IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 002946

# FINDING INTO DEATH WITHOUT INQUEST

*Form 38 Rule 63(2)*
*Section 67 of the* ***Coroners Act 2008***

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| Findings of: | Coroner Paresa Antoniadis Spanos |
| Deceased: | JL |
| Date of birth: | 2003 |
| Date of death: | 9 or 10 June 2019 |
| Cause of death: | 1(a) Hanging |
| Place of death: | Middle Park Community Playground, Canterbury Road, Middle Park, Victoria |
| Key words: | Mental health, adolescent, Major Depressive Disorder, Bulimia Nervosa, continuity of care |

## INTRODUCTION

1. On 10 June 2019, JL was 15 years old when she was found deceased in a public area in circumstances suggesting she had taken her own life. At the time, JL lived in Victoria with her mother.

2. JL moved to Melbourne from South America in January 2016 to live with her mother, JE, who had been living in Melbourne for 15 months. She commenced Year 7 and was described as engaged, performing similarly to her native English-speaking peers, well connected to her friendship group, and with friendly and mature working relationships with her teachers. She had no attendance issues throughout Years 7 to 10 aside from avoiding Wednesday afternoon sport classes in Year 10 in the months immediately preceding her death. Her friends denied that she was bullied, she was reported to have many friends across different friendship groups, and she did not have contact with Student Wellbeing Services.

## THE CORONIAL INVESTIGATION

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

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

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

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

7. This finding draws on the totality of the coronial investigation into JL's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

### Identity of the deceased

8. On 13 June 2019, JL was visually identified by her father who signed a formal Statement of Identification to this effect.

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

### Medical cause of death

10. Forensic Pathologist, Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 11 June 2019 and provided an amended written report of her findings dated 21 June 2019.

11. The post-mortem examination was consistent with the reported circumstances,

12. Routine toxicological analysis of post-mortem samples did not detect any alcohol or any commonly encountered drugs or poisons.

13. Dr Baber provided an opinion that the medical cause of JL's death was *"1(a) Hanging"*.

14. I accept Dr Baber's opinion.

### Circumstances in which the death occurred

15. In mid-2017, JE noticed that JL had become quiet and found food in the bathroom sink, which JL reported to be due to reflux. JE did not believe her daughter and took her to a general practitioner (**GP**), Dr Matthew Penn. Following this appointment, Dr Penn told JE that JL had an eating disorder and provided a referral to Melissa Bourchier, private psychologist at Vida Psychology.

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

16. Ms Bourchier went on to diagnose JL with Major Depressive Disorder Moderate with Anxious Distress[2] and Bulimia Nervosa.[3] She assessed JL's eating disorder to be impacted by family discord, depression, anxiety, and limited coping.

17. JL engaged well in psychotherapy and completed homework tasks. She reported finding treatment with Ms Bourchier helpful. She first disclosed suicidal ideation during a less structured session focusing on reflection on 1 November 2017. JL reported a plan to jump in front of a train and that she had contacted Kids Helpline which had helped, and that she no longer had intent to act on suicidal thoughts. Ms Bourchier considered that having less structured future sessions might facilitate JL being more open with her emotions and therefore enable psychotherapy around distress tolerance.

18. Following an appointment in April 2018 (the final appointment on the GP Mental Health Care Plan), JE contacted Ms Bourchier to advise that JL was better and declined any further services.

19. On 11 September 2018 JL contacted Ms Bourchier by email reporting that she was not doing well and had not been well for some months. She spoke to Ms Bourchier via phone on 20 September 2018 and disclosed suicidal ideation with a plan to hang herself, saying she had written a suicide note but had no immediate intent. JE was overseas at the time, and JL stated that she believed she would act on these thoughts once her mother had returned.[4] Ms Bourchier advised JL to contact Orygen Youth Health, Kids Helpline, 000, or go to hospital. Ms Bourchier was unable to contact JE by phone, so provided her with an update via email.

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[2] Major depressive disorder is characterised by five or more of the following symptoms every day (or nearly every day) during the same two week period: depressed mood for most of the day, diminished interest/pleasure in all or most activities, decreased appetite or an unintentional change of 5% body weight in a month, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive/inappropriate guilt, diminished ability to concentrate or make decisions, recurrent thoughts of death/suicide. Of the five symptoms required for a diagnosis, one must be depressed mood or diminished interest/pleasure. The specifier anxious distress refers to at least two of the following symptoms during the majority of days: Feeling keyed up or tense, feeling unusually restless, difficulty concentrating due to worry, fear that something awful may happen, feeling that the individual may lose control of himself or herself

[3] Bulimia Nervosa is characterised by recurrent episodes of binge eating (eating a large amount of food in a discrete time period or a sense of lack of control overeating) and compensatory behaviours (vomiting, misuse of laxatives, fasting, excessive exercise) occurring on average weekly over three months and as a result of self-evaluation of body shape and weight; JL did not satisfy diagnostic criteria for Bulimia Nervosa when she began seeing Ms Bourchier. She satisfied diagnostic criteria some months after commencing treatment, however by this time her binging and purging behaviours were less frequent.

[4] JL was staying with JE's sister in Sydney.

20. When JE subsequently spoke to her daughter, JL told her mother that Ms Bourchier had been exaggerating and that she was not planning to take her own life.

21. Ms Bourchier had further contact with JL and JE by phone on 25 September 2018 and they both subsequently agreed to follow up with the services recommended (which included Orygen and Alfred Child and Youth Mental Health Service). Two days later, JL reported that she had contacted Orygen and was advised that she was not in their catchment area but they had given her contact details for Alfred Health.[5] JL advised Ms Bourchier that she would contact Alfred Health.

22. Ms Bourchier spoke to JL on the phone on 4 October 2018 at which time she recommended and provided contact details of other services, including the Royal Children's Hospital Child and Adolescent Mental Health Services. She recommended that JL should contact her GP regarding other services that may be available and provided JL with the details of some other services to contact, including Merri Health, Headspace, and the University of Melbourne Psychology Clinic.

23. Ms Bourchier sent correspondence to Dr Dimitri Giannakopoulos (who had since taken over from Dr Penn as the family's GP) on 4 October 2018. In response, he advised that JL had not attended the clinic since March 2018 and that referral to Alfred Health Child and Adolescent Mental Health Services or Albert Road Clinic[6] might be appropriate. Ms Bourchier stated that she interpreted this letter as Dr Giannakopoulos saying that he would provide a referral for JL to Alfred Children & Youth Mental Health Services or the Albert Road Clinic, as it is usual practice for referrals to come from a general practitioner.

24. In December 2018, JL went overseas to visit family. JE believed that the trip would help her, but she was concerned to see JL looking *"very, very thin"* when she returned to Australia.

25. On 22 February 2019, JE emailed Ms Bourchier requesting an urgent appointment for JL as she had been unwell since returning from a long trip overseas. It was unclear whether JL had accessed services since the previous contacts in September 2018 however there was no record of her having attended her usual GP during that time.

26. On 6 March 2019 Ms Bourchier saw JL for the final time, initially alone and then with JE present. JL had lost weight, was binge eating and purging at every meal, was self-harming

[5] Confirmed by Orygen screening records, 27 September 2018.
[6] Private mental health ward.

without suicidal intent, and had suicidal ideation with no plan. Ms Bourchier advised that tertiary services were required due to the severity, risks, and need for family support. She advised JE and JL to contact the Alfred Hospital Eating Disorder Clinic, obtain a referral for the Royal Children's Hospital Eating Disorder Clinic from their GP, and/or contact the Butterfly Foundation. Ms Bourchier stated that JE and JL agreed to engage with these services, however it appears that did not happen and there is no evidence that they returned to JL's usual GP.

27. According to JE, on 8 June 2019, she asked her daughter whether she was losing weight again. JL replied that she was not. JE reminded JL that she was still growing and needed nutrients. JE noted, *"She didn't like to talk about it. She was very angry with me asking her".*

28. On 9 June 2019 JL went to the park in the morning and returned home to have lunch with her mother. JE had no concerns about her daughter's welfare at this time, stating *"she was normal again".*

29. At 5.30pm JE went out for a run. JL was putting on makeup and JE asked if she was going out. JL stated that she was not going out but was putting on makeup to take photos.

30. At 5.55pm JE received a message from JL's friend asking her to check on JL because she had posted on Instagram that she was going to suicide. She subsequently ran home, finding JL gone. A suicide note written in her first language was on the table.

31. JE contacted police and reported JL missing. Victoria Police members patrolled local areas that JL was known to frequent but did not find her.

32. Between 7.50am and 8.16am the next morning, 10 June 2019, multiple members of the public saw JL hanging from a playground and contacted emergency service. Responding Ambulance Victoria members verified JL's death at the scene. A further suicide note was found in JL's backpack.

## FURTHER INVESTIGATION INTO CARE PROVIDED TO JL

33. Given JL was so young at the time of her death, as part of my investigation I obtained advice from the Coroners Prevention Unit[7] (**CPU**) regarding the mental health care she received in the months leading to her death and whether there were any prevention opportunities.

[7] The Coroners Prevention Unit is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under

## JL's contact with other mental health services

34. As part of this process, I also obtained statements from The Butterfly Foundation, the Chief Psychiatrist, and medical records from Orygen Youth Health which indicated that JE and JL did not have contact with The Butterfly Foundation or public mental health services after the final appointment with Ms Bourchier on 6 March 2019.[8] It therefore appeared that JE and JL did not action Ms Bourchier's recommendations for more intensive treatment. As JL and JE had moved to Australia from overseas a few years earlier, she was not eligible for Medicare and information about potential health contacts were not available via Medicare.

## Mental health care provided by Ms Bourchier in 2017 and 2018

35. The treatment provided by Ms Bourchier for JL's eating disorder, depression and parent-child difficulties appeared generally appropriate within the confines of a GP Mental Health Care Plan.

36. There was level I[9] evidence for the use of cognitive behaviour therapy (**CBT**) in treating depression in 12–18-year-olds.[10] There was level I evidence for the use of family interventions[11] in treating bulimia nervosa in 12–18-year-olds and level II evidence for the use of CBT.[12]

37. The National Eating Disorders Collaboration *National Practice Standards for Eating Disorders* also identify CBT, Guided Self-Help CBT and Family Based Therapy (**FBT**) as

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consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised. In this case the review was undertaken by a Mental Health Investigator.

[8] The information in the CMI database recording public mental health contacts is limited and restricted to statutory information. Prior to July 2021 not all contacts with mental health services generated formal registration of the consumer with the service (e.g., a brief triage telephone contact would have been unlikely to generate registration).

[9] Level I evidence involves a meta-analysis or a systematic review of level II studies that included a quantitative analysis. Level II evidence involves a study of test accuracy with: an independent, blinded comparison with a valid reference standard, among consecutive persons with a defined clinical presentation. Level III-1 evidence involves a pseudorandomised controlled trial (i.e., alternate allocation or some other method). Level III-2 evidence involves a comparative study with concurrent controls such as non-randomised experimental trial, cohort study, case-control study, or interrupted time series with a control group. Level III-3 evidence involves a comparative study without concurrent controls such as historical control study, two or more single arm study, interrupted time series without a parallel control group. Level IV evidence involves case series with either post-test or pre-test/post-test outcomes.

[10] There is also level I evidence for the use of interpersonal therapy in 12–18-year-olds.

[11] Family interventions (including behavioural parent-training interventions) are defined as interventions that explicitly focus on altering interactions between or among family members in order to improve the functioning of the family as a unit, its subsystems, and/or the functioning of the individual members of the family. This framework includes formal family therapy work such as systemic family therapy that views the presenting problem(s) as patterns or systems that need changing and adjusting, rather than viewing problems as residing in a particular person.

[12] There is also level II evidence for the use of psychodynamic therapy in 14–18-year-olds; Australian Psychological Society, Evidence-based Psychological Interventions in the Treatment of Mental Disorders: A Review of the Literature, Fourth Ed. 2018.

evidence-based treatment for eating disorders.[13] The National Eating Disorders Collaboration *Eating Disorders: The Way Forward – An Australian National Framework* states that the treatment with the most empirical support for bulimia nervosa is CBT, usually comprising of 16 to 20 sessions over a six-month period.[14] This is not achievable under a GP Mental Health Care Plan, which provides 6 to 10 sessions over a 12 month period. JL's treatment was limited to the sessions available under her GP Mental Health Care Plan, which is often insufficient in treating eating disorders. However, changes have been made to Medicare services since JL's death improving availability of services for those with eating disorders.[15]

38. Ms Bourchier conducted an assessment with JE present over three sessions in which she developed a formulation of JL's difficulties and a treatment plan. This was communicated to the referring GP. Ms Bourchier engaged JL in various strategies within a CBT framework, including psychoeducation, thought diaries, cognitive restructuring, emotion/attention regulation, distress tolerance and self/identity context. Ms Bourchier also advised JE to seek psychotherapy to manage her anxiety around JL's behaviours and support her to engage with JL without emotional escalation.

**Mental health care and advice provided by Ms Bourchier in 2019**

39. JL had not been a patient of Ms Bourchier between April 2018 and March 2019. Although JL contacted Ms Bourchier in September 2018, JL was not an active client at that time and Ms Bourchier provided advice regarding access to other services to seek treatment. JL did not attend an appointment with Ms Bourchier again until 6 March 2019.

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[13] National Eating Disorders Collaboration, National Practice Standards for eating disorders, https://www.nedc.com.au/assets/NEDC-Resources/national-practice-standards-for-eating-disorders.pdf.

[14] National Eating Disorders Collaboration, Eating Disorders: The Way Forward – An Australian National Framework, https://nedc.com.au/eating-disorder-resources/find-resources/show/eating-disorders-the-way-forward-an-australian-national-framework/.

[15] On 1 November 2019 (after JL's death), a new suite of 64 Medicare Benefits Schedule (**MBS**) items was introduced to support a model of best practice evidence-based care for patients with anorexia nervosa and other eligible patients with eating disorders. This new item structure means eligible patients will be able to receive a Medicare rebate when eligible providers undertake the development of an Eating Disorder treatment and management plan or a review which will activate 1) a course of evidence based eating disorder psychological treatment services (up to a total of 40 psychological services in a 12-month period) and 2) up to 20 dietetic services, in a 1- month period, depending on their treatment needs. It is intended that the MBS services will be provided by practitioners with the knowledge, skills, and experience in providing treatment to patients with eating disorders and treatment provided under the Eating Disorder Psychological Treatment items are limited to the defined list of evidence-based eating disorder specific treatments. Eligibility for an Eating Disorder Plan can be assessed by a GP, psychiatrist, or paediatrician: Australian Government, Department of Health and Aged Care, MBS Online, Medicare Benefits Schedule, Upcoming changes to MBS items - Eating Disorders, http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-EatingDisorders.

40. During the final appointment on 6 March 2019 Ms Bourchier identified that JL required referral to tertiary services. In her further statement, Ms Bourchier stated that she did not continue treatment with JL after the single session on 6 March 2019 (following an 11-month disengagement) as she felt that JL required tertiary mental health services. Her rationale for this was reasonable, stating that JL's mental state had deteriorated since she disengaged and she required a multidisciplinary approach,[16] more frequent sessions, monitoring of suicidality and non-suicidal self-injury, and family-based therapy.

41. Ms Bourchier stated that she did not contact JL's GP after the 6 March 2019 appointment to advise of the deterioration in mental state or recommendations for more intensive treatment. Following JL's brief email and phone contact with Ms Bourchier in September 2018, Ms Bourchier notified Dr Giannakopoulos of JL's deterioration and Dr Giannakopoulos wrote a letter back advising that JL had not attended the clinic since March 2018, and he was unsure whether she was still an active patient. He had recommended referral to the Alfred Children & Youth Mental Health Services or the Albert Road Clinic. As a psychologist, Ms Bourchier could not make these referrals and so assumed Dr Giannakopoulos would do so. It appears Ms Bourchier believed that JL was not engaged with Dr Giannakopoulos when she re-engaged with Ms Bourchier in March 2019 although Ms Bourchier did not confirm this.

42. Ms Bourchier further stated that she believed JE would follow the recommendations provided, especially since she had sought Ms Bourchier's assistance for JL in the past.

43. Although Ms Bourchier's rationale for not informing Dr Giannakopoulos of JL's deterioration in mental state and recommendations included (in part) that she was informed five months earlier that JL had not attended for several months, one of the services recommended for JL (Royal Children's Hospital Eating Disorders Clinic) required a GP referral according to Ms Bourchier's medical record.

44. The *Australian Psychological Society Code of Ethics*[17] standard B.11.3 – B.11.5 *Termination of Psychological Services* states:

    (a) Psychologists make reasonable arrangements for the continuity of service provision when they are no longer able to deliver the psychological service;

[16] Including consideration of prescribed medications, assessment of physical health in the context of eating disordered behaviours, and specialist eating disorder clinicians.
[17] Australian Psychological Society, Code of Ethics, https://psychology.org.au/about-us/what-we-do/ethics-and-practice-standards/aps-code-of-ethics.

(b) Psychologists make reasonable arrangements for the continuity of service provision for clients whose financial position does not allow them to continue with the psychological service; and

(c) When confronted with evidence of a problem or a situation with which they are not competent to deal, or when a client is not benefiting from their psychological services, psychologists: (a) provide clients with an explanation of the need for the termination; (b) take reasonable steps to safeguard the client's ongoing welfare; and (c) offer to help the client locate alternative sources of assistance.

45. Based on these guidelines, it could be considered that Ms Bourchier providing contact details for tertiary mental health services to JE was a reasonable arrangement for continuity of service provision. Ms Bourchier stated that she discussed this with a senior peer and to the best of her recollection, the peer agreed that providing details of tertiary services was adequate.

46. In circumstances where Ms Bourchier believed that JL's presentation and risks necessitated a higher level of care than she could provide, the CPU considered that it would also have been reasonable for Ms Bourchier to notify another health provider of this recommendation. This could have been by Ms Bourchier making the referrals herself (if possible) or providing correspondence to JL's GP who could follow this up at the next appointment. Alternatively, Ms Bourchier could have followed up with JL and JE to ensure that they were able to access the recommended services.

47. However, given JL did not return to see Dr Giannakopoulos (or any other doctor at the clinic) between 6 March 2019 and her death,[18] it cannot be concluded that this would have prevented JL's death as it was JL and JE's right not to follow the recommendations provided by Ms Bourchier. There was insufficient evidence that JL was at immediate risk such that she was required to contact police or Child Protection Services.

48. Nevertheless, the CPU suggested that the circumstances may warrant a recommendation aimed at improving continuity of care in cases where a psychologist identifies a need to escalate care so as to decrease the likelihood of such recommendations not being actioned. I accept and agree with the CPU's advice in this regard.

[18] JL was not eligible for Medicare services and it is therefore not known whether she saw a GP at a different practice during this time.

**Conclusion**

49. JL received treatment from private psychologist Ms Bourchier for depression, an eating disorder, and difficulties in the parent-child relationship. As a psychologist, Ms Bourchier was adequately qualified to provide treatment for eating disorders.

50. The treatment provided to JL by Ms Bourchier until she disengaged in April 2018 was reasonable within the confines of a GP Mental Health Care Plan, which did not allow for best practice treatment of eating disorders at the time of JL's death.

51. When Ms Bourchier saw JL for single session on 6 March 2019, the assessment that she needed a higher level of care than could be provided by Ms Bourchier and recommendations to escalate her care were reasonable. Ms Bourchier acted in accordance with the *Australian Psychological Society Code of Ethics* by ensuring that she provided details of alternative appropriate services and discussed the plan with a colleague, which was good practice. However, it appeared that JE and JL did not action the recommendations made by Ms Bourchier. It is unclear why this did not occur.

52. In circumstances where a need to escalate care has been identified, this is often accompanied by some level of risk that requires monitoring and addressing, hence the need to escalate care. In order to ensure continuity of care for patients identified to be vulnerable and/or at risk, it would be reasonable to take some action to ensure that the patient has been able to access the recommended services, and if not then assist in addressing any barriers to appropriate care.

**FINDINGS AND CONCLUSION**

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

    (a) the identity of the deceased was JL, born 2003;

    (b) the death occurred on 9 or 10 June 2019 at Middle Park Community Playground, Canterbury Road, Middle Park, Victoria;

    (c) the cause of JL's death was hanging; and

    (d) the death occurred in the circumstances described above.

54. Having considered all of the evidence, including the lethality of means chosen and her handwritten suicide note, I am satisfied that JL intentionally took her own life.

## COMMENTS

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

55. 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.

56. The VSR indicates the annual frequency of suicides occurring in the state of Victoria has been steadily increasing for the past decade, from 550 deaths in 2011 to a peak of 758 deaths in 2022.[19]

57. The primary purpose of gathering suicide data in the VSR is to assist Coroners with prevention-oriented aspects of their suicide death investigations. VSR data is often used to contextualise an individual suicide with respect to other similar suicides; this can generate insights into broader patterns and trends and themes not immediately apparent from the individual death, which in turn can lead to recommendations to reduce the risk that further such suicides will occur in the future.

58. So much is still unknown about suicide and, given that every suicide occurs in unique circumstances to a person with a unique history and life experience, possibly there is much we will never be able to quantify and understand. But through recording information about each individual suicide in the VSR, particularly information about the health and other services with whom the person had contact, and then looking at what has happened across time and across people, we hope the VSR can at least lead us to new understandings of how people who are suicidal might better be supported in our community.

## RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation on a matter connected with the death, including matters relating to public health and safety or the administration of justice:

1. To improve access to services and continuity of care for patients deemed to be vulnerable and/or at risk, I **recommend** the **Australian Psychological Society** advise its members that when confronted with evidence of a problem or situation beyond their capacity, or when a client is not benefiting from their psychological services, psychologists should take reasonable steps to ensure that the patient has been able to access the recommended alternate services if

[19] Coroners Court Monthly Suicide Data report, February 2023 update. Published 21 March 2023.

they choose to do so, and/or provide a handover to another health professional (such as a general practitioner) who can ensure that the patient is able to access the recommended services and can assist them to manage any barriers to accessing appropriate care.

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

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

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

Senior next of kin

Melissa Bourchier (care of DLA Piper Australia)

Office of the Chief Psychiatrist

Australian Psychological Society

Senior Constable Kirsten Bell, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 19 April 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.