IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 000357

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Amanda Jane Stapledon
Date of birth:	11 February 1963
Date of death:	18 January 2022
Cause of death:	1(a) Mixed drug toxicity (oxycodone, temazepam, diazepam, oxazepam, citalopram, fluoxetine, prochlorperazine)
Place of death:	Stringybark Drive, Cranbourne Gardens, Botanic Drive, Cranbourne, Victoria, 3977
Keywords:	Drug overdose, IBAC investigation, witness welfare

INTRODUCTION

1. On 18 January 2022, Amanda Jane Stapledon was 58 years old when she was found deceased in her car. At the time of her death, Ms Stapledon lived in Cranbourne North with her son, Peter Stapledon. She is survived by Peter, her husband Gary Stapledon, her father Robert Lord, and her three siblings.

2. Ms Stapledon is warmly remembered by family, friends and colleagues as a caring and generous person who was dedicated to serving her community.

BACKGROUND

3. Ms Stapledon was the primary carer for her son, who suffered from a number of disabilities. She was committed to ensuring that he enjoyed a healthy and fulfilling life.

4. Ms Stapledon was elected and served as a councillor for the City of Casey between November 2008 and February 2020. She served as Mayor between 2012 to 2013 and 2018 to 2019. She was subsequently employed at WFM Services, which supplies and instals facilities and equipment to assist the aged and disabled at home.

Operation Sandon

5. On 7 August 2018, the Independent Broad-based Anti-corruption Commission (**IBAC**) commenced an investigation into allegations of serious corrupt conduct in relation to planning and property development decisions at the City of Casey council (**Operation Sandon**). A focus of the investigation was whether some councillors had accepted undeclared payments, gifts, or other benefits from property developers, in exchange for favourable council outcomes in relation to planning and development matters. Ms Stapledon was a person of interest in the investigation.[1]

6. On 23 September 2019, Ms Stapledon was personally served with a summons by IBAC to produce documents. Ms Stapledon retained lawyers to advise her in relation to her involvement in Operation Sandon. She subsequently produced documents in response to the summons in October 2019.

[1] Statement of Christine Stafford dated 4 November 2022.

7. On 23 October 2019, Ms Stapledon was personally served with a summons by IBAC to give evidence at a public hearing. She was not served with a confidentiality notice under the *Independent Broad-based Anti-corruption Commission Act 2011* (**IBAC Act**).

8. On 18 February 2020, the Casey Council was sacked by the State Parliament after the adverse findings of the Municipal Monitor, who had been appointed to review some of the allegations raised in the IBAC investigation concerning the management of conflicts of interest.

9. On 16 and 17 March 2020, Ms Stapledon appeared at a public hearing as part of Operation Sandon and gave evidence before IBAC Commissioner Robert Redlich, after which her summons was discharged. She was represented by counsel. Her friend, Kerril Burns, accompanied her to the hearing as her support person.

10. The public hearings in relation to Operation Sandon were concluded by IBAC on 8 December 2021 and subsequently, IBAC prepared a draft report. Under the IBAC Act, if IBAC intends to include a comment or opinion in a report which is adverse to any person, it must first provide them with a reasonable opportunity to respond. The draft report contained comments or opinions which were, or were considered to be, adverse to Ms Stapledon. Accordingly, IBAC was required to provide her with an opportunity to respond.

11. On 3 December 2021, Ms Stapledon's lawyers were advised by IBAC that a draft report in relation to Operation Sandon would be provided to them shortly. Later that day, Ms Stapledon spoke with her lawyers and told them that she had heard about the impending release of the draft report and that *"she had been informed that criminal proceedings would be commenced against her."* Further, she advised that she had engaged criminal lawyers to assist her, in the event that such proceedings were commenced.[2]

12. On 14 January 2022, IBAC wrote to Ms Stapledon's lawyers, advising that it had prepared a draft report in relation to Operation Sandon and that it included comments or opinions which were, or could be, considered adverse to their client. The letter included a link to a secure file sharing platform which contained a copy of relevant extracts of the draft report. The draft report had not yet been read by Ms Stapledon's lawyers prior to her death and they had not yet provided a copy of it to her.

[2] Correspondence from Barry Nilsson dated 19 February 2023.

13. IBAC stated that it had not contemplated and did not intend to bring criminal proceedings against Ms Stapledon or refer her to any prosecutorial body as a result of her evidence in the public hearing. That was unless information was subsequently brought to its attention (which was not then known), as a result of the natural justice process undertaken with the circulation of the draft report.[3]

14. The release of the IBAC report in Operation Sandon has been delayed by associated litigation in the Supreme Court of Victoria and has not yet been submitted to the Victorian Parliament.

Ms Stapledon's mental health

15. Ms Stapledon's friend Mr Burns, observed that the IBAC investigation had *"a massive impact on her mental health."* He stated that she was *"really scared"* that IBAC would refer her for prosecution, and that the associated legal fees she would incur, would cause her to lose her home and other assets. She was also concerned that her son would be left without a home. Mr Burns tried to reassure her but she *"had it in her head that she was being prosecuted and she was going to be sent to jail."*[4]

16. In relation to the IBAC public hearing, Ms Stapledon told a former colleague, Ms Janet Halsall, that *"she had no idea just how awful the ordeal would be, and that the reality was even worse than her expectations."* Ms Halsall met with Ms Stapledon on a number of occasions between December 2021 and January 2022 where Ms Stapledon expressed concern and anxiety about the prospect of being referred to the Director of Public Prosecutions, and the associated costs of having to defend criminal proceedings.

17. On 1 January 2022, Ms Stapledon told Ms Halsall that she had decided her son *"would be better off without her"* as the costs of defending criminal proceedings would require her to sell her house, and he would no longer have a home. Ms Halsall sought to persuade Ms Stapledon not to take any further steps about ongoing legal representation until she received a copy of the draft report. She saw Ms Stapledon again on 10 January 2022 and observed that she appeared more settled. However, Ms Stapledon continued to express concern about the likely contents of the draft report.[5]

[3] Statement of Christine Stafford dated 4 November 2022.
[4] Statement of Kerril Burns dated 20 January 2022.
[5] Submission to the Coroners Court of Victoria from Janet Halsall.

18. On 2 November 2019, Ms Stapledon attended her General Practitioner (**GP**) and reported stress and anxiety symptoms due to work related issues. She was prescribed anti-depressant medication and was also referred to a psychologist. In November 2021, she reported to her GP that she was *"in an extremely stressful situation"* but did not further elaborate. She requested a further mental health plan to enable her to continue to see her psychologist.[6]

19. Between November 2019 and throughout 2021, Ms Stapledon attended 15 sessions with psychologist Dr Helen Kothrakis where she presented with symptoms of severe depression and anxiety. In a statement provided to the Court, Dr Kothrakis reported that Ms Stapledon had disclosed her involvement in the IBAC investigation, although she did not discuss the details surrounding the allegations. She stated that Ms Stapledon *"found it extremely difficult to reconcile who she knows herself to be and the problems she found herself in"*. Dr Kothrakis reported that Ms Stapledon had developed insomnia and paranoid delusions of being followed and having her conversations recorded. Further, she stated that Ms Stapledon was *"fearful of going to jail, losing her house"* and *"leaving her son homeless"*. Ms Stapledon disclosed to Dr Kothrakis that she had suicidal thoughts but after extensive assessment, she reassured Dr Kothrakis that she would not act on her ideations and identified her son and father as protective factors.[7]

THE CORONIAL INVESTIGATION

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

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

22. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of

[6] Statement of Dr Vetha Rajeswaran dated 19 May 2022.
[7] Statement of Dr Helen Kothrakis dated 15 May 2022.

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

23. Section 7 of the Act provides that a coroner should liaise with other investigative authorities, official bodies or statutory officers, to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation of deaths.

24. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Stapledon's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, friends, the forensic pathologist, treating clinicians and IBAC officers – and submitted a coronial brief of evidence. Further, submissions have been received from friends, associates, and former colleagues. I also directed that further evidence be obtained.

25. The Court has received requests that an inquest be held into Ms Stapledon's death from Ms Susan Serey and Mr John Woodman. These requests were refused on 2 and 28 February 2023 respectively, as I was satisfied that an inquest was not necessary or appropriate, for me to make the findings which are required to be made pursuant to section 67 of the Act.

26. This finding draws on the totality of the coronial investigation into the death of Ms Stapledon including evidence contained in the coronial brief. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[8]

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

Circumstances in which the death occurred

27. On Friday 14 January 2022, Peter attended respite care at Blairlogie where he spent the weekend. He caught the bus home on Monday 17 March 2022 and was collected from the bus stop at around 3.30pm by his disability care worker, Leo Tyminski. Mr Tyminski's routine was to take Peter home and look after him until Ms Stapledon returned home. Ms Stapledon had told Mr Tyminski that she would be home at 7.00pm.[9]

[8] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[9] Statement of Leo Tyminski dated 20 January 2020.

28. However, Ms Stapledon did not return home and after trying to contact her a number of times, Mr Tyminski contacted Victoria Police at around 10.00pm. Her employer subsequently advised that Ms Stapledon had called in sick that day.[10]

29. The following morning at around 10.45am, Victoria Police attended Ms Stapledon's address where they were joined by a number of her friends and former colleagues who were concerned for her welfare. Using the "Find My Phone" App on her laptop computer, they were able to track Ms Stapledon's phone to Stringybark Drive at Cranbourne Gardens.

30. At around 12.30pm, Victoria Police located Ms Stapledon unresponsive in her vehicle, in the carpark at Cranbourne Gardens. She was observed to have band-aids on both her wrists, covering what appeared to be superficial self-inflicted wounds. An empty bottle of temazepam which had been prescribed to Ms Stapledon was located in the vehicle, along with three empty packets of diazepam. Further, a handwritten note was located in her handbag which contained the passcode to her mobile phone, and which also stated, *"I cannot believe how badly I have behaved – I am so sorry!!"*. Victoria Police contacted Ambulance Victoria who attended and pronounced her deceased at 1.09pm.[11]

31. Examination of Ms Stapledon's phone revealed that it had last been used by her in the afternoon on 17 January 2022. The gates to Cranbourne Gardens close at 5.00pm and after speaking with the Chief Warden, Victoria Police believe Ms Stapledon had arrived before this time on 17 January 2022.[12]

32. Letters written by Ms Stapledon to her family and friends were located at her house. In the letters, she expressed regret and shame for her actions, and it is clear from their context that she intended to take her life. She also expressed concern about losing her home and access to her son.

Identity of the deceased

33. On 18 January 2022, Amanda Jane Stapledon, born 11 February 1963, was visually identified by her friend, Kerril Burns.

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

[10] Statement of Leo Tyminski dated 20 January 2020; Statement of Kerril Burns dated 20 January 2022.
[11] Statement of Detective Senior Constable Samantha Johnson dated 19 December 2022; Statement of Senior Constable Zach Goplan dated 13 December 2022.
[12] Statement of Detective Senior Constable Samantha Johnson dated 19 December 2022

Medical cause of death

35. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine, conducted an examination on 20 January 2022 and provided a written report of his findings dated 17 March 2022.

36. Dr Lynch observed injuries to both wrists, which he considered to be suggestive of self-harm.

37. Toxicological analysis of post-mortem samples identified the presence of oxycodone,[13] temazepam (and its metabolite oxazepam),[14] diazepam (and its metabolite nordiazepam)[15], citalopram,[16] fluoxetine,[17] and prochlorperazine.[18] The presence of these drugs may result in respiratory depression and sedation.

38. Dr Lynch provided an opinion that the medical cause of death was 1 (a) Mixed drug toxicity (oxycodone, temazepam, diazepam, oxazepam, citalopram, fluoxetine, prochlorperazine).

39. I accept Dr Lynch's opinion.

WITNESS WELFARE MANAGEMENT

40. IBAC provided Ms Stapledon with a welfare support services information sheet in October 2019, at the time she was served with the summons to give evidence at the public hearing. The information sheet provided information about the welfare services available, including details of Converge, IBAC's independent, confidential, and free witness welfare provider.

41. Ms Stapledon disclosed to the IBAC officers who served the summons upon her, that she had been experiencing stress as a result of her interactions with IBAC. In response, the officers *"talked Amanda through each of the documents served"* and she *"confirmed she understood her rights and obligations and stated she would contact her own lawyer"*. The officers *"emphasised to Amanda the availability of welfare services before, during and after the public examination"*. Ms Stapledon said that she wanted to clear things up and *"tell her side of the story"*.[19]

[13] Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine used clinically to treat moderate to severe pain.
[14] Temazepam is a sedative/hypnotic drug used for the treatment of insomnia.
[15] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[16] Citalopram is used for major depression and panic disorders.
[17] Fluoxetine is used for major depression, obsessive compulsive disorder, and premenstrual dysphoric disorder.
[18] Prochlorperazine is used for nausea and vomiting.
[19] Statement of Christine Stafford dated 4 November 2022.

42. IBAC sent subsequent correspondence over the following months to Ms Stapledon's lawyers which included a further copy of the welfare information sheet and explained the process for the public examinations and access arrangements for transcripts, exhibits and videos of evidence. The support available through Converge remained ongoing throughout Operation Sandon, including before and during the public examinations, and through the natural justice process that followed.

43. On 30 January 2020, IBAC conducted a Risk Assessment for Ms Stapledon, which referred to Ms Stapledon's disclosure of stress relating to the process and detailed the planned welfare management strategies. This assessment was subsequently discussed with the IBAC Commissioner.

44. During Ms Stapledon's examination on 16 and 17 March 2020, IBAC provided an on-site counsellor from Converge. The counsellor introduced herself to Ms Stapledon prior to her examination and explained her role and availability to provide support with access to a private room if required. Ms Stapledon was advised by the Commissioner at the commencement of her examination that she could request a break at any stage if she required it.

45. IBAC has stated that *"it was not alerted to and did not identify any concerns about Amanda's health or welfare or signs or symptoms of distress that warranted further intervention"*. Further, it stated that at no stage did *"Amanda or her lawyers indicate to IBAC that she was suffering distress as a consequence of taking part in the public examination"*.[20]

46. The Victorian Inspectorate oversees a number of key integrity agencies, including the IBAC, by monitoring their compliance with the law, their use of coercive powers and their conformity with procedural fairness requirements. In October 2018, the Victorian Inspectorate tabled a report in Parliament on IBAC's management of witness welfare and made recommendations for improvements. IBAC subsequently completed an independent review of its management of witness welfare and made a number of improvements to strengthen and formalise its approach.

47. As a result of its review, IBAC developed a Welfare Management for IBAC Investigations Policy (**WMP**), setting out IBAC's expectations and requirements for managing the welfare of witnesses arising from investigations and the use of its coercive powers. A Welfare Management for IBAC Investigations Interim Guideline (**WMG**) was also developed, to

[20] Statement of Christine Stafford dated 4 November 2022.

strengthen the guidance and support provided to IBAC officers in assessing and managing welfare risks. The policy and guideline create a framework to assist with:

- Assessment and treatment of risk;
- Monitoring, review, and escalation of risk;
- Communication;
- Support services;
- Identifying and responding to emotional distress; and
- Individualised supports.

48. In terms of its management of witness welfare, IBAC concedes that it *is "dependent upon witnesses, their legal representative, or other agencies where relevant, informing it that there may be welfare concerns."*

49. In 2022, IBAC conducted a review of its WMP, WMG and broader witness welfare management policies, with the guidance of a consultant psychologist. This review identified that there were opportunities for further improvement to provide:

- Clearer communication with witnesses and persons of interest during the non-investigative process; and

- Currency and consistency of policies, procedures, and other supporting documentation.

50. As a result of the 2022 review, IBAC has developed a new overarching Witness Wellbeing Policy which was approved in-principle on 13 October 2022. The policy will be supported by a Witness Wellbeing Procedure, which is under development. The new policy and procedure are designed to:

- Ensure risks in psychological wellbeing are, so far as reasonably practicable, eliminated, reduced, or managed.
- Ensure witnesses, persons of interest and other involved in IBAC activities are treated with respect dignity and fairness.
- Ensure the health, safety and psychological wellbeing of witnesses and persons of interest and others subject to the exercise of IBAC's duties, functions, and powers, are identified, assessed, and managed at all stages of its operations.

- Balance the psychological wellbeing of witnesses and persons of interest with IBAC's mandated purpose, to identify, investigate, expose, and prevent serious and systemic corrupt conduct and police misconduct.
- Provide a systemic approach to identify, assess, and manage risks to the health, safety and psychological wellbeing of witnesses and persons of interest subject to the exercise of IBAC's duties, functions, and powers, so far as is reasonably practicable.
- Meet all relevant obligations under the IBAC Act, the *Occupational Health and Safety Act 2004*, the Charter of Human Rights and Responsibilities, and applicable subordinate instruments.

51. IBAC has stated that the implementation of the new policy is being progressively rolled out, with training provided to IBAC officers on identifying, assessing, and managing psychological wellbeing risks to witnesses, persons of interest and others involved in IBAC's operations.[21]

Potential prosecution

52. IBAC stated that it is mindful that the stress and discomfort experienced by many of the witnesses appearing during examinations before it, may be compounded by uncertainty as to the outcome of the investigation. For example, the prospect that a witness may face criminal prosecution as a result of potential conduct exposed during an investigation would be an obvious source of stress and anxiety. However, IBAC considers that its ability to manage the stress and anxiety of a witness in this regard is constrained as follows:

    a) The IBAC Act precludes IBAC from disclosing in any report that it has concluded that a witness has committed an offence, or engaged in corrupt conduct, or that it would recommend a prosecution to a prosecutorial body. *"Consequently, to report a conclusion that some witnesses have not committed an offence or engaged in corrupt conduct but remain silent as to other witnesses, so as to give rise to the inference that they have been guilty of corrupt conduct or a crime, has always been regarded as inconsistent with parliament's intention that IBAC's reports should suggest that an individual's conduct amount to criminal or corrupt conduct"*;

    b) The ability of IBAC to privately communicate to a witness its views about whether they may be referred for prosecution, is impacted by the natural justice process which

[21] Statement of David Wolf dated 4 November 2022.

may result in further evidence being produced which materially alters IBAC's assessment of the conduct of the witness;[22] and

c) IBAC's current practice is to refer the potential prosecution of witnesses to the Office of Public Prosecution for advice which may result in other witnesses being identified for prosecution.

PARLIAMENTARY INQUIRY

53. The Victorian Parliament's Integrity and Oversight Committee (**the Committee**) is responsible for monitoring and reviewing the performance of the duties and functions of Victoria's leading integrity agencies, including IBAC. In 2022, it conducted a review which focussed on the welfare of witnesses involved in the investigations of the integrity agencies.

54. The Committee received written submissions from Victoria's integrity agencies, interstate and international integrity agencies, non-integrity organisations with expertise and experience in witness welfare, and members of the public. It also conducted public hearings on 9 and 16 May 2022, during which, a number of witnesses gave evidence, including the IBAC Commissioner, a Deputy Commissioner, and the Chief Executive Officer. In addition to oral and written evidence, the Committee undertook primary and secondary research, including reviewing agency reports and expert literature, especially to identify best practice principles on witness welfare management.

55. In October 2022, the Committee published its report after concluding its review on the performance of Victoria's integrity agencies with a focus on witness welfare.[23]

56. The Committee identified the following best practice principles for witness welfare management:

a) Welfare support should be appropriate and effective, which included the following dimensions:

b) Welfare support should be provided proactively; and

c) Welfare support should be provided by persons with clinical expertise and experience.

[22] Statement of David Wolf dated 4 November 2022.
[23] Performance of the Victorian integrity agencies 2020/21: Focus on witness welfare dated October 2022.

57. As part of the review, the Committee evaluated IBAC's witness welfare framework and its welfare policies, procedures, and standard practices. The Committee reached the following conclusions:

> IBAC's approach to witness welfare management is comprehensive and robust. The agency's policies, procedures and practices reflect its serious commitment to identifying potential risks to the health, safety and welfare of persons involved in its investigations and documenting and implementing measures to remove or minimise such risks.
>
> IBAC's power to hold public examinations is extraordinary. While it is an important and necessary power to enable the agency to perform its anti-corruption and police misconduct functions, it is clear from the evidence received by the Committee during the review, that the public examination process places a significant welfare burden on those subjected to it.
>
> Similarly, while the Committee recognises that IBAC's power to issue strict confidentiality notices is crucial to maintaining the integrity of its highly sensitive investigations, it is clear from the evidence received by the Committee during the review that such notices have the potential to take a heavy emotional toll on recipients, including engendering feelings of isolation.
>
> IBAC has taken significant steps to ensure that witnesses are supported throughout the public examination process, including implementing the findings of a 2019 independent expert review of its policies, procedures, and practices regarding its coercive information-gathering powers. In particular, IBAC has introduced an independent specialist welfare support service for witnesses provided through its Employee Assistance Program (EAP) provider, Converge. Further, it requires its officers to perform operational risk assessments for public examinations (including individual welfare risk assessments), using a risk assessment matrix tool, to ensure that potential risks are identified, assessed, and managed in a considered and systematic way. Finally, it ensures that specialist risk treatments are implemented for those considered at high risk, such as facilitating the presence of an on-site counsellor during the examination and implementing other measures in consultation with Converge, or a witness's treating health practitioner, where appropriate.

However, IBAC investigators face significant barriers to obtaining accurate and relevant welfare information to inform their individual risk assessments, including their lack of clinical expertise and experience. Additionally, the nature of their interactions with examinees inhibits trust and the kind of rapport-building necessary to conduct meaningful welfare assessments.

The policies and procedures provided by IBAC to the Committee in confidence during the review, do not provide specific guidance on assessment of mandatory criteria for holding a public examination under s 117(1) of the IBAC Act, including guidance on what may constitute '*unreasonable* damage to a person's reputation, safety or wellbeing'. Nor do they provide specific guidance on decision-making regarding requests received under s 117(3A)(a) of the IBAC Act for part of a public examination to be held in private.

Considering the seriousness of the potential welfare ramifications of being subject to a strict confidentiality notice or IBAC's public examination process, the Committee has made a number of recommendations. These recommendations are designed to enhance public trust in IBAC's decision-making processes regarding the exercise of its powers with respect to public examinations and confidentiality notices, and to ensure that the agency's witness welfare management practices reflect best practice.

58. The Committee made the following recommendations in relation to IBAC:

a) to consider the appropriateness and feasibility of creating a new position within its Operations Division (Investigations), for a person with appropriate psychological qualifications, expertise, and experience, to oversee the agency's management of witness welfare.

b) to allow persons seeking mental health crisis support who are subject to an IBAC confidentiality notice to disclose a restricted matter to a mental health helpline, even if the operator is not a registered health practitioner (unless IBAC directs otherwise).

c) to require IBAC to develop procedural guidelines relating to the requirements it must meet under s 117 of the IBAC Act in order to hold a public examination (hearing), including guidance on what may constitute "*unreasonable* damage to a person's reputation, safety or wellbeing".

d) to require IBAC to include in its written report under s 117 of the IBAC Act to the Victorian Inspectorate, giving reasons for its decision to hold a public examination, information about its compliance with those procedural guidelines.

e) to require IBAC to include in a special report tabled under s 162 of the IBAC Act, on an investigation in which public examinations were held, information setting out, in general terms, the Commissioner's decision to hold public examinations in the investigation, which addresses the mandatory criteria in s 117 of the IBAC Act—including the *"exceptional circumstances"* leading to the decision and the consideration given to risks that any person's reputation would be damaged.

59. The report of the Committee, the submissions of the parties and the transcript of the evidence given at the hearing are publicly available on the website of the Victorian Parliament.

IBAC's response

60. IBAC is continuing to review its policies and procedures in response to the Committee's report and has implemented a number of further changes, including the following:

a) An updated information sheet which is provided to witnesses with a summons, and provides guidance for making complaints about reputational harm or damage and how complaints can be made to the Victorian Inspectorate. The information sheet also provides guidance on how witnesses can make an application under s117(3A)(a) of the Act to seek a private examination; and

b) The establishment of a witness welfare liaison team to assist IBAC to identify, assess and manage welfare risks of witnesses. The team comprises a witness liaison manager and two witness liaison officers.

61. I am satisfied that IBAC has conducted a sufficient review of its policies and procedures in relation to witness welfare since Ms Stapledon's death, and subject to the matter raised in the "Comments" section below, has implemented reasonable and appropriate changes designed to manage the risk to witnesses.

FINDINGS AND CONCLUSION

62. It is clear that Ms Stapledon's mental health had suffered during the course of her prolonged involvement in Operation Sandon. In particular, she was concerned about being referred for prosecution and the impact that criminal proceedings may have on her financial stability and

the future wellbeing of her son. She also appeared to be troubled by *"the disconnect between her values and behaviour"*[24] which had been exposed in the course of the IBAC investigation.

63. Ms Stapleton had given evidence in Operation Sandon ten months before her death. The uncertainty as to whether she would face criminal prosecution was a significant stressor which became exacerbated over time. It is likely that her stress and anxiety would have been appreciably alleviated had she been informed that on the evidence before it, IBAC was not contemplating and did not intend to bring criminal proceedings against her or refer her to any prosecutorial body. It is acknowledged that the Operation Sandon investigation was still going through a natural justice process at the time of Ms Stapledon's death which, among other things, impacted IBAC's assessment of when it was appropriate to disclose to witnesses that they were not being contemplated for prosecution.

64. Pursuant to section 67(1) of the Act, I make the following findings:

    a) the identity of the deceased was Amanda Jane Stapledon, born 11 February 1963;

    b) the death occurred on 18 January 2022 at Stringybark Drive, Cranbourne Gardens, Botanic Drive, Cranbourne, Victoria, from mixed drug toxicity (oxycodone, temazepam, diazepam, oxazepam, citalopram, fluoxetine, prochlorperazine); and

    c) the death occurred in the circumstances described above.

65. Having considered all of the circumstances, I am satisfied that Ms Stapledon intentionally took her own life.

COMMENTS

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

66. Giving evidence in any court or tribunal can be an incredibly stressful and traumatic experience. This can be particularly acute where the witness perceives that their conduct is being scrutinised and judged in a public forum, which may impact their reputation and lead to potential prosecution. The impact of stress being experienced by witnesses may not always be obvious from their demeanour during an examination. The welfare of witnesses may be

[24] Transcript of evidence of Amanda Stapledon in IBAC proceeding dated 17 March 2020, p 2326.

particularly vulnerable where they are subject to legislative provisions which limit their ability to discuss the process with others.

67. Living with the uncertainty of the potential consequences of an investigation over a prolonged period has the potential to exacerbate the stress of a witness which, although initially well managed, may swell to a point of crisis.

68. It is in the public interest that IBAC has the power to conduct hearings in public where appropriate, and at times, the integrity of investigations will require that restrictions be placed on the capacity of witnesses to discuss with other individuals their involvement in the process or their evidence. However, in some cases, a delicate balance may need to be struck between the potential for an investigation to be prejudiced and the risk of serious mental harm to a witness.

69. The prospect that a witness may face criminal prosecution as a result of potential conduct exposed during an IBAC investigation would be an obvious source of stress and anxiety. Managing this stress and anxiety (and the associated risk of psychological harm) by disclosing IBAC's views to a witness as early as possible during the investigation, may need to be finely balanced against the potential for further evidence to be disclosed, which materially alters IBAC's assessment of the conduct of the witness. It is important that IBAC officers have the power and flexibility to exercise their discretion in appropriate circumstances to disclose to witnesses as early as possible during the course of an investigation that it is not contemplating a referral for prosecution.

RECOMMENDATIONS

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

(i) That IBAC review the operation of its legislation, and amend its policies, and procedures, where appropriate to ensure that there is no impediment in appropriate circumstances to advising witnesses as early as possible after a decision has been made, that their conduct is not under contemplation for the purpose of prosecution.

I convey my sincere condolences to Ms Stapledon's family for their loss.

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

Gary Stapledon, Senior Next of Kin

James McCathie, Parliament of Victoria

Geoffrey Ablett

Susan Serey

Sam Aziz

Janet Halsall

Wayne Smith

John Woodman

Kerril Burns

Chloe Armstrong, Independent Broad-based Anti-corruption Commission

Detective Senior Constable Samantha Johnson, Coroner's Investigator

Signature:

Coroner David Ryan

Date : 06 June 2023

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