significantly from a contagion and postvention perspective, the key messaging we sent out was 'You didn't have to know Bridget, you don't have to be immediately, have immediate kinship to be impacted to reach out to support and please do*' – *see* T-498 lines 26-30.
[410] *See generally* the evidence of Mr J. Ball and Ms A. Bernasochi, T-488, line 19 to T-493 line 16.
[411] Evidence of Mr Ball, Switchboard, T-489, lines 14-20.

such suicides occurring in the future, and for the ongoing resourcing of culturally-appropriate postvention supports to TGD people.

363. A pertinent recommendation will follow.

6 – Social and emotional wellbeing supports

364. The sixth item in the scope of inquest is '*[t]he availability of and issues concerning provision of culturally-appropriate social and emotional wellbeing supports to TGD people in Victoria*'.

365. I heard evidence at Inquest that, over and above the barriers in accessing gender-affirming medical care for those who seek it, TGD people may also experience discrimination and poor treatment in accessing mental health and other services that may mean they avoid accessing those services.[412] Mr McMahon noted in this connection that '*poor quality of care is extraordinarily damaging to future help-seeking behaviour, not to mention the existential threat to the lives of trans and gender diverse people*'.[413]

366. Mx Harden confirmed that the difficulties of TGD people in accessing health and other services do not just relate to gender-affirming care but that '*we have difficulty accessing any kind of healthcare or support that affirms our gender*'.[414] In the same vein, Ms Bernasochi gave evidence that '*not everyone who's trans and gender diverse seeks medical affirmation and that if we're actually thinking about preventing suicide it's not just that around the supports for people who are seeking to medically affirm their gender*'.[415]

Barriers for TGD people accessing mainstream mental health and other health services

367. At Inquest, Dr Coventry, Chief Psychiatrist, posited several reasons for TGD people facing such barriers in the context of accessing mental health services, which he noted to include: (i) anticipation of discrimination based on past negative contact; (ii) the desire not to be a

[412] *See in this regard* the evidence of Dr S. Vivienne, Transgender Victoria, T-468, line 27 to T-469, line 3; Mr E. McMahon of Drummond Street Services, T-469 line 9 to T-470 line 14; Dr N. Coventry, Chief Psychiatrist, T-322 line 27 to T-323 line 18; and Commissioner Fernando, T-464 line 1 to T-465 line 18.
[413] Evidence of Mr E. McMahon, Drummond Street Services, T-25-28.
[414] Evidence of Mx Harden, Thorne Harbor Health, T-455 line 24 to T-456 line 7.
[415] Evidence of Ms A. Bernasochi, T-432, lines 6-12.

burden, described by Dr Coventry thusly, '*there's also a sense I think for many people when they're in crisis in mental health that they don't want to be seen as a bulk burden, it becomes their self-narrative that can block them accessing services*'; (iii) a lack of awareness as to the crisis support services that are available before the requirement for an acute in-patient setting; and (iv) geographical barriers for those in rural and regional Victoria.[416]

368. Dr Nguyen noted that a perceived lack of cultural safety can also feed into TGD peoples' experience of accessing mainstream health services, which is likely to occur '*at the point where you're most vulnerable and then to have experience of discrimination, misgendering, having to disclose your gender in public spaces, having intrusive or inappropriate physical examinations, and - so there is likely to be secondary to that an avoidance of services and not feeling safe*'.[417]

369. Dr Nguyen referred to a study from Latrobe University which found that '*the physical and mental health of TGD Australians continues to be poorer than the general population. Accessing healthcare for our participants was highly problematic, with high levels of unmet healthcare needs, discomfort discussing their needs, feeling misunderstood, emergency department avoidance, barriers to care, numerous instances of poor treatment in the healthcare system and hesitancy to disclose their gender'*.[418]

370. Ms Gillespie of Thorne Harbour Health observed, in relation to Natalie's experience (who reportedly expressed that, after a period of time in a youth psychiatric ward in 2004, she had formed the impression that she felt that she had to deny her female gender identity to be able to leave the ward and she developed mistrust of hospitals and psychiatric intervention),[419] the '*the long tail of singular instances of discrimination and invisibility making*'.[420] Dr Kalra acknowledged that there have been historical issues with TGD people accessing mainstream

[416] Evidence of Dr N. Coventry, Chief Psychiatrist, T-322 line 27 to T-323 line 18.
[417] Evidence of Dr. T. Nguyen, RCH Gender Service, T-323 line 23 to T-324 line 8.
[418] *See* evidence of Dr T. Nguyen, T-324, lines 4-8. *See further in this regard* Kerr et. al., 2019, p. 6 . Mx Harden also gave evidence on this point, noting that TGD people often delay accessing healthcare and that '*health conditions that would benefit from early intervention are prolonged and then get to the point where emergency attention is needed*' – *see* T-456 lines 1-7.
[419] Statement of C. Wilson, CB in the matter of Natalie Wilson pp. 16-17; Statement of R. Berthelsen, CB in the matter of Natalie Wilson p. 52.
[420] Evidence of C. Gillespie, Thorne Harbour Health, T-324 line 19 to T-325 line 9.

health services but '*the confidence in [the] trans and gender diverse community in coming out perhaps and seeking help has improved over time.*'[421]

371. However, the Community Panel gave evidence that there remain distinct and current barriers for members of the LGBTIQA+ community accessing mainstream health services. Commissioner Fernando noted that it is little more than four years since the World Health Organization stopped categorising being TGD as a mental health disorder, and opined that:

> '*LGBTQIA+ people have been living in a world where we're taught by many, including those in the professions supposed to help us, to be diseased, to be carriers of those diseases or potential carriers of those diseases but the health practitioners in those services I think we need to recognise were taught by a generation of teachers who were operating at a different standard – or under a different standard of care. But the point I think I'm trying to make is that there is a history because of that curriculum or because of that teaching or way of practice, that many in our communities don't feel that they have trust in services*'.[422]

372. Ms Michelle McNamara of Transgender Victoria emphasised the fatigue experienced by some TGD people associated with '*trans broken arm syndrome*', where a TGD person might, for example, present at an emergency department in a mental health crisis, but have the presenting issue ignored, and instead the focus is on the person being TGD.[423] Mx Harden of Thorne Harbour Health noted a further dimension to this fear on the part of TGD people accessing mainstream health services can also relate to the fear that their hormone medication may be '*stopped or blamed for their mental health*'.[424]

373. Commissioner Fernando noted the importance of CAT teams and other frontline mental health services undergoing proper TGD sensitivity training to ensure that TGD people presenting to health services in mental health crisis can receive culturally sensitive care.[425] He also spoke of the need to ensure current models of mental health and suicide prevention

[421] Evidence of Dr G. Kalra, T-325, lines 13-22.
[422] Evidence of Commissioner Fernando, T-464 line 14 to T-465, line 3.
[423] Evidence of Ms M. McNamara, Transgender Victoria, T-465 line 27 to T-466 line 8.
[424] Evidence of Mx V. Harden, Thorne Harbour Health, T-468 lines 7-12.
[425] Evidence of Commissioner Fernando, T-465 lines 4-18.

care for LGBTIQA+ communities are responsive to community needs, by, for example, embedding peer workers (who are connected with LGBTIQA+-led organisations) within mainstream health services.[426]

374. To this end, as noted in the preceding section, Ms Anna Bernasochi of Switchboard advocated for further cultural safety training of mainstream health practitioners and embedding of peer workers in hospital settings to improve the cultural safety of mainstream health services for LGBTIQA+ persons, using a model of care that aligns with the way in which LGBTIQA+ communities intervene and provide suicide prevention and mental healthcare within LGBTIQA+-specific services.[427]

Examples of the social and emotional wellbeing supports required by the TGD community

Support for families to promote connection with family of origin

375. Evidence was heard at Inquest that providing support for families and parents of TGD people is critical to improving social and emotional wellbeing and reducing suicidality amongst the TGD population, on the basis that a supportive family of origin is considered a protective factor against suicide for TGD people, underscoring the importance of family cohesion.[428]

376. Mr McMahon gave evidence of the programs run by Drummond Street Services to promote the wellbeing of families, including provision of intensive supports to families in which there is Child Protection involvement and one of the family members is LGBTIQA+, as well as 'The Village', a seven-week program supporting parents of TGD children, structured around themes including anxiety, navigating educational settings, family dynamics and relationships.[429] Ms McNamara noted the work of Transcend in working with parents of

[426] Evidence of Commissioner Fernando, T-466 lines 19-24. This was endorsed by Ms A. Bernasochi – *see* T-511, lines 21-29.
[427] Evidence of Ms A. Bernasochi, Switchboard, T-466, line 10 to T-468 line 2 (part of this appears to be misattributed to Commissioner Fernando in the transcript).
[428] *See* evidence of Mr J. Ball, T-452, lines 17-29.
[429] Evidence of Mr E. McMahon, T-450, line 27-T-451, line 25. *See in this regard* 'The Village' *Queerspace* (Web Page) <https://www.queerspace.org.au/our-programs/the-village/>.

TGD young people, as well as the work of Transfamily, which provides peer support to parents, siblings and other loved ones of TGD people.[430]

377. Mx Harden and Mr Ball also noted the need for ongoing support for parents and family members of TGD people who might be otherwise unfamiliar with even the concept of being TGD and who might be struggling to understand this in relation to a child or family member (with Mr Ball noting that for some parents '*the first trans and gender diverse person they ever met was their child*'), opining that support services for families ought also to be accessible and visible, and provided through mainstream services, GP clinics and community health settings.[431]

Supports for older TGD people

378. I heard evidence at Inquest from Mx Harden that a significant stressor for older TGD people is what will happen if they face a condition such as dementia, and the way in which that might impact their gender identity, including whether that gender identity will be denied in an aged care setting.[432] The requirement for the social and emotional wellbeing needs of older TGD people to be catered to was also canvassed by Ms Bernasochi, who referred to Switchboard's 'Out and About' program, where volunteers visit LGBTIQA+ older people who are living in care or on care packages as a means to stay connected and enjoy hobbies,[433] and for which Ms McNamara is a volunteer. She gave evidence of her work with this program and emphasised the need for social and emotional wellbeing supports in the older cohort, noting, '*I see isolated people and I go and visit isolated people and see them at risk of suicide through their ill-health and isolation*'.[434]

[430] Evidence of Ms M. McNamara, Transgender Victoria, T-461 line 10 to T-462 line 1. *See in this regard* 'Transcend' (Web Page) <https://transcend.org.au/> and 'Transfamily' (Web Page) <https://www.transfamily.org.au/>.
[431] Evidence of Mx Harden, Thorne Harbour Health, T-451 line 27 to T-452 line 15 and of Mr J. Ball of Switchboard, T-452 line 17 to T-453 line 24.
[432] Evidence of Mx Harden, Thorne Harbour Health, T-471 line 19 to T-472 line 7.
[433] Evidence of Ms A. Bernasochi, T-432, lines 17-20. *See* 'Out and About' *Switchboard* (Web Page) <https://www.switchboard.org.au/out-and-about>.
[434] Evidence of Ms M. McNamara, T-484 lines 7-11.

Multidisciplinary approach to social and emotional wellbeing supports in TGD communities

379. Dr Vivienne of Transgender Victoria spoke of the role of peer navigation as a means of promoting social and emotional wellbeing in TGD people accessing health services and social and emotional wellbeing supports, by facilitating '*the connection between care domains that are otherwise quite siloed*', for example, providing a peer support service to '*join the dots*' between a gender clinic and an eating disorder clinic.[435] Mx Harden of Thorne Harbour Health also noted that the care provided at Equinox is multidisciplinary in nature and that existing patients can and are connected to external counselling services (though the reverse route, from those counselling services back to Equinox, will entail traversing the already-described issues with the Equinox waitlist).[436]

Other factors related to the social and emotional wellbeing of the TGD population

380. Evidence was heard at Inquest that certain of the social and emotional wellbeing supports for the LGBTIQA+ community are not necessarily offered through services alone but through connection and participation in the broader community.

381. Mr Ball of Switchboard gave evidence that, in LGBTIQA+ communities, there are three commonly-accepted factors that protect against suicide: (i) a supportive family of origin; (ii) having a concept and vision of one's future; and (iii) connection to community in the broader sense (that is, not just connection with the LGBTIQA+ community but being able to access opportunities in the community at large, such as sports, faith-based activities, and other spaces, without discrimination).[437] Indeed, Ms Lane gave evidence of the joy and connection she experiences in attending ballet,[438] and Ms McNamara gave evidence of the fulfilment she receives through singing in a TGD-specific choir and Buddhist women's study group.[439]

[435] Evidence of Dr S. Vivienne, T-472, lines 14-26.
[436] Evidence of Mx Harden, T-475 lines 5-17.
[437] Evidence of Mr J. Ball, T-440, line 23 to T-441-T-442, line 9.
[438] Evidence of Ms E. Lane, T-29 lines 10-15.
[439] Evidence of Ms M. McNamara, T-444, lines 2-14.

Commissioner Fernando noted the importance for Aboriginal people in the LGBTIQA+ community to be connected to Country as a key factor in reducing social exclusion.[440]

Analysis

Improved access to mental and other healthcare services for TGD Victorians

382. I consider that the risks to the wellbeing of TGD patients from long waitlists for gender-affirming care, high costs, and ongoing workforce issues are compounded by the fact that mainstream health and mental health services may not be genuinely accessible or culturally safe for many in the TGD community. The Inquest heard evidence that TGD people face barriers in attending emergency departments when suicidal, due to fear of ridicule, discrimination or rejection, or based on a past experience of discrimination (as exemplified by Bridget avoiding an admission through the public mental health system in favour of a private mental health admission). The wellbeing of TGD people is thus placed at further risk by a public health system that at times, struggles to be responsive to the basic needs of some of its most vulnerable community members.

383. I consider that the evidence at Inquest has established a clear need to devise and implement a statewide framework for the provision of culturally-appropriate care to TGD people in public hospitals and health services, including in rural and regional Victoria, with additional training to support staff in delivering culturally-appropriate care to TGD persons. This will ensure that a cohort that has a higher risk of mental ill health, distress, and suicidality will have greater degree of safety in accessing mainstream services, including in crisis. This work will build upon the existing commendable efforts of the Department of Health to make mainstream health services more culturally-safe for TGD people including, since July 2024, collecting data that can accommodate where one's identified gender differs from birth sex, with concomitant guidance for health practitioners collecting this data.

384. A pertinent recommendation will follow.

[440] Evidence of Commissioner Fernando, T-444, line 16 to T-445, line 9. I note that Commissioner Fernando identifies as a queer cisgendered Wiradjuri man, descended from the Kalari Peoples.

Improved access to other culturally-appropriate social and emotional wellbeing supports

385. I consider that the evidence at Inquest demonstrated there is a need to ensure provision of culturally-appropriate supports for TGD people and their families as a means to reduce social isolation, improve connectedness and address wellbeing in the context of the community's high rates of suicide, distress and mental ill health.

386. As noted earlier in this Finding, I received evidence during this investigation that AS and Matt lived isolated lives, often confining themselves to their bedrooms, with both reluctant to reach out to services for counselling and other wellbeing supports in the lead-up to their deaths.

387. Evidence at Inquest demonstrated that social and emotional wellbeing supports are required not just for TGD people but also for their loved ones. The need for support services for family of origin was demonstrated by the eloquent evidence at Inquest of Angela, Bridget's sister, who noted that, in order to support Bridget in the process of affirming her gender (which she came to support, having found the process confronting at first), she tried to find a means to educate herself about the journey her sister was on, including via Google searches. At that stage she was unaware of the support services that existed and ultimately never received any support for her own role as a family member of a TGD person on an affirmation pathway.[441]

388. Finally, I note that, at present, the provision of social and emotional wellbeing supports to the TGD community occurs through a number of community-controlled and government-funded services and covers a wide range of potential initiatives (some of which overlap with the suicide prevention initiatives outlined in the previous section), and which have different focuses and aims. One example is the 'Trans and Gender Diverse Peer Support Program'

[441] Evidence of A. Pucci-Love, T-55, line 15 to T-57 line 4. While not evidence, I note for completeness in this connection the coronial impact statement (**CIS**) of Rachel Byrne, Matt's mother, included this observation in relation to Matt's gender affirmation process, of which she was supportive but throughout which Matt was reluctant to allow her parents to use 'she/her' pronouns: '*Classed as an adult, there was no support around having these conversations with parents which I believe is a missed opportunity for any family with a loved one undergoing the transition process*'. *See* CIS of Rachel Byrne, p. 8, Court File.

funded by the Department of the Health and delivered by Transgender Victoria, and through which various social and emotional wellbeing are delivered.[442]

389. Transgender Victoria made submissions at Inquest that, in consultation with TGD people, a framework should be developed at state and federal level promoting access to professional social support services for TGD people. At Inquest, Ms McNamara noted the importance of programs to address social inclusion of TGD people as a means to promote social and emotional wellbeing. She referred to promoting inclusion of TGD people in '*both their own communities, the LGBTIQA+ communities, but broadly their faith communities and other parts of their lives which intersect with their identities*', with the need for a comprehensive framework underpinning the same.[443]

390. As with all scope items, this raises the issue of improving data in relation to the number of TGD people in Victoria and recognising TGD status on data collection systems. As Dr Vivienne opined, '*at every step along the way, if there's no scope to be seen, then there's no scope to be cared for*'.[444] This was also noted by Commissioner Fernando, who stated that '*governments cannot resource what [they don't] know about communities*'.[445]

391. A pertinent recommendation will follow.

7 – Prevention opportunities

392. The seventh item in the scope of inquest is *'[p]revention opportunities flowing from the above'.*

393. The majority of prevention opportunities flowing from these proceedings have been canvassed and outlined throughout this Finding. However, there is a discrete set of issues related to the systems and practices of the Coroners Court that were raised prior to and during Inquest that I will detail in this section. As Counsel Assisting noted at the first Directions

[442] *See in this regard* the second Statement of Professor Euan Wallace, Secretary of the Department of Health dated 23 November 2023, AM-4.
[443] Evidence of Ms M. McNamara, T-448, lines 21-28.
[444] Evidence of Dr S. Vivienne, T-486, lines 3-4.
[445] Evidence of Commissioner Fernando, T-401 lines 3-4.

Hearing for this Inquest, '*the Court will not shy away from reflecting on areas for its own improvement as a critical part of these proceedings*'.[446]

Improved data collection to assist in identification of suicides in the TGD community

394. One of the resounding themes of the Inquest was the need for improved data collection in relation to: (i) the number of people who make up the TGD community itself; (ii) the systems that exist across government entities and their capacity to capture all gender identities; and (iii) the ways in which to capture better data on the incidence of TGD suicide. The Coroners Court has an important role in (ii) and (iii).

395. In May 2024, the Coroners Court implemented key changes to its internal database to give it the functionality to capture additional data, including 'preferred name', 'sex at birth' and 'gender' (the record of 'gender' being independent to that of 'sex at birth'). Following a co-design process, these reforms will align with the new database being designed for the Victorian Institute of Forensic Medicine, which will be used by staff at Coronial Admissions and Enquiries who take reports of deaths on behalf of the Coroner. Accordingly, the Court's systems are now well-placed to capture accurate data on the gender identities of those whose deaths reported to the Coroner.

396. Given that the initial report of a death is often actioned by police members, it is important that changes are made to Victoria Police systems and forms, including the Form 83 Report of Death for the Coroner, so that details such as preferred name and gender can be captured as early as possible in the coronial investigation.[447] However, the updates to the Court's internal database mean that it is capable of recording such details at *any point* of a coronial investigation. This means that, regardless of whether preferred names and gender are identified in a Form 83, Coroners and their staff will be able to record these details later in an investigation where applicable.

[446] Transcript of Directions Hearing on 13 October 2023, T-21, lines 27-29.
[447] The Coroners Court will receive a 'Form 83 – Report of death for the Coroner' for the vast majority of deaths even where these are reported by other persons, such as medical practitioners.

The role of the Court in postvention responses following the suicide of a TGD person

397. As noted in this Finding, as part of the existing Memorandum of Understanding between the Coroners Court and Department of Health, the Department's Suicide Prevention and Response Office receives notification of suspected suicides among high priority communities, including LGBTIQA+ people. The Department works with the Court to monitor suspected suicides of TGD Victorians, including working to ensure that culturally-appropriate postvention takes place.[448] This is done in conjunction with community-controlled organisations such as Switchboard.

398. It is recognised that these alerts, as they currently operate, may not be maximising opportunities for effective postvention. One issue the Court encounters, is that coroners do not always know about a deceased person's LGBTIQA+ identity (or if applicable, TGD identity) when a suspected suicide is reported.[449] Another issue is that sharing information about deaths under investigation involves a balancing of complex, sometimes competing considerations: for example, the deceased person and their loved ones' right to privacy, versus the prevention imperative of identifying peers so they can be supported.

399. There are often further issues at a very early stage of an investigation in which an understanding of the deceased's intent upon initial report of a death is based on only limited information and is subject to revision as the coroner's investigation develops. All of these

[448] *See in this regard* the second Statement of Professor Euan Wallace, Secretary of the Department of Health dated 23 November 2023, AM-4.

[449] The reasons for this are explained in detail in Coroners Court of Victoria, *Suicide among LGBTIQ+ people*, published 14 October 2022, and include that: (i) witnesses may not wish to disclose information to police members and the Court about the deceased's LGBTIQA+ identity, to protect the privacy of the deceased, especially for people who may be newly identifying as LGBTIQA+ or may not be 'out' to their families or work colleagues; (ii) family members and other witnesses with whom the coroner's investigator engages, may not be aware or accepting of the deceased's LGBTIQA+ identity, and therefore this information is not provided in their witness statements; (iii) police members writing reports for the coroner may omit information on the deceased's LGBTIQA+ identity because they deem it not to be relevant; or may use broad terms and vague language which does not explicitly communicate the deceased's LGBTIQA+ identity; (iv) consulting stakeholders have informed the Court that communicating with police and coroners following a suicide can be a deeply traumatic process due to negative historical interactions with police. This might be a reason why the deceased's LGBTIQA+ identity might not be disclosed to police; (v) when police attend the scene of a death to be reported to the Court, they are required to fill out a form titled Initial Report of Death to the Coroner. This initial report of death does not prompt the police member to ask any questions about the deceased's gender and sexual identity; and (vi) there can be inconsistencies and ambiguities in the coronial material regarding the deceased person's gender and sexual identity. Additionally, gender and sexual identity themselves are complex and deeply personal, such that the deceased's loved ones may struggle to express these in communications with police.

factors make information-sharing a complex (at times, fraught) exercise. The Court is very open to dialogue on these issues, including the ways in which it can best support suicide postvention efforts to reduce the likelihood that suicide contagion may occur.

Issues associated with the 'senior next of kin' hierarchy under section 3 of the Coroners Act 2008

400. I heard evidence at Inquest that the Court's 'senior next of kin' hierarchy can raise complexities for the loved ones of a deceased where the deceased is a member of the LGBTIQA+ community. The 'senior next of kin' is defined in section 3 of the Act, which sets out a 'cascading hierarchy', or an 'order of priority' of persons, the first of whom will have certain rights and responsibilities in the coronial process (such as being able to make an objection to an autopsy direction, or apply for release of the deceased's body).[450] The Supreme Court has confirmed that there is no residual discretion for the Coroner to appoint someone as senior next of kin who is *lower* in the hierarchy,[451] nor, in the context of a dispute between biological family members and 'chosen family' for release of a body under section 48(3) of the Act, to *dispense with* this hierarchy.[452]

401. Angela, Bridget's sister, noted at Inquest that the 'senior next of kin' hierarchy raised significant issues for her family following Bridget's death. She gave evidence that Bridget's father was her 'senior next of kin' under the Coroners Act (a 'parent' coming before a 'sibling' under the hierarchy in the Act). However, Bridget's father did not accept Bridget's gender identity and Angela reported difficulties in the course of the death investigation process in ensuring it proceeded in accordance with Bridget's affirmed identity, noting that '*I, in the background, have had … a lot of stress to try and make sure that what I thought*

[450] For definition of 'senior next of kin', *see* 3(1), 3(2) and 3(3) of the Act, providing for the 'senior next of kin' to be a spouse or domestic partner, or if none available, a son or daughter of or over the age of 18 years, or if none available, a parent, or if none available, a sibling of or over the age of 18 years, or if none available, a person named in the will as an executor, or if none available, a person who, immediately before the death, was a personal representative of the deceased person, or if none available, a person determined to be the 'senior next of kin' by a Coroner because of the closeness of the person's relationship with the deceased person immediately before the death. For the right to object to autopsy, *see* section 26(2) of the Act; for release of body, *see* section 48 of the Act.

[451] *Trinh v Coroners Court of Victoria* [2019] VSC 133, [5]; *Lawrence v Coroners Court of Victoria* [2013] VSC 77, [15].

[452] In commenting upon the 'mandatory hierarchy' imposed by section 48(3) of the Act (within which the 'senior next of kin' hierarchy is replicated by virtue of section 48(3)(b) of the Act), her Honour Justice Forbes in *Vallianos v Coroners Court (Vic)* (2023) 69 VR 276 noted at [87] that this '*may not assist those who are estranged from some or all of their family and who develop other close relationships in its place. I accept that the hierarchy may well be based upon assumptions that are less likely to hold true for groups including those who identify as LGBTQI*'.

was respectful to Bridget as a transgender woman happened and I had to fight our father for that on her behalf'.[453] Angela noted that LGBTIQA+ people may be estranged from their biological family and '*more likely to have chosen family',* and '*if there's any way of taking that into consideration it would again vastly improve an already really stressful situation*' when someone dies in reportable circumstances.[454]

402. This may have particular resonance where those to whom the deceased's body is released will be making funeral arrangements, as is usually the case. Commissioner Fernando noted that '*the former Commissioner [for LGBTIQA+ Communities] recalls going to funerals of young LGBTI people and families didn't know that they were queer or trans or gender diverse.*'[455] contributing to a further lack of visibility of members of this cohort.

403. I consider that the evidence at Inquest established that the 'senior next of kin' hierarchy under section 3(1) of the Act may create hurdles and undue distress for the loved ones of LGBTIQA+ Victorians who die in reportable circumstances. A pertinent recommendation will follow.

Other ways in which the Court has improved its approach to cultural safety and inclusivity

404. Finally, it is relevant to recall that the Coroners Court, over the past year, has taken a series of steps to enhance its approach to cultural safety for a number of groups in the community, including Aboriginal and Torres Strait Islander people, multifaith and multicultural groups, and members of the LGBTIQA+ community, in order to create a sense of cultural safety for court users from a range of backgrounds. To enhance cultural safety for investigations involving LGBTIQA+ deceased and their loved ones, the Court has:

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[453] *See* evidence of A. Pucci-Love, T-83 line 27 to T-84 line 5. Angela also noted that the issue as that her father, as senior next of kin, was '*the ultimate decision maker and gatekeeper in whatever happened and so he'd get information first and even when it was about deciding where the body went once it left the Coroners Court, I had quite strong views based on my relationship with Bridget of what should happen with her and it was only through wearing him down that I got to make those decisions 'cause he would have made vastly different decisions. He did not refer to her by her lived name and the idea of him dealing with that process with anything else I found heartbreaking. … she left a note and in her note she made it very clear who she was in her note and to not have that reflected just would have broken my heart.*' – *see* T-91 line 19 to T-92 line 7.
[454] Evidence of A. Pucci-Love, T-84 lines 11-14.
[455] Evidence of Commissioner Fernando, T-416, lines 23-25.

- Offered workshops to coroners and staff on Trans and Gender Diverse Awareness, to enhance cultural safety and promote awareness of the particular issues faced by the TGD community;
- Circulated for whole-of-Court use the 'Inclusive Language and Communication Guide', released by Court Services Victoria in May 2024; and
- Placed the details of 'Rainbow Door', the free specialist LGBTIQA+ helpline providing information, support, and referral to all LGBTIQA+ Victorians (run by Switchboard), on the Support Services page on the Coroners Court website.[456]

405. Finally, the State Coroner has sought to enhance the cultural safety and respect for participants within Court proceedings across a number of priority groups through issuing, under section 107 of the Act, '*Practice Note 1 of 2024 - Pronunciation of Names and Forms of Address in Coronial Proceedings*' to (i) provide guidance on expectations for the correct pronunciation of names and forms of address in coronial proceedings; and (ii) facilitate a simple process by which families, interested parties and legal representatives can provide, and the Court can seek, clarification on correct pronunciation of names and appropriate forms of address (including pronouns and honorifics).[457]

Analysis

406. It is crucial that the Coroners Court processes accord cultural safety, visibility, dignity and respect to all deceased persons and their loved ones. This is not only required as a function of section 8 of the Act but also, as this Inquest has demonstrated, it is a critical pillar in the Court's prevention function.

407. We cannot comprehensively identify appropriate initiatives aimed at reducing preventable deaths in the TGD community if we do not have the systems visibility to capture the identities of those whose deaths we are investigating. Therefore, improvements to the

[456] *See in this regard* 'Grief & bereavement counselling & support services' *Coroners Court of Victoria* (Web Page) <https://www.coronerscourt.vic.gov.au/families/supports-and-resources/services/grief-bereavement-counselling-support-services> and Proposed Recommendations of the Commissioner for LGBTIQA+ Communities, p. 2, Court File.
[457] *See* 'Practice Note 1 of 2024 – Pronunciation of Names and Forms of Address in Coronial Proceedings', issued on 17 June 2024 by his Honour State Coroner Judge John Cain.

Court's processes, when occurring in concert with other entities such as Victoria Police, will allow for greater visibility of preventable deaths in the TGD community and more targeted strategies to reduce them.

408. This Inquest has represented a concrete opportunity to assess, from the perspective of those in the TGD community, the degree of accessibility and cultural safety of Coroners Court processes and investigations, including identifying areas in which improvements are still required. Some areas include continuing staff education, accessible infrastructure (such as all-gender toilets) and broader facilitation of the use of pronouns and inclusive language in the courtroom. The ability to participate safely and comfortably in coronial proceedings that impact those in TGD communities is critical to the strategies advanced under the Court's prevention mandate, which must be informed, shaped and advanced by lived experience.

409. A pertinent recommendation will follow.

FINDINGS AND CONCLUSION

410. Having investigated the death of Bridget Erin Flack, and having held an Inquest in relation to Bridget Erin Flack's death from 27-29 November 2023 (inclusive) and 21 February 2024 at the Coroners Court of Victoria at Melbourne, I make the following findings, pursuant to section 67(1) of the Coroners Act:

    (a) that the identity of the deceased was Bridget Erin Flack, born 18 August 1992;

    (b) that Bridget Erin Flack died at the Kew Billabong, Kew, at some time between 30 November 2020 and 11 December 2020 from 1 (a) compression of the neck and 1 (b) hanging;

    (c) in the circumstances described above.

Adequacy of mental health services engaged by Bridget in lead-up to her passing

411. The available evidence suggests that various mental health treatment options were available to Bridget in the lead-up to her passing, including inpatient public mental health services. Bridget had an extensive knowledge of how and when to access public mental health services

and crisis services. When Bridget did access public mental health services, she did not want a voluntary admission to an acute inpatient unit and did not meet the requirements for compulsory treatment under the *Mental Health Act 2014* (Vic) (as then applied). Bridget told Inner West Area Mental Health Service (**IWAMHS**) she was to be admitted to Delmont Private Hospital (**Delmont**) and there is no evidence to suggest IWAMHS were made aware that the planned admission did not progress.

412. It appeared that Bridget not having appropriate private health insurance was a primary factor in her requests for a private mental health admission not being accepted. The Coroners Prevention Unit advises, and I accept, that this is not unreasonable, as private psychiatrists are not obliged to accept referrals, and self-funded admissions can be problematic as they are expensive, can cause financial distress, can affect the therapeutic relationship and can result in unexpected costs if the patient does not progress as planned, including requiring a longer admission or being discharged early due to financial stressors rather than clinical appropriateness.

413. I note further that when the declined admission to Delmont was communicated to Bridget by Bed Brokers on 30 November 2020, an appropriate plan was made for an out-patient referral via her GP.

414. However, no contact was initiated with Bridget in the interim regarding her initially-planned admission to Delmont, which she believed was to commence either 27 or 28 November, until after these dates had passed. In a context in which Bridget was actively help-seeking and was in contact with IWAMHS exploring other avenues for mental health support that she de-prioritised in favour of the Delmont admission, I considered this lack of communication represented a lost opportunity for Bridget to have been accurately informed in a timely manner of the options that were available to her in seeking help for her declining mental health.

415. Delmont has submitted to the Court that intake coordinators do not specify dates for admission on acceptance of referrals, as admissions are subject to doctor availability, bed availability and financial means to cover the admission. Delmont's usual process is to advise a potential patient to call back over the next 48 hours unless their clinical presentation has

changed, and to contact the Crisis Assessment and Treatment Team (**CATT**) or the emergency department if needed. It is unclear, on the basis of the evidence provided to the Court, whether this or a different process was followed in relation to Bridget.

416. I find that appropriate support was provided to Bridget in the lead-up to her death by her general practitioners, counsellor, Queerspace (which is part of Drummond Street Services) and IWAMHS. I find in particular that the assessment and support provided by IWAMHS, including the plan devised with Bridget, which was to engage with Bridget, at her request, after her expected private hospital admission ended, was evidence-based, comprehensive, and included shared decision-making with Bridget.

417. Despite this, Bridget faced barriers in accessing the specific care she needed, including due to: (i) her own reluctance to engage in public mental health system due to previous reported negative experiences, with a preference for an admission to a private facility, which proved difficult due to Bridget's lack of appropriate health insurance; (ii) the fact that she was not considered to meet the criteria under the *Mental Health Act 2014* (as then applied) but was still experiencing a high degree of mental distress that she was trying to address through an inpatient admission; (iii) in the view of Angela and Mx Leigh, Bridget may have presented as 'too "together"' when trying to access support, meaning that the services that Bridget was engaging did not have an appreciation of her actual risk of suicidality in the weeks leading up to her disappearance;[458] and (iv) at times Bridget demonstrated a preference to access mental health support via trans or gender diverse mental health practitioners, which often entailed an extensive waitlist.[459]

418. In this connection, Angela reported that '*Bridget didn't feel safe accessing help in certain places for fear of retribution for being a transgender woman*'.[460] Therefore, while I consider on the whole that the mental health treatment offered and provided to Bridget in the lead-up to her passing was appropriate, I consider this brings into sharp relief the importance of

[458] *See for example* statement of H. Leigh, CB p. 46; A. Pucci-Love, CB, pp. 67-68; Evidence of A. Pucci-Love, T-70 line 24 – T-71 line 10. Mx Leigh observed that Bridget '*sounded to me too calm and considered when on the phone to them*'.
[459] *See for example* statement of K. Field, CB, p. 78.
[460] Statement of A. Pucci-Love, CB, p. 69.

public and other mental health services being responsive to the needs of trans and gender diverse patients, which I have addressed earlier in this finding.

Determination as to intent

419. Having considered all of the circumstances of Bridget's passing, including the lethality of the means chosen, I am satisfied that Bridget intentionally ended her own life in the context of multiple stressors and longstanding mental health issues, which further deteriorated in the period prior to her death.

420. While I cannot identify any particular stressor or stressors that led to her decision to take her life, it is apparent on the evidence before me that she had recently experienced a relationship breakdown, had increased her use of alcohol, and had experienced a significant decline in her mental health, which necessitated a period of leave from work. Bridget also reported increasing isolation in the face of COVID-19 pandemic lockdown, which had precluded her from moving to the United Kingdom in late 2020 as she had planned to do.

421. As a result of this constellation of factors, I find that Bridget was facing increased suicidal ideation, though her level of suicide risk fluctuated in the days leading up to her passing. I find that Bridget was actively help-seeking and well-supported by her loved ones, including Angela and Mx Leigh, who provided a high level of emotional, financial, and practical support to Bridget as her mental health deteriorated.

422. While the uncertainty regarding her proposed in-patient admission to Delmont added to Bridget's distress and uncertainty, I consider that the evidence demonstrates Bridget was aware of the ways in which she could access mental health assistance (including crisis services) and I cannot say with any certitude that the lack of communication about this admission contributed to her decision to take her life.

423. I find that Bridget had reported her increased reliance on alcohol since the breakdown of her relationship and that she was more likely to experience suicidal thinking when using alcohol. Post-mortem toxicology supports she had been using alcohol proximate to her death.

424. Further, I note that Bridget was using her newly prescribed anti-depressant prior to death, which was also apparent upon examination of the toxicological results. She was also prescribed diazepam for use on a daily basis and had changed medications as part of her gender-affirming hormone therapy in the months prior to death. While these medications may have negative side effects in some individuals (including an increased risk of suicide), there is an insufficient cogency of evidence to make any finding as to whether, or how, the use of these prescribed medications may have affected her state of mind. Bridget's decision to take her life was preceded by a long history of mental ill health and a number of stressors.

425. I am satisfied that Bridget took her own life sometime between 30 November 2020, when she was last seen alive, and 11 December 2020, when her body was found.[461] Specifically, I am satisfied on the balance of probabilities, having considered all the available evidence, including as related to her phone activity, that she took her own life shortly after her last known contact, which was at approximately 2pm on 30 November 2020.

Victoria Police missing persons investigation

426. I find that there was a failure to appropriately identify and record the risks posed to Bridget in the initial Missing Person Report filed on 1 December 2020 that infected the time-critical steps in the investigation that were subsequently open to be taken by police.

427. I find that the decision not to approve triangulation of Bridget's phone until it was too late to obtain any data from it, to be a significant lost opportunity to locate Bridget with precision and in a timely manner.

428. For completeness, I consider the decision to decline authorisation of the first triangulation request was not causal or contributory in any way to Bridget's death. The evidence before me is that Bridget appears to have taken her own life soon after she went missing, noting

[461] I note that the mechanism of death was hanging. Hanging is a form of asphyxia due to compression of the neck structures by a ligature tightened by the weight of the body, as was the case for Bridget. Death may be due to reflex cardiac arrest, occlusion of the blood vessels in the neck or airway obstruction. In cases of hanging, unconsciousness can occur very rapidly, and death follows shortly thereafter.

that her last outgoing phone activity was at 11:04am on 30 November 2020 and last Facebook messages were sent to Mx Leigh at 1:46pm that same day.

429. I find, however, that the decision not to authorise triangulation of her phone on the first request led to the physical search for Bridget being based on the much-less reliable data provided by the last 'pinged' location of her mobile phone, which dramatically increased the geographic area in which she could be located, and which led to a significant delay in her body being found. This led to considerable distress for Bridget's sister and for Mx Leigh. It also led to significant disquiet, fear, and outrage in the LGBTIQA+ community.

430. I find that the decision to transfer the missing persons investigation to the Melbourne Crime Investigation Unit on 4 December 2020, due to the uniform branch not having sufficient resources or expertise to conduct the intensive investigation required, was appropriate. The evidence pointed to significantly increased investigative efforts being deployed by Victoria Police once DSC Garside took carriage of the investigation of 4 December 2020, consistent with the greater capacity of the CIU.

431. I find, however, that the broader Victoria Police approach to the search for Bridget had concerning gaps. No ground searches were conducted for Bridget in the last 'pinged' location by Victoria Police members acting in their professional capacity. This task was undertaken by members of the LGBTIQA+ community who mobilised and coordinated their search activity through social media.

432. Police did not attend or support the searches of community members looking for Bridget, though they had knowledge that these searches were occurring through monitoring of the Facebook group, which had 6000+ members, and police had provided information about Bridget's last known approximate location with the knowledge it would be passed on to community members who were searching for her.

433. By Victoria Police failing to engage with community members in search activity they knew was being carried out, I find that they failed to consider the safety and wellbeing of the community members searching for Bridget, many of whom were LGBTIQA+. More

specifically, police left a vulnerable community to search for one of their own, in the knowledge that Bridget might be found deceased.

434. I find that the issues in the Victoria Police missing persons investigation for Bridget, that have been identified in hindsight, prevailed at an organisational rather than at an individual level. I do not make any adverse findings against the individual police members involved in the investigation.

435. I find the actions of DSC Garside in the missing persons investigation relating to Bridget were dedicated, compassionate, and culturally-sensitive. However, he had assumed carriage of an investigation that was already compromised given the lack of triangulation data and lack of comprehensive risk assessment conducted in the earliest days of the investigation.

436. To this end, I consider that individual police members were not adequately supported by Victoria Police with readily-accessible guidance as to the time-critical steps they were required to take. I consider that a consolidation of the current patchwork of guidance is urgently required to allow police to do their job and appropriately address the risks posed to the many Victorians who go missing every day, along with training that is specific to increase cultural competence with the LGBTIQA+, and more specifically, TGD, communities.

437. I find that, while there were serious deficiencies in the Victoria Police missing persons investigation for Bridget, there is no evidence that the investigation was not taken seriously because she was transgender. Rather, I find police failed to appreciate the actual risk of suicide that Bridget presented, in relation to which they had information from Mx Leigh, and were at the same time unaware or did not consider the heightened risk of suicidality that she posed as a member of the TGD community. The deficiencies in the investigation emanated, in part, from this failure.

438. The implementation of the OSCIR recommendations is of critical importance to the LGBTIQA+ community, and in particular to the TGD community, to promote cultural safety in interactions with police through, at a minimum, implementing the lessons learned from Bridget's missing persons investigation in a timely manner.

439. I find that, while Victoria Police have made commendable improvements in recent years in their interactions with the LGBTIQA+ community, it must acknowledged that the task of building trust with the community is an ongoing one. Real change, such as committing to and taking the lead on capturing additional gender identities in police systems and implementing OSCIR recommendations after having commissioned such a robust internal review, should be prioritised.

Mental ill health and suicidality in the trans and gender diverse community

440. The expert evidence at Inquest demonstrated that those in the TGD community face disproportionate rates of distress, mental ill health, and suicidality compared to the population as a whole. The reasons for this are multifactorial, intersecting, and are frequently linked to extrinsic factors associated with the broader community's responses to TGD people, which can include discrimination, violence and exclusion, that erode the TGD community's wellbeing and can contribute to mental ill health and suicidality.

441. There is nothing inherent in being TGD that comprises or causes mental ill health or suicidality.

442. While noting that there is clear evidence of disproportionate mental ill health, distress, and suicidality amongst the TGD population, the data on this issue is widely considered to be incomplete, including in relation to the incidence of completed suicides. Robust data (including population level data on the number of TGD people in Victoria) is needed as a matter of priority to inform health, wellbeing, and suicide prevention initiatives in the TGD community.

Provision of culturally-appropriate gender-affirming care

443. The expert evidence at Inquest demonstrated that significant barriers still exist for TGD people affirming their identities, particularly via a medical pathway, including due to issues of cost, access and long waitlists in the face of increasing demand for access to gender-affirming care.

444. Given the evidence I heard that delayed or denied access to treatment among trans people pursuing medical transition was linked to a greater likelihood of suicidality compared to those whose treatment was timely and comprehensive, I consider these ongoing barriers to gender-affirming care to raise serious and unacceptable concerns in relation to the health and wellbeing of TGD Victorians.

445. I find there is a clear need for improved access to gender-affirming healthcare, including gender-affirming medical care, to TGD people in the state of Victoria.

Provision of suicide prevention and postvention supports

446. The expert evidence at Inquest demonstrated the critical importance of ensuring culturally-appropriate suicide prevention and postvention supports are available to the LGBTIQA+ community and in particular, the TGD community, given the high rates of self-harm and suicidality in these communities.

447. I find this to be particularly critical given the impacts of suicide contagion on and in TGD communities. Suicide contagion was a factor in at least three out of five suicides in the present cluster proceedings.

Provision of social and emotional wellbeing supports

448. I find that the risks to the wellbeing of TGD patients from long waitlists for gender-affirming care, high costs, and ongoing workforce issues are compounded by the fact that mainstream health services are often not genuinely accessible or culturally safe for many in the TGD community.

449. I find that the evidence at Inquest has established a clear need to devise and implement a statewide framework for the provision of culturally-appropriate care to TGD people in public hospitals and health services, including in rural and regional Victoria, with additional training to support staff in delivering culturally-appropriate care to TGD persons. This is critical to ensuring that mainstream services are genuinely accessible for TGD people, including those presenting in crisis.

450. I find there is also a need to ensure provision of culturally-appropriate supports for TGD people and their families as a means to reduce social isolation, improve connectedness and address wellbeing in the context of the community's high rates of suicide, distress and mental ill health.

Further prevention opportunities

451. It is crucial that the Coroners Court processes accord cultural safety, visibility, dignity and respect to all deceased persons and their loved ones. This is not only required as a function of section 8 of the Act but also, as this Inquest has demonstrated, it is a critical pillar in the Court's prevention function.

452. Improvements to the Court's processes, when occurring in concert with other entities such as Victoria Police, will allow for greater visibility of preventable deaths in the TGD community and more targeted strategies to reduce them.

COMMENTS

I make the following comment(s) connected with the deaths under section 67(3) of the Act:

1. Access to healthcare is a fundamental human right. Under article 12 of the International Covenant on Economic, Social and Cultural Rights (**ICESCR**), which Australia ratified in 1975 (and thus has undertaken to be bound by its terms under international law), everyone has the right to the enjoyment of the highest attainable standard of physical and mental health.[462]

2. In 2000, the United Nations Committee on Economic, Social and Cultural Rights issued General Comment 14, stating that the right to health '*must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health*', which should be accessible '*without*

[462] *See* International Covenant on Economic, Social and Cultural Rights, opened for signature 16 December 1966, 993 UNTS 3 (entered int force 3 January 1976) art 12(1). Accessible at <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights>. *See generally in this regard* Ronli Sifris and Paula Gerber 'Sexual and Reproductive Health Care For Trans and Gender Diverse People: Imagining a Human Rights Based Approach' (2013) 48(3) *Alternative Law Journal* 159-165. (**Sifris and Gerber 2023**). DOI: https://doi.org/10.1177/1037969X231188066.

discrimination'. Paragraph 43(a) then sets out a core obligation of non-discrimination on the part of States Parties (including Australia) to ensure '*the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups*'.[463]

3. While Australia has not incorporated the ICESCR into domestic law, and the Victorian *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**the Charter**) does not explicitly include a right to healthcare, the *Equal Opportunity Act 2010* (Vic) precludes discrimination on the basis of certain attributes (including gender identity) in the provision of services (including health services), and contains a positive duty to eliminate discrimination.[464] There exists, therefore, a duty on the part of health service providers to prevent discrimination from occurring in the provision of those services.

4. Further, a human-rights based approach to healthcare for the TGD community requires '*availability, accessibility, acceptability, participation, non-discrimination, transparency and accountability*'.[465] The rights to autonomy and equality are thus engaged in provision of healthcare, which necessitates consideration of what may constitute 'substantive' over mere 'formal' equality. Substantive equality is '*premised on the basis that rights, entitlements, opportunities and access are not equally distributed throughout society and that a one size fits all approach will not achieve equality*'.[466]

5. In this connection, in its General Comment on article 18 of the *International Covenant on Civil and Political Rights* (**ICCPR**) (which enshrines the principle of non-discrimination and upon which the right to equality in section 8 of the Charter is based),[467] the Human Rights Committee stated that *'[t]he enjoyment of rights and freedoms on an equal footing,*

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[463] *See* Committee on Economic, Social and Cultural Rights, *General Comment No 14 (2000): The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN ESCOR, 22nd sess, Agenda Item 3, UN Doc E/C.12/2000/4 (11 August 2000) [9], [12b] and [43a]. Accessible at: <https://www.refworld.org/legal/general/cescr/2000/en/36991>.
[464] *See in this regard Equal Opportunity Act 2010* (Vic) s 6(d), Part 3.
[465] Sifris and Gerber 2023 p. 161, referring to Sofia Gruskin, Dina Bogechi, Laura Ferguson '"Rights-based approaches" to health policies and programs: articulations, ambiguities, and assessment' (2010) 31(2) *Journal of Public Health Policy* 124-145. DOI: 10.1057/jphp.2010.7.
[466] Sifris and Geber 2023 referring to Australian Law Reform Commission, *Pathways to Justice: Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report 133, 9 January 2018) Executive Summary.
[467] Explanatory Memorandum, Charter of Human Rights and Responsibilities Bill 2006 (Vic) 2.

however, does not mean identical treatment in every instance.' In the context of access to gender-affirming health care for TGD people, a substantive equality approach would entail recognition that while the majority of the population does not require access to such care, access to gender-affirming care '*may be essential for TGD people to achieve the highest attainable standard of physical and mental health*'.[468]

6. I consider that this human rights framework ought to be borne in mind in resourcing, planning, and designing health services in Victoria, including in actively ensuring that such services are culturally safe, accessible, and inclusive, and not directly or indirectly discriminating against TGD people.

7. Indeed, the evidence at Inquest has demonstrated that the rights of TGD people in Victoria are often imperilled in a healthcare setting.

8. I heard evidence from Professor Zajac of the experience of a young transman who was '*scarred for years*' after being yelled at to '*get out*' of a dermatologist's waiting room.[469] I heard from Ms Elisabeth Lane, the Court's lived experience expert, that, when her regular GP went on leave in 2016, she explicitly directed Ms Lane not to approach two other GPs at the clinic, and circled the names of those who would be safe for Ms Lane to see.[470] In relation to the other GPs, Ms Lane stated '*She told me, do not see them… they will not look after you*'.[471]

9. I also heard evidence of what can constitute culturally-appropriate, affirming care for the TGD community in a healthcare setting. Ms Lane noted the value of visible signs of inclusion such as rainbow flags and lanyards, appropriate use of pronouns, and of training for clinicians '*so that the medical profession can understand life through the transgender lens. They can understand that the community has extra barriers*'.[472] In her view, and as has been demonstrated by multiple witnesses at Inquest in relation to access to healthcare, '*the*

[468] Sifris and Geber 2023 referring to Human Rights Committee, *CCPR General Comment No 18: Non-Discrimination*, 37th sess, CCPR/C/21/Rev.1/Add.1 (10 November1989) [8].
[469] Evidence of Professor Zajc, Austin Health, T-309 lines 20-26.
[470] Evidence of Ms E. Lane, T-31 line 23 to T-32, line 6.
[471] Evidence of Ms E. Lane, T-34 lines 12-14.
[472] Evidence of Ms E. Lane, T-35 lines 21-23.

community has been explicitly excluded and you have to explicitly include them, so they know it's safe.[473]

10. I consider that, in 2024, it is wholly unacceptable that a TGD person should have to consider which clinicians are 'safe' and which are 'unsafe' to consult with. As a TGD person, you should not, as Mr Elliot McMahon stated, '*feel profound fear and dread'* at the thought of encountering *'a doctor or a person who's in a position of power [who] looks at you and says "You don't know who you are, I do"'*.[474] There should not be a '*myriad of horror stories that circulate in [the TGD] community about what can happen if you go through the wrong door to get support*.[475]

11. In 2024, there must be 'no wrong door' for TGD people to receive healthcare or referrals to healthcare that affirm their identity, dignity and personhood. This is the right of every TGD person attending upon a GP or any other clinician in Victoria, and I intend to make a series of recommendations on this front.

12. On the subject of recommendations, pursuant to section 72(2) of the Act, I note that I am only empowered to make recommendations that are '*connected with a death or deaths*'. I received an abundance of proposed recommendations from Counsel Assisting, Interested Parties and submitting organisations in the lead-up to and at closing submissions – by my count, a total of 65 proposed recommendations were sought – some of which overlapped in subject matter, aims and intention, some of which include specific resourcing proposals, and not all of which I am empowered to make.

13. Nevertheless, I consider that the evidence at Inquest and concomitant recommendations sought by Interested Parties and organisations contain invaluable guidance on the ways in which gender-affirming healthcare, mental health and social and emotional wellbeing supports for TGD people could be strengthened in Victoria. As noted by Mr Ball of

[473] Evidence of Ms E. Lane, T-34 line 30 to T-35 line 3.
[474] Evidence of Mr E. McMahon, Drummond Street Services, T-469, lines 9-29.
[475] Evidence of Mr E. McMahon, Drummond Street Services, T-469 lines 27-29.

Switchboard, a form of '*needs analysis*'[476] was conducted through the unfolding of this evidence that I strongly believe should be reviewed by the Department of Health (whose approach to these proceedings has been commendable) and other entities in considering the operationalisation of the coronial recommendations I intend to make.

14. I make one final comment in relation to the five TGD people whose deaths I have investigated as part of this cluster, and of the impact of gender-affirming care in the context of the ultimate decision each made to take their own lives. It is worth recalling that I received evidence of improved mental wellbeing and/or increased happiness upon commencing a gender affirmation process in four out of the five people in the cluster.[477]

15. However, as cautioned by Switchboard, the provision of gender-affirming medical care is not the 'full picture' when it comes to providing affirming care to TGD people who may be suicidal:

> *Gender affirming care helps people live affirming lives. However – and this is imperative in understanding trans and gender diverse suicide prevention – for people already experiencing suicidal distress, gender affirming care can significantly help mental health and well-being – it does not prevent suicide. It can deeply help and support trans people experiencing suicidality – but significantly – hormones alone do not create protection against suicidality. People who have medically affirmed their gender may still experience suicidal distress. What is needed is affirming culture around their gender.*[478]

16. I consider this throws into sharp relief the need for a broad conception of care that is affirming of all gender identities – inclusive of mental healthcare, and social and emotional

[476] Evidence of Mr J. Ball, Switchboard, *'[The evidence of the Medical Panel at Inquest] was a needs analysis that took place like I've never seen before with that panel of experts who identified needs and gaps…. So I think – I just want to say that there was one done yesterday, I feel, and I would like…[that] to be used hopefully in the future by the Victorian government*' – *see* T-405 line 25 to T-406 line 4. This is in part why I have elected to draft the finding in such granular detail.
[477] In relation to **Bridget**; *see* statement of H. Leigh, CB, p. 39 and evidence of A. Pucci-Love, T-55 line 10-11; in relation to **Natalie**; see statement of C. Wilson, CB, pp. 16-18; in relation to **Heather**, *see* CIS of K. Pierard, Court file; in relation to **Matt**, *see* statement of Dr P. Wong, CB, p.42. There is a dearth of evidence in relation to the positive experience of '**AS**' upon commencing her gender affirmation process, noting this occurred in Queensland.
[478] Submissions of Switchboard, Collated Brief, p. 158.

wellbeing supports – and of a broader recognition of the impacts of discrimination, isolation and violence on TGD people's wellbeing. I make this comment acknowledging that this is – or should be – a very basic proposition that is already recognised as such within TGD communities and those who deliver services to them.

17. Ultimately, the way in which members of our TGD communities in Victoria are engaged with through health services and by the community at large is a measure of our respect for human rights, dignity, and our collective humanity. As noted very simply by Dr Nguyen at Inquest, '*being trans and gender diverse is a wonderful part of human diversity, to be celebrated'*.

RECOMMENDATIONS

I make the following recommendations connected with the death under section 72(2) of the Act:

1. That **Victoria Police** implement, as a matter of priority, all five recommendations contained in the Victoria Police Operational Safety Committee Incident review (**OSCIR**) relating to Bridget Flack's missing person investigation, dated 1 December 2021, including through amendments to the Law Enforcement Assistance Program (**LEAP**) or as otherwise deemed appropriate. These recommendations require that Victoria Police:

    i. Develop a **prompt sheet** to guide members through the compilation of a missing person's report, including when to seek expert advice when the missing person is vulnerable or a member of a priority community;

    ii. Review the **missing person risk assessment** to help identify risks specific to priority communities and vulnerable people, and to consider including 'LGBTIQA+' and/or specifically 'TGD' status as discrete factors to take into account in assessing risk;

    iii. Review the electronic and hard copy **missing person risk assessment forms**, to achieve consistency between the two; and

iv. Review the 'Crime Investigative Guidelines – Missing Persons' and 'Missing Persons Squad - Initial Action Guide' to provide for **specific procedures applicable to missing persons investigations occurring in urban areas**, including through reference to the application of the 'Victoria Police Practice Guide on Spontaneous Volunteers'; and

v. Develop a **risk assessment matrix** in line with risk status/factors, to provide greater clarity in determining what may constitute a 'serious threat to the life or health of a person', to assist informing the **mobile phone triangulation** decision-making process in missing persons investigations.

2. That **Victoria Police**, under the guidance of experts from TGD community, make LGBTIQA+ awareness training mandatory for all police members and staff. Such training should include a TGD-specific component, addressing factors that can contribute to the risk of suicide in LGBTIQA+ and TGD communities, and the ways in which police members can appropriately assess and respond to such risks.

3. That **Victoria Police**, in accordance with Priority Area 3 of 'Pride in our future: Victoria's LGBTIQA+ strategy 2022-32' progress, as a matter of priority, steps to improve data collection in relation to TGD people to capture all gender identities, by amending the Law Enforcement Assistance Program (**LEAP**) or as otherwise deemed appropriate. This should include amending the Form 83 'Police Report of Death for the Coroner' to include fields to capture all gender identities, to assist in improving the accuracy of data on deaths in the TGD communities, and specify a timeframe for this to be carried out.

4. That the **Attorney-General of Victoria, the Honourable Jaclyn Symes**, consider (or refer for the consideration of the Victorian Law Reform Commission) whether the current definition of 'senior next of kin' in section 3 of the *Coroners Act 2008* can be reformulated to reduce the hurdles and distress it can create for the loved ones of LGBTIQA+ Victorians who die in reportable circumstances, including where they may be estranged from family

members, while still allowing for the 'senior next of kin' to be 'identified quickly and with certainty'.[479]

5. That the **Victorian Department of Health,** as lead, in conjunction with the **Department of Families, Fairness and Housing** and any other relevant Victorian Government departments, consider urgently increasing resourcing to meet the growing demand for publicly funded health services delivering gender-affirming care to TGD patients, in order to reduce the current waitlists and to support and expand the existing health workforce delivering such care. The Department may consider whether this should involve revision of the existing framework for delivery of gender-affirming healthcare and supports to TGD Victorians.

6. That the **Victorian Department of Health**, under the guidance of experts from TGD communities, consider devising and implementing a statewide framework for the provision of culturally-appropriate care to TGD people in public hospitals and health services, including in rural and regional Victoria, with additional training to support staff in delivering culturally-appropriate care to TGD patients.

7. That the **Victorian Department of Health**, as lead, in conjunction with the **Department of Families, Fairness and Housing** and any other relevant Victorian Government departments, consider ongoing funding options available to ensure that TGD people and their families have appropriate access to culturally appropriate: (i) social and emotional wellbeing supports; and (ii) suicide prevention, postvention and bereavement supports, as a means by which to address the high levels of suicidality, social exclusion and mental ill health in the TGD community.[480]

[479] *See in this regard* the comments of her Honour Justice Richards in *Smith v Coroners Court of Victoria* [2018] VCS 307 at [29].

[480] To assist in identifying culturally-appropriate TGD-led strategies to achieve this, the Victorian Department of Health should consider its very helpful 'Table of Proposed Recommendations' contained at Annexure 1 of the Department of Health's 'Outline of Submissions of the Secretary to the Department of Health', dated 13 February 2024, which contains a summary of all proposed recommendations made by Interested Parties and community-controlled organisations following this Inquest.

8. That the **Royal Australian College of General Practitioners (RACGP)** and **Royal Australian and New Zealand College of Psychiatrists (RANZCP)**, under the guidance of experts from TGD communities, develop and offer training and support to all healthcare professionals under their remits, including those who provide or want to provide care to TGD people, with the aim of ensuring cultural safety for TGD people accessing health services across these settings and which includes training on the factors that can contribute to the risk of suicide in these communities.

9. That the **State Coroner of the Coroners Court of Victoria, Judge John Cain**, under the guidance of experts from TGD communities, consider introduction of a LGBTIQA+ awareness training module, with a TGD-specific component, into the induction training for all staff and Coroners, specifically addressing the factors that can contribute to the risk of suicide in these communities.

ACKNOWLEDGEMENTS

I convey my sincerest sympathy to Bridget's family, chosen family, friends and community. I acknowledge the grief and devastation that you have endured as a result of your loss. I read and listened carefully to the coronial impact statements provided in connection with Bridget's passing and was greatly assisted and moved by the personal reflections made in those statements. I thank Bridget's loved ones for their active participation and assistance in these proceedings with such grace, dignity and patience, and I acknowledge the great difficulty in undertaking this so long after her passing. I also thank the Family Liaison Officers for supporting Bridget's family with dedication over the past years.

I thank Counsel Assisting, Ms Cafarella, and the counsel and solicitors who represented the interested parties for their assistance, comprehensive submissions and collegial approach to these proceedings. I also acknowledge and thank George Carrington, Janet Lee, Kajhal McIntyre and Olivia Collings at the Coroners Court for their invaluable assistance in this investigation, and for striving to ensure that these proceedings could be as culturally safe as possible for the members of the LGBTIQA+ community in attendance.

I also acknowledge the work of my colleagues who previously had carriage of this investigation and who worked tirelessly to progress it long before I assumed carriage of these proceedings. I thank the CPU for its excellent ongoing assistance, including for obtaining the statements and submissions that formed the backbone of the Inquest. In this connection, I also wish to thank each and every witness who provided statements and/or came to give evidence at Inquest, and who shared their personal and professional experiences for the purposes of assisting the Court's understanding of the issues.

ORDERS AND DIRECTIONS

I order that a copy of this finding be published on the Coroners Court of Victoria website in accordance with the *Coroners Court Rules 2019*.

I further direct that a copy of this Finding be provided to:

Angela Pucci-Love
Chief Commissioner of Police, c/o Victorian Government Solicitor's Office
Victorian Department of Health, c/o Department's in-house lawyers
Monash Health, c/o K&L Gates
Austin Health, c/o Lander & Rogers
Transgender Victoria, c/o Allens
Detective Senior Constable Daniel Garside, c/o Hall & Wilcox
Elisabeth Lane
The Office of the Chief Psychiatrist of Victoria
Thorne Harbour Health
The Royal Children's Hospital Melbourne
Royal Australian College of General Practitioners
Australian Psychological Society
Royal Australian and New Zealand College of Psychiatrists
Drummond Street Services
Victorian Commissioner for LGBTIQA+ Communities
Switchboard Victoria

Australian Bureau of Statistics

Those to whom recommendations are directed (and who are not otherwise listed above):

Attorney-General of Victoria, the Honourable Jaclyn Symes

Department of Families, Fairness and Housing

State Coroner of the Coroners Court of Victoria, Judge John Cain

Findings in relation to the other deaths investigated as part of this cluster inquest are available on the Coroners Court website at https://www.coronerscourt.vic.gov.au/inquests-findings/findings.

Signature:

INGRID GILES
Coroner

Date: 29 August 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.