IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000264

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Mr MS[1]
Date of birth:	1964
Date of death:	13 January 2023
Cause of death:	1a: Gunshot wound to the head
Place of death:	Moorabbin Police Station, 1011-1013 Nepean Highway, Moorabbin, Victoria, 3189
Keywords:	Victoria Police; Suicide; Police Suicide Rates; Mental Health

[1] This finding has been de-identified in accordance with the family's wishes.

INTRODUCTION

1. On 13 January 2023, Mr MS was 58 years old when he was found deceased at the Moorabbin Police Complex in circumstances suggestive of suicide. At the time, Mr MS lived in Beaconsfield with his wife, Mrs MS.

2. Mr MS was born in Manchester, England in 1964. He had known his wife, Mrs MS since they were both children as Mr MS was close friends with his then future wife's brother. The couple had been married for 36 years at the time of his death and shared two sons together.

3. While still living in the United Kingdom, Mr MS joined the Greater Manchester Police where he worked for about seven years before he and his family emigrated to Australia in the early 1990s. Having lived and worked in the area, Mr MS was a devoted Manchester United football supporter.

4. Upon arriving in Australia Mr MS briefly worked in security before joining Victoria Police in 1994. His duties with Victoria Police included general policing duties at Springvale, St. Kilda, Mordialloc and Caulfield Police Stations as he subsequently took promotion through the ranks from Constable to Senior Constable to Sergeant and ultimately to Senior Sergeant.

5. At the time of his death, Mr MS performed the role of a Family Violence Training Officer. This involved him providing training and advice to other Victoria Police members in how to deal with family violence incidents. In that role Mr MS was stationed at the Moorabbin Police Complex.

6. He is affectionately remembered by his loved ones as a family man who was happiest when around his wife, sons, and grandchildren.

THE CORONIAL INVESTIGATION

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

8. 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.

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

10. Victoria Police assigned Detective Senior Sergeant Mark Colbert (**Det. Colbert**) of the Homicide Squad to be the Coronial Investigator for the investigation of Mr MS' death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

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

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

Identity of the deceased

12. On 13 January 2023, Mr MS, born in 1964, was visually identified by his colleague, Paul Rudd, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

14. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 16 January 2023 and provided a written report of her findings dated 7 March 2023.

15. The post-mortem examination and post-mortem computerised tomography (**CT**) scan showed a single gunshot entry and exit wound to the head. No other significant injuries were observed.

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

16. Routine toxicological analysis of post-mortem samples detected the antidepressant agomelatine. No alcohol or other commonly encountered drugs or poisons were detected.

17. Dr Archer provided an opinion that the medical cause of death was *1(a) gunshot wound to the head*.

18. I accept Dr Archer's opinion.

Circumstances in which Death Occurred - Background

19. Mr MS attended General Practitioner (**GP**) Dr Craig Mulligan and other GPs of the Narre Warren Medical Centre since 2000. He first presented with mental ill health in 2015 when he was diagnosed with stress, anxiety and mild depression. Over a six-month period, Mr MS was prescribed a low dose antidepressant and referred to counselling. Dr Mulligan stated he responded well to this treatment and the evidence suggests his mental health remained stable over the years that followed.

20. In 2020, Mr MS made a WorkCover claim in relation to a leg and back injury that he had sustained at work. According to Mrs MS, her husband's WorkCover claim was handled poorly by his superiors at Victoria Police, including an instance where he was inadvertently copied into an email questioning the validity of his injury. In an interview with Det. Colbert, Mrs MS stated the handling of this injury "*devastated him*" at the time, although he did not dwell upon it.[3]

21. In about 2021, Mr MS' mental health appeared to deteriorate. Around this time one of his sons became unwell and it appears Mr MS fixated on unfounded beliefs that his son was suffering a terminal disease (he was not) and that information was being withheld from him by doctors and members of his family.

22. In November 2021, Mr MS again presented to Dr Mulligan with a relapse of mild depression and anxiety. He was again prescribed a low dose of antidepressant medication, was given two brief periods off work, and was referred to counselling.

23. Mr MS first attended Ms Joanne Knezevic for counselling on 16 December 2021. Although Ms Knezevic clarified that she is unable to diagnose patients in her role as a counsellor, in her

[3] Transcript of interview with the MS family, coronial brief pg 148; 153.

opinion Mr MS presented with high levels of anxiety and symptoms of depression throughout their counselling sessions. She further stated:

> *These symptoms involved him being in a very negative headspace, low self-esteem, catastrophising situations and inability to manage emotions. The client had difficulty focusing on anything positive and became overwhelmed often with excessive and obsessive thoughts.*[4]

24. Mr MS attended upon Ms Knezevic 11 times in total with their final session in late August 2022. Throughout their sessions, Mr MS stressed the love he held for his wife, sons and grandchildren. In her statement included in the coronial brief, Ms Knezevic did not refer to Mr MS ever presenting with any suicidal thoughts, plan or intent.

25. Throughout 2022, Mr MS attended various GPs at the Narre Warren Medical Centre about experiencing anxiety. Management included low-dose antidepressant therapy. His final appointment with a GP about anxiety was with Dr Kantheepan on 19 December 2022 when the dosage of his antidepressant was increased, and Dr Kantheepan noted no evidence of self-harm ideation, suicidal intent or plans.

26. In relation to Mr MS' overall clinical impression, Dr Mulligan stated:

> *To our knowledge [Mr MS] had never required hospitalisation, prolonged periods of time off work, high dose medication or specialist psychiatric care for any mental health issues. As such his anxiety and depression always presented as of mild or at worst moderate severity and his prognosis would have been regarded as reasonably good. It came as a complete shock to all at this clinic when we heard of the [circumstances] of his passing.*[5]

27. Mr MS was referred to Ms Knezevic as part of the Victoria Police Employee Assistance Program (**EAP**). After Mr MS' 11 sessions of counselling with Ms Knezevic, it was discovered that she was not an approved EAP provider as she was a qualified counsellor, not a psychologist, as required by the Victoria Police EAP contract. The evidence in the brief does not support the assertion that Ms Knezevic's care of Mr MS was deficient or that he was disadvantaged by her treatment as a counsellor and not a psychologist.

[4] Statement of Joanne Knezevic dated 6 July 2023, coronial brief pg 117.
[5] Statement of Dr Craig Mulligan dated 6 July 2023, coronial brief pg 115.

28. Subsequently, in October 2022 Mr MS was referred to psychologist Andrea Fisher. Their first appointment was on 19 October 2022 and Ms Fisher assessed that Mr MS presented with major depression and anxiety. He also displayed some "*secondary trauma characteristics also known as vicarious trauma, possibly related to previous work experience*."[6]

29. Mr MS also presented with symptoms of sleep disorder, low motivation, self-criticism, sadness, tearfulness, magnified importance of negative events, disqualifying positive things, and catastrophising. In relation to his work as a police officer, Ms Fisher stated that Mr MS reported he liked his job, felt competent at it, and otherwise did not discuss his work in any great detail.

30. In the weeks leading up to his death, Mr MS appeared stable although his wife noted he had been quiet at home for some time. He and his family enjoyed a holiday on the Gold Coast shortly prior to his death and his wife believed his mental health was progressing well.[7]

31. The evidence suggests that at no point prior to his death did Mr MS present as suicidal to his family or any of his treating clinicians.

Proximate circumstances in which the death occurred

32. On 13 January 2023, Mr MS attended his workplace at the Moorabbin Police Complex. CCTV and swipe card access records capture Mr MS entering the rear carpark at 12.03 pm and then entering the building at 12.04 pm. At the time, Mr MS was on leave.

33. Minutes later at 12.08 pm, Mr MS attended the equipment issue area of the Moorabbin Police Complex where he signed out his personal issue semi-automatic pistol along with a baton and OC (pepper) spray. Having retrieved his equipment, Mr MS retreated to his office on the first floor of the building and locked the door.

34. Mrs MS and other members of Mr MS' family had been trying to contact him throughout the day without success. At around 6.50 pm, Mrs MS phoned her husband's friend and colleague, Senior Constable Troy Hastings (**SC Hastings**), and asked he check on Mr MS as he had been uncontactable.

[6] Statement of Andrea Fisher dated 22 August 2023, coronial brief pg 120.
[7] Transcript of interview with the MS family, coronial brief pg 168-171.

35. SC Hastings attempted to enter Mr MS' office. When he found the door locked and the blinds drawn, he tried to peer through the window but was unable to see inside the office.

36. SC Hastings raised his concerns about Mr MS' welfare with Acting Senior Sergeant John Ballas (**A/Snr Sgt Ballas**). Together they retrieved the spare key to Mr MS' office and gained access to the office. Inside, they found Mr MS, clearly deceased and seated on the ground against the rear wall with his firearm in his left hand. A fired cartridge case was found nearby.

37. Victoria Police members present at the Moorabbin Police Complex on 13 January 2023 did not hear a gunshot at any point throughout the day.

38. Both A/Snr Sgt Ballas and SC Hastings considered Mr MS had been deceased for some time and did not attempt cardiopulmonary resuscitation (**CPR**). Attending police contacted Ambulance Victoria paramedics who attended, assessed Mr MS and verified he was deceased at the scene.

39. Located on Mr MS' desk were a series of sticky notes expressing a clear intent to end his own life. A detective from the Homicide Squad as well as other senior police members attended and did not identify any evidence to suggest anyone else was involved or that Mr MS otherwise died in suspicious circumstances.

40. Following his death, Mr MS' firearm was assessed by a member of the Victoria Police Ballistics unit. The firearm was found to be operating effectively with all safety features functional and effective.

41. Coroner's Investigator, Det. Colbert conducted a search of Mr MS' phone and discovered a series of internet searches relating to suicide stemming back to October 2022.

42. Mr MS' death was reported to WorkSafe Victoria as it clearly occurred within his workplace. Having investigated Mr MS' death, the Victorian WorkCover Authority decided to take no further action in connection to his death.

Access to Firearm

43. On 13 January 2023, First Constable Benjamin Anderson (**FC Anderson**) was working the watchhouse keeper and equipment officer shift at the Moorabbin Police Complex. FC Anderson recalled Mr MS retrieved his equipment on 13 January 2023 and stated he recalled he had issued him equipment maybe once in the last two years.

44. Mr MS provided his Victoria Police employee number but did not provide an identification card to be scanned. Mr MS could not recall what filing drawer his firearm and other operational equipment was stored in, and FC Anderson had to rely upon a list to locate his equipment. FC Anderson retrieved Mr MS' firearm, baton, OC spray, and 15 rounds of ammunition.

45. FC Anderson scanned the barcode on Mr MS' firearm and no warnings displayed on the Victoria Police 'Equipment Tracking and Management System' (**ETMS**). Subsequently, he provided the firearm and equipment to Mr MS and stated that nothing struck him as out of the ordinary apart from a throwaway comment he made about the police academy.

46. The ETMS software is designed to restrict members from accessing or being issued with operational equipment, such as firearms, when they are not eligible to do so. For example, if a member had not completed Operational Safety Tactics and Training (**OSTT**) or if their OSTT qualification had been suspended.

47. When the ETMS was first being designed, consideration was given to restricting access to operational equipment based on a member's shift rostering status. This was ultimately ruled out as there is no live roster for Victoria Police and for operational reasons, such as members being called in to work without notice. In any event, in Mr MS' capacity as a Senior Sergeant he would have had the ability to change his rostered shift and bypass any theoretical roster-based safeguard.

48. On the date of his death, Mr MS was OSTT qualified and did not have any restrictions or suspension of his qualifications.

CPU Mental Health Review

49. As part of my investigation, I obtained advice from the Coroners Prevention Unit (**CPU**) about the management of Mr MS' mental health proximate to his death.

50. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided to the deceased by reviewing the medical records, and any particular concerns which have been raised.

51. Based on a review of the statements contained within the coronial brief, the CPU advised that the mental health management of Mr MS appeared reasonable. At no point did Mr MS present as suicidal, or at risk of suicide, to any of his treating team.

52. The issue with Mr MS being referred to a counsellor (Ms Knezevic) and not a psychologist as required by the Victoria Police EAP contract had been resolved prior to his death and in any event, Mr MS had been well engaged in counselling with her and did not appear to result in lesser care being provided.

53. I accept the CPU's advice.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Mr MS, born in 1964;

    b) the death occurred on 13 January 2023 at Moorabbin Police Station, 1011-1013 Nepean Highway, Moorabbin, Victoria, 3189;

    c) the cause of Mr MS' death was from a gunshot wound to the head; and

    d) the death occurred in the circumstances described above.

55. The available evidence including the lethality of the means chosen, presence of a suicide note, and evidence in Mr MS' mobile phone, supports a finding that Mr MS intentionally took his own life.

56. The evidence does not support a finding that there was any want of clinical management or care on the part of Mr MS' treating team or on the part of Victoria Police as his employer that caused or contributed to Mr MS' death.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comment:

57. The role of a police officer is inherently stressful and involves routine exposure to traumatic, stressful and dangerous situations. Evidence in the coronial brief suggests Mr MS' family believed he suffered Post-Traumatic Stress Disorder (**PTSD**) as a result of his service within Victoria Police. However, there is no evidence from any of his treating clinicians to support such a diagnosis.

58. Upon my request, the Coroners Prevention Unit[8] (**CPU**) collated data on the prevalence of suicide amongst active Victoria Police members (both sworn and unsworn).

59. When collating the data, the CPU considered all deaths recorded in the Victorian Suicide Register[9] (**VSR**) reported to a Victorian coroner between 1 January 2009 and 31 August 2024. The CPU also used the National Coronial Information System[10] (**NCIS**) as a supplementary data source.

60. The CPU identified 35 suicides of Victoria Police employees between January 2009 and August 2024, with 30 of those deceased being sworn members. Of those deaths, 80% were male noting that males comprise 65% of the police workforce in Victoria.[11]

61. In eight of the deaths (including Mr MS'), the deceased used their Victoria Police service firearms, with six of those deaths occurring within the deceased's workplace.

62. The CPU reviewed each of the 35 Victoria Police member suicides and considered if the deceased experienced any work-related stressors proximate to their death. The work-related stressors were categorised as operational incident exposure; vicarious trauma; organisational factors; and other work-related factors.

63. The CPU identified work-related stressors were present in 25 of the 35 Victoria Police member suicides. Organisational factors were the most prevalent work-related factors and were identified in 16 cases. The main recurring factor was bullying, which was explicitly

[8] See the definition at paragraph 33 above.
[9] The Victorian Suicide Register (**VSR**) is a database containing detailed information on suicides that have been reported to and investigated by Victorian Coroners between 1 January 2000 and the present.
[10] The NCIS is a database containing information on deaths reported to a coroner in any of the Australian States and Territories and in New Zealand. Data includes demographic information on the deceased and contextual details on the nature of the fatality.
[11] Victoria Police, *Victoria Police Gender Equality Action Plan 2022-2024*, Docklands: Victoria Police, July 2022.

mentioned in seven of the 16 cases. The two other organisational factors that most recurred in the cases were issues with excessive workload, and issues related to shift work and rostering.

64. Evidence of diagnosed mental illness was found in 22 of the 35 Victoria Police employee suicides with depression being the most common at 17. PTSD was identified in eight cases. Unsurprisingly, there was a substantial overlap between work-related stressors, personal factors and mental ill health reflected in the data.

Suicide rate of Victoria Police members

65. Over the past decade Victoria's average annual suicide rate for the general population has been 10.5 suicides per 100,000 population per year, with only very slight variation from year to year. A crude average annual suicide rate for Victoria Police members over the same period is 12.6 suicides per 100,000 Victoria Police members and is therefore higher than the general population rate.

66. However, the CPU noted the Victoria Police suicide rate is a 'crude' estimate as it is calculated simply from the size of the Victoria Police workforce without accounting for the characteristics of the individuals that make up the workforce (such as the age, sex, geographic distribution, etc.).

67. The majority of Victoria Police members who suicided were male (28 of 35) and/or were aged 35-54 years (22 of 35). It is well documented that the suicide rate in males and those aged 35-54 years is substantially elevated compared to the general population.

68. Put another way, most Victoria Police members who suicided were in the sex and age group categories with the highest suicide rates regardless of their employment with Victoria Police. When viewed in this light, a crude rate of 12.6 suicides per 100,000 members may (in fact) be lower than expected given their demographic profile. As such, the CPU were unable to draw any strong conclusions from the data about the existence of any increased suicide risk for active Victoria Police members.

69. While there is no evidentiary basis here for any adverse finding or comment against Victoria Police as Mr MS' employer, and none should be inferred, I would suggest that Victoria Police carefully considers how they support their members mental health and welfare in the inherently challenging roles they perform for the benefit of the Victorian community at large.

I convey my sincere condolences to Mr MS' wife, sons and loved ones more broadly for their loss, as well as his colleagues within Victoria Police.

PUBLICATION OF FINDING

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

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

Mrs MS, senior next of kin C/- Maurice Blackburn Lawyers

Worksafe

Chief Commissioner of Police C/- Maddocks Lawyers

Victoria Police Professional Standards Command

Detective Senior Sergeant Mark Colbert, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 25 February 2025

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.