IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 005654

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	WB
Date of birth:	[redacted]
Date of death:	9 November 2018
Cause of death:	1(a) Gunshot wound of head
Place of death:	Olinda Police Station, 549A Mount Dandenong Tourist Road, Olinda, Victoria, 3788

INTRODUCTION

1. On 9 November 2018, WB was 59 years old when he died from a self-inflicted gunshot wound. At the time of his death, WB lived in [redacted] with his wife.

2. WB is remembered as a loving, kind and caring family man. He was responsible, laid back and generous with his time, with a dry sense of humour. He loved horse racing and AFL football but above all was devoted to his family, particularly his grandchildren.

3. WB was a long serving member of Victoria Police, having joined in 1978. He worked at several police stations including Ashburton, Malvern, Glen Waverley, Knox and Belgrave, where he worked from March 2010 until his death. At the time of his death, he held the rank of Leading Senior Constable.

4. WB and his wife owned 9 investment properties as well as their primary residence. They were members of an investment group called the Property Management Club, which WB had been introduced to by Victoria Police colleagues.[1]

THE CORONIAL INVESTIGATION

5. WB'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.

6. 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.

7. 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.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of WB's death. The Coroner's Investigator conducted inquiries on my behalf, including taking

[1] Coronial Brief (**CB**), Statement of WB's wife, dated 11 June 2019.

statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of WB 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

Circumstances in which the death occurred

Events proximate to death

10. Between 28 May 2017 and 18 August 2018, WB worked at Olinda Police Station (**Olinda**) on temporary duties as a 'reward' for his work standards. He appeared to enjoy the change.[3]

11. WB worked at Belgrave Police Station (**Belgrave)** between 19 August and 15 September 2018 and then took recreational leave until 30 September 2018.

12. While on leave, on 26 September 2018, WB visited his accountant in the context of a falling housing market and increased monthly outgoings following a shift from interest only to principal and interest mortgage repayments. The accountant advised that their investment property portfolio had been incorrectly structured to minimise tax liability. Around this time, WB and his wife also saw their Westpac banker to request a change of loan terms. According to his wife 'although he could see how stressed WB was, [the banker] said that [he] couldn't do anything and the loan couldn't be changed'. Their debt was in excess of one million dollars and WB was reportedly 'ashamed of the situation he got [his family] into' and 'felt responsible'.[4]

13. Between 30 September and 5 October 2018, WB worked from Belgrave. During his shift on 3 October 2018, WB confided in peer support officer Senior Constable (**SC**) Ross Mitchell that he planned to retire in February when he turned 60 and described his financial stressors.

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[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.

[3] CB, Statement of Senior Sergeant Douglas Berglund, dated 3 January 2019.

[4] CB, Statement of WB's wife, dated 11 June 2019.

SC Mitchell noted that 'it appeared that he had no one … to support him' and 'he had no interests outside of his life as a policeman'. SC Mitchell was concerned for his welfare.[5]

14. On 5 October 2018, WB announced to two senior members that he intended to take sick leave until his retirement in February 2019. SC Mitchell told him that this was a 'dreadful idea' and encouraged him to continue working where he was supported, and to seek support for each of his issues. At the end of his shift, SC Mitchell gave WB the contact details for Victoria Police Wellbeing Services, supporting literature and his own phone number.[6] Senior Sergeant (**S/Sgt**) Douglas Berglund also provided advice to WB and suggested he contact the police superannuation service and speak to a financial adviser, and to contact police Wellbeing Services.[7] SC Mitchell advised S/Sgt Berglund of his concerns for WB's welfare.

15. That day, WB phoned Wellbeing Services seeking counselling to help him cope with financial issues. Notes made by the call taker indicate that WB had already spoken to Optum[8]. WB reported no drug or alcohol nor suicide and self-harm issues. Wellbeing Services referred WB to SMG Health[9], Victoria Police's Employee Assistance Program (**EAP**) provider, and an appointment was arranged for him to see Bruce Perham, a social worker, family and narrative therapist, on 10 October 2018.[10]

16. Between 8 and 19 October 2018, WB was absent from work on sick leave.[11]

17. On 8 October 2018, WB (accompanied by his wife) consulted general practitioner (**GP**) Dr Suntharavalli Ganeshanandan ("Dr Ganesh") at The Glen Medical Practice about anxiety and insomnia in the context of severe financial stress. He was prescribed diazepam[12] and the

[5] CB, Statement of Senior Constable Ross Mitchell, dated 28 November 2018.

[6] CB, Statement of Senior Constable Ross Mitchell, dated 28 November 2018. SC Mitchell noted that WB had spoken to him 'in confidence'; it is unclear if he was acting in his capacity as a peer support officer during this conversation.

[7] CB, Statement of Senior Sergeant Douglas Berglund, dated 3 January 2019.

[8] Optum is an Employee Assistance Program provider and provides counselling funded by the Police Association.

[9] SMG Health is now known as TELUS Health (SMG Australia). For clarity, I will refer to the entity by the name of SMG Health throughout my Finding.

[10] CB Exhibit 17, Activity Records between Victoria Police Welfare and WB.

[11] CB Exhibit 16, Leave Record for WB.

[12] Diazepam is a long-acting benzodiazepine with anxiolytic, sedative, hypnotic, muscle relaxant and antiepileptic effects. It is indicated in the short-term management of anxiety.

script was given to his wife 'for safe-keeping', and Dr Ganesh placed him on personal leave.[13]

18. On 10 or 11 October 2018[14], WB (accompanied by his wife) attended the first of three counselling sessions with Mr Perham. Mr Perham identified the primary complaint was WB's concern about his financial situation and that he presented as 'agitated and depressed' in the session.[15]

19. On 12 October 2018, WB returned to see Dr Ganesh with ongoing insomnia. They had a 'more extended' discussion of his financial stressors, and he was provided with a trial of melatonin[16].[17]

20. The same day, SC Mitchell visited WB at home. WB reported that he seen a counsellor via Wellbeing Services, that his GP had prescribed medication for sleep and he was walking a lot. He said he would keep his wife involved in all decisions but still thought his only 'way out' was accessing his superannuation and selling the family home. WB's wife and SC Mitchell hoped WB's 'outlook would improve' once he obtained financial advice. SC Mitchell reported back to S/Sgt Berglund.[18]

21. On 17 October 2018, WB sent SC Mitchell a text message to report that the bank was 'working out a plan' and that he would return to work on Monday, stating it was 'better to work than sit at home'.[19]

22. On 18 October 2018, WB presented to Dr Ganesh and requested temazepam[20] as he had seen no improvement using melatonin. Temazepam was prescribed and the script given to his wife. WB reported having seen a 'workplace counsellor, financial planner and workplace financial services advisor'.[21]

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[13] CB, Statement of Dr Suntharavalli Ganeshanandan, dated 4 October 2020.

[14] Mr Perham's statement refers to 10 October, but the medical record indicates the session occurred on 11 October 2018.

[15] CB, Statement of Bruce Perham, dated 19 November 2020; Exhibit 18, Session Notes of Bruce Perham.

[16] Melatonin is a supplement used for treatment of primary insomnia.

[17] CB, Statement of Dr Suntharavalli Ganeshanandan, dated 4 October 2020.

[18] CB, Statement of Senior Constable Ross Mitchell, dated 28 November 2018.

[19] Ibid.

[20] Temazepam is a benzodiazepine, is habit-forming and used in the short-term treatment of insomnia.

[21] CB, Statement of Dr Suntharavalli Ganeshanandan, dated 4 October 2020.

23. On the same day, a representative from Wellbeing Services called WB. He told them he had returned to work after attending one counselling session, an appointment with a superannuation educator and his bank, with other appointments scheduled. The representative provided WB with a debt helpline number and planned for a follow-up call in two weeks' time.[22]

24. WB returned to work from 22 to 25 October 2018 but he was 'not his usual self' and 'was not engaging as he usually would'. He again went on sick leave from 26 October 2018.[23]

25. On 23 October 2018, Dr Ganesh had a long conversation with WB who reported that he was still not sleeping, but the diazepam helped him relax. The quote 'have to move on with life' was documented in the medical record.[24]

26. On 26 October 2018, WB (and his wife) attended another appointment with Dr Ganesh in the context of ongoing rumination about his finances. He reported concern about attending his workplace due to access to firearms and his risk of self-harm.[25] Dr Ganesh issued a long-term medical certificate, queried if there was a need for an antidepressant and planned to review WB in four days.[26]

27. On 30 October 2018, WB (and his wife) saw Dr Ganesh with ongoing insomnia. He was 'no longer suicidal' and felt his mood had improved and reported seeing 'another counsellor' and a financial planner. A script for nitrazepam[27] was provided, along with a referral to psychiatrist Associate Professor (**A/Prof**) Brendan Murphy.[28]

28. Later that day, SC Mitchell visited WB at home. WB appeared 'anxious and depressed', had lost weight and was ashamed by his situation and that he'd 'become a person he'd previously held in contempt', a 'loser'. WB's view of 'everything financial was negative and hopeless' even though the actual advice was that he could work his way out of the situation. SC Mitchell was concerned by WB's 'catastrophic thinking' and thought he was 'not in a good place to make decisions', a view with which WB agreed. SC Mitchell arranged an

[22] CB Exhibit 17, Activity Records between Victoria Police Welfare and WB.

[23] CB Exhibit 16, Leave Record for WB.

[24] The Glen Medical Centre, medical record, image 9.

[25] The medical record refers to suicide, but further details are unclear.

[26] CB, Statement of Dr Suntharavalli Ganeshanandan, dated 4 October 2020.

[27] Nitrazepam is a benzodiazepine, is habit-forming and used in the treatment of insomnia.

[28] CB, Statement of Dr Suntharavalli Ganeshanandan, dated 4 October 2020.

appointment for financial advice on 2 November, which he would attend with WB and his wife. SC Mitchell reported back to S/Sgt Berglund and explained that he 'believed mental health was inextricably meshed with [WB's] financial dilemma and that good financial advice and planning was … necessary to get him well'.[29]

29. On 1 November 2018, WB attended his second appointment with Mr Perham (again accompanied by his wife). He reported feeling like a personal failure, a weight loss of 10 kilograms and was having trouble sleeping. From Dr Perham's notes, it appears likely that during this session WB disclosed that he often thought about taking his own life, and that he hated wearing his gun at work for fear of what he might do with it. This concern was shared by his wife. WB did not want to return to work because he didn't want access to a firearm.[30]

30. On 2 November 2018, WB, his wife and SC Mitchell attended the appointment with Simone Vanden-Driessen of Leishman Financial Services that had been arranged by SC Mitchell. The couple were advised that they could 'trade out' of their current situation, with improvements to their financial circumstances predicted within 2-3 months and a solution within two years. The financial adviser was to provide a detailed plan the following week. According to SC Mitchell, WB was still 'low' after the meeting, but SC Mitchell was 'reassured by the involvement of a GP and counsellor'. WB sent SC Mitchell a text to thank him that evening.[31]

31. At some point, SC Mitchell updated S/Sgt Berglund about WB's 'state of mind'. S/Sgt Bergland stated that 'it was our understanding that he was under the care of a doctor and I believed he was under stress, but the medication may need time to take effect and that the visit to the financial adviser [on 2 November 2018] would provide the safety net for his concerns'.[32]

32. On 7 November 2018, WB (accompanied by his wife) presented to Dr Ganesh. The earliest available appointment with A/Prof Murphy was in January 2019 and WB had said to his wife 'I won't last that long'.[33] Dr Ganesh agreed to contact A/Prof Murphy's rooms directly or find an alternative psychiatrist. WB reported that his mood and sleep had improved and that he did not feel at risk of self-harm and felt well enough to return to work. Dr Ganesh disagreed

[29] CB, Statement of Senior Constable Ross Mitchell, dated 28 November 2018.

[30] CB, Statement of Bruce Perham, dated 19 November 2020; CB, Statement of WB's wife, dated 11 June 2019; Exhibit 18, Session Notes of Bruce Perham. Mr Perham's session notes are handwritten and difficult to read in parts.

[31] CB, Statement of Senior Constable Ross Mitchell, dated 28 November 2018.

[32] CB, Statement of Senior Sergeant Douglas Berglund, dated 3 January 2019.

[33] CB, Statement of WB's wife, dated 11 June 2019.

that he was fit to return to work and asked that Mr Perham contact her following their next review.[34]

33. On the morning of 8 November 2018, WB and his wife attended an appointment with Mr Perham. WB was more 'morose and negative', expressed 'no hope' and stated that he 'just wanted to end it' but didn't 'have the guts'. Mr Perham told WB that he was not fit for work, which he agreed with, and urged him to ask Dr Ganesh to bring forward an appointment with a psychiatrist.[35]

34. Later that day,[36] Mr Perham called Dr Ganesh to discuss WB. They were reportedly both of the view that he was a 'high risk of carrying out his threats of taking his own life and he was not medically fit to return to work'. According to Mr Perham, Dr Ganesh was going to contact a psychiatrist for an urgent assessment and did not provide clearance for WB to return to work, which Mr Perham assumed meant he would not have access to a firearm.[37]

35. Following the phone call, Dr Ganesh contacted psychiatrist Dr Mahalingam who recommended she prescribe mirtazapine[38] and he would review WB the following week. According to Dr Ganesh they discussed hospital admission, but Dr Mahalingam did not have capacity to admit, and WB had 'refused alternative options such as ECAT referral or presentation to the emergency department'[39]. Dr Ganesh provided the mirtazapine script to WB's wife. Dr Ganesh stated that WB's mental state had improved at last review on 7 November 2018 and since his access to firearms had been averted by him not returning to work, she did not believe 'the risk of self-harm was high enough to warrant calling an ambulance to send him to hospital.'[40]

36. According to WB's wife, Dr Ganesh called her to advise about the appointment with Dr Mahalingam and advised her to take WB to the emergency department if he continued to talk

[34] CB, Statement of Dr Suntharavalli Ganeshanandan, dated 4 October 2020.

[35] CB Exhibit 19, Letter from Bruce to Wojciech Pryba dated 26 April 2019; Exhibit 18, Session Notes of Bruce Perham.

[36] Statement of Dr Suntharavalli Ganeshanandan, dated 1 December 2021. Dr Ganesh believes this contact occurred the next day on 9 November 2018. However, given WB was found deceased on the morning of 9 December it is likely it occurred on 8 December 2018.

[37] CB Exhibit 19, Letter from Bruce to Wojciech Pryba dated 26 April 2019.

[38] Mirtazapine is an antidepressant used in the treatment of major depression. Unlike many other antidepressants, it has sedating properties and is therefore chosen by some practitioners to treat patients for whom sleep disturbance is a feature of their depression.

[39] It is unclear from the medical record if these options had been discussed with WB.

[40] Statement of Dr Suntharavalli Ganeshanandan, dated 1 December 2021.

about suicide. WB's wife had discussed this with WB who said 'it's no use, they send people home the next day and they kill themselves anyway', a view based on his experience at work. WB's wife felt she 'couldn't humiliate him by calling an ambulance or the police to take him, not when he'd been a policeman for 40 years.'[41]

Day of death

37. In the early afternoon of 8 November 2018 WB attended at Olinda Police Station having been invited by Sgt Andrew Herdman who had given him a 'friend to friend' welfare call and invited him to visit the station. WB told Sgt Herdman that he needed to check a brief before court the next day and after he had done so[42] they had coffee and chatted in the muster room with colleagues. WB discussed trying to sell his properties in order to clear his debt and shrugged and told Sgt Herdman 'it will work itself out'. He seemed in reasonable spirits[43], and did not give any indication that he was suicidal.[44]

38. That evening, WB told his wife that he was going for a drive as this had helped him the night before. He kissed her and said 'don't worry, everything will be alright'.

39. WB drove to Olinda and used his Schlage access card at 9:53pm to enter the car park and police station. Once inside he opened a safe with a combination keypad to obtain keys to the station's firearms storage. Using a police-issue semi-automatic pistol (**SAP**) and 0.40 calibre ammunition obtained from firearms storage, WB took his own life.

40. Before 8am on 9 November 2018, Sgt Herdman arrived at Olinda Police Station. He saw WB's car parked in the carpark and noticed that the light at the rear door of the station indicating that the alarm had been turned off. He entered the station calling out to WB, and located him in the disabled toilet, deceased.

41. Sgt Herdman immediately contacted S/Sgt Berglund and S/Sgt Goldrich, supervising Senior Sergeant for the Yarra Ranges, as per protocol, before leaving the station to await Senior Sgts Berglund and Goldrich to arrive.

[41] CB, Statement of WB's wife, dated 11 June 2019.

[42] An audit of the Law Enforcement Assistance Program (LEAP) database confirms he did this, see CB Exhibit 11, Leap Audit.

[43] CB, Statement of Leading Senior Constable Tim Wall, dated 21 November 2018.

[44] CB, Statement of Sergeant Andrew Linton Herdman, dated 12 November 2018.

42. A length of rope tied into a noose was located in WB's vehicle.

Identity of the deceased

43. On 13 November 2018, fingerprints from the deceased were positively identified with prints on file for WB.

44. On the same date, Coroner Jacqui Hawkins considered the available evidence and determined that the cogency and consistency of all available evidence relevant to identification supported a finding that the deceased was WB, born [redacted]. Accordingly, she signed a Determination by Coroner of Identity of Deceased (Form 8).

Medical cause of death

45. Senior Forensic Pathologist Dr Matthew Joseph Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of the body of WB on 12 November 2018. Dr Lynch considered the Victoria Police Report of Death (Form 83), post mortem computed tomography (**CT**), VIFM contact log and medical records from The Glen Medical Centre and provided a written report of his findings dated 13 November 2018.

46. The findings at external examination were consistent with the history, including a contact range gunshot entrance injury in the right temporal region and an exit in the left frontotemporal region. The post mortem CT scan revealed comminuted skull fracturing with an entry in the right temple, exit left temple and a wound track passing right to left, slightly posterior to anterior and slightly inferior to superior.

47. Toxicological analysis of post mortem blood samples identified the presence of diazepam (~ 0.03 mg/L), nordiazepam (~ 0.05 mg/L) and 7-aminonitrazepam (~ 0.03 mg/L).

48. Dr Lynch provided an opinion that the medical cause of death was 1 (a) GUNSHOT WOUND OF HEAD.

WORKSAFE INVESTIGATION

49. WorkSafe Victoria conducted an investigation into WB's death and compiled a brief of evidence, which they provided to the Court and remains on the Court file.

50. On 21 April 2022, WorkSafe advised that they did not commence a prosecution in relation to WB's death as there did not appear to have been a breach of the *Occupational Health and Safety Act 2004* (Cth) on the part of Victoria Police.[45]

51. SMG Health was not scoped for prosecution as it was WorkSafe's view that any potential liability was most appropriately dealt with by the Australian Health Practitioner Regulation Agency.[46]

MANAGEMENT OF WB'S MENTAL HEALTH

52. Having regard to the circumstances of WB's death, I referred the matter to the Coroners Prevention Unit (**CPU**)[47] and requested that a clinician from the Mental Health and Disability team review the management of WB's mental health by Victoria Police, Bruce Perham and Dr Suntharavalli Ganeshanandan.

Victoria Police

53. Dr Alexandra West, Senior Police Psychologist of the Police Psychology Unit (**PPU**) provided a detailed statement regarding the provision of welfare services and the assessment and management of risk of suicide or self-harm.[48]

54. Victoria Police's management of WB's mental health was largely limited to his engagement with Peer Support Officer SC Mitchell and other colleagues, and Wellbeing Services' referral to SMG Health.

55. It is apparent from the evidence that WB's colleagues cared for and were supportive of him. SC Mitchell in particularly went 'above and beyond' in attending at WB's home and

[45] Letter from Alexis Hurwitz, WorkSafe Victoria to Coroners Court of Victoria, dated 21 April 2022.

[46] Ibid.

[47] The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

[48] CB, Statement of Dr Alexandra West, dated 28 June 2019.

organising and attending appointments with financial services. He appropriately escalated his concerns for WB's welfare, and he and S/Sgt Berglund both encouraged WB to contact Victoria Police Wellbeing Services.

56. WB contacted Wellbeing Services on 5 October 2018 seeking counselling, and the referral from Wellbeing Services to SMG Health was made the same day. Wellbeing Services appropriately followed up by phone call to WB and provided the phone number for the National Debt Helpline.[49]

57. As I will discuss further below, the PPU were unaware of WB's risk of suicide or self-harm and did not have access to notes created by external counselling services. As such, there was no need for them to enact specific risk-management practices.

Victoria Police culture

58. I note the comments of WB's wife that she was reluctant to involve a hospital, ambulance or police, fearing that as a police officer, this would humiliate WB.

59. Dr West was asked to comment on police workplace culture in relation to mental health in the context of WB's wife's comments. Dr West described appropriate ongoing efforts since 2017 to address this issue, focusing on leadership, psychologically healthy workplaces, and access to services and support, with some measurable reduction in stigma and improved help-seeking behaviour.[50]

60. Dr West acknowledged that the issue of police feeling humiliated if taken to the emergency department by another police officer and/or paramedic is complex, and outlined a range of contributary factors, not all related to police culture. Importantly, Dr West indicated, where it can be done safely, it is possible for Wellbeing Services to arrange to have the CATT team assess the member at home and engage in safety planning until a bed is available in a private hospital. While this option is not going to be safe in all cases, it is likely to be a more palatable option for many police members. Unfortunately, this option was not available to WB, given the PPU/wellbeing Services were unaware of his risk level.

[49] CB, Statement of Dr Alexandra West, dated 31 May 2019.

[50] CB, Statement of Dr Alexandra West, dated 24 February 2022.

Mr Perham and SMG Health

61. I note at the outset that reviewing the care provided by Mr Perham was constrained by the nature of the medical records and contemporaneous notes which were at times illegible and largely provided snippets of information with no context. However, information was able to be drawn from the statements he provided during the coronial investigation.

62. I also note that at the time of WB's death, it was unclear what was expected of SMG Health's EAP contractors in relation to treatment. However, according to the SMG Health *EAP Clinician Handbook* of 17 February 2020, the EAP provides short-term solution-focused counselling using appropriate therapeutic interventions[51]. My analysis of the management provided by Dr Perham is based on what I am informed by the CPU would be expected of a reasonable clinician providing counselling to a client such as WB.

63. Mr Perham did not document any mental state examinations or comprehensive risk assessments at his three sessions with WB, despite noting that WB repeatedly made reference to suicide and his wife was also concerned about his safety. I am informed by the CPU that a detailed mental health assessment inclusive of risk assessment would be expected to establish a baseline, with ongoing monitoring to occur at further sessions.

64. Mr Perham believed that WB was at high risk of suicide.[52] As someone providing care to WB, Mr Perham needed to ensure WB's safety, but it appears that influenced by his discussions with WB, his focus was on restricting his access to a police firearm. Mr Perham acknowledged that he assumed the risk of suicide was negated if WB was not at work, and it appears that he therefore never questioned whether WB may turn to other means[53]. Although it is not possible to know whether WB would have disclosed whether he still had access to firearms while on leave or was considering other means to take his life, the CPU have advised me that a reasonable clinician in this area of practice would ideally have explored these issues.

65. Safety planning requires more than reducing access to potential lethal means; it would have been reasonable to expect Mr Perham to assist WB to identify triggers and develop strategies

51 If the client has complex needs requiring longer-term counselling, then ultimately a referral on to a more specialised service may be warranted.

52 CB Exhibit 19, Letter from Bruce Perham to Wojciech Pryba dated 26 April 2019.

53 Such as the rope tied into a noose located in WB's car at Olinda police station.

to help him manage the suicidal thoughts when they occurred. There was no documented discussion of this in the medical record, and no detailed safety plan.

66. I note that Mr Perham only saw WB on three occasions, however the CPU have advised me that it would be reasonable to expect that Mr Perham would have developed an initial case formulation inclusive of suicidality, any diagnoses, counselling goals and interventions to alleviate the emotional distress and psychological drivers of WB's suicidal thoughts. There was no case formulation, goals or treatment plan documented, and it is unclear what evidence-based interventions were employed other than supportive counselling, although I acknowledge that Mr Perham did support WB to seek expert advice regarding his financial situation and that this was a reasonable approach given his stressors appeared to be entirely related to finances.

67. WB's mental health appeared to have deteriorated by the session on 8 November 2018. Mr Perham considered that WB had decided suicide was the only solution to his financial situation but accepted that he 'did not have the guts'; it appears Mr Perham considered WB's risk of suicide was high but not immediate. With WB's consent, Mr Perham contacted Dr Ganesh which was an appropriate and commendable action. Mr Perham would have been expected to adhere to the Australian Association of Social Workers Code of Ethics which provides that '*before taking action to disclose clients' confidences without consent, the level of perceived risk will be carefully assessed, preferably in consultation with other professionals.*'[54] Although it is unknown to what extend Mr Perham discussed the level of perceived risk with Dr Ganesh, it was appropriate that he consult with her about the management of WB. There is however no reference in the medical record to Mr Perham consulting with peers or clinical supervisors to support his management of WB.

68. Mr Perham considered his phone call to Dr Ganesh met his objectives in that it led to an accelerated psychiatric review and in his assessment confirmed that WB would not have access to a firearm. While both are appropriate actions, it would also have been reasonable to document and provide WB and his wife with an updated safety plan, and to take steps to ensure more frequent monitoring of WB, which could have been done in collaboration with Dr Ganesh.

<u>Mandated reporting to Victoria Police</u>

[54] Australian Association of Social Workers Code of Ethics (2010), section 5.2.4(f).

69. When first contracted on 1 May 2018, the agreement between Victoria Police and SMG Health provided that SMG Health were mandated to notify the PPU if:

- *A practitioner has concerns about an employee's ability to carry out their duty the Supplier/Practitioner must immediately notify the Police Psychology Unit for further consultation and advice*

- *In addition the Supplier/Practitioner must notify the Police Psychology Unit in the following circumstances:*

    - *Where the individual poses a risk to themselves, their work colleagues, members of the public or others, whether due to deteriorating mental health that means they are not able to safely carry out their duties, or due to self-harm/suicide risks.*

    - *Where the Practitioner is unsure as to the nature of the duties of the individual and therefore is unable to make a well-informed decision as to an employee's psychological risk.*[55]

70. Mr Perham did not notify Victoria Police of his concerns for WB's safety.

71. However, Mr Perham was contracted as an independent contractor to SMG Health on 1 February 2018, prior to the agreement between SMG Health and Victoria Police, and his contract did not outline mandatory reporting requirements. Further, at the time of WB's death, SMG Health did not have in place written policies regarding mandatory reporting to the PPU. Contractors were verbally informed about the mandatory reporting requirements around August to September 2018,[56] and it appears Mr Perham was not contacted.

Dr Suntharavalli Ganeshanandan

72. As in the case of Mr Perham, it was difficult to review and comment on the care provided by Dr Ganesh due to the illegibility of much of the hand-written medical record, though it was supplemented by additional statements.

[55] CB Exhibit 21, Agreement for the Provision of General Services between Victoria Police and SMG Health, Schedule 2 section 7.5.

[56] Statement of Olivia Boyle, TELUS Health (Formerly SMG Health), dated 21 May 2024.

73. Dr Ganesh's treatment plan appeared to be focussed on medication for anxiety and insomnia. On 26 October 2018 she considered prescribing an antidepressant, though did not follow through with this until Dr Mahalingam recommended she do so on the day prior to the fatal incident. It is unclear whether Dr Ganesh carried out a comprehensive assessment of WB's mental state, but I have been informed by the CPU that the symptoms reported by WB would likely have met the criteria for major depressive disorder, and it would have been reasonable for Dr Ganesh to prescribe an antidepressant. However, given the short time frame between the onset of symptoms and opportunities to prescribe, there may not have been enough time for an antidepressant to reach therapeutic levels and begin to relieve WB's symptoms.

74. Dr Ganesh was aware of WB's suicide risk, but there does not appear to be any formal suicide risk assessments documented in the medical record. She was however diligent in her monitoring of WB – she reviewed him seven times between 8 October 2018 and 7 November 2018. While WB had disclosed his concern about self-harm using a police firearm, Dr Ganesh, like Mr Perham, appeared to erroneously assume that this risk was negated should he remain on leave.

75. It was particularly challenging to assess Dr Ganesh's management for the period of 7 – 8 November 2018 due to illegibility of the medical record, inconsistencies between Dr Ganesh's statement and the medical records and inconsistencies between Dr Ganesh and Mr Perham's descriptions of their phone call on 8 November 2018.

76. It appears that Dr Ganesh believed WB presented as somewhat improved on 7 November 2018,[57] and she did not believe the phone call with Mr Perham on 8 November 2018 identified any new concerns. On this basis, I accept that it was reasonable for Dr Ganesh to not consider the risk to WB was immediate. I note that she sought to expedite a psychiatric review, and provided the script for mirtazapine the same day it was recommended. Further, she appropriately recommended to WB's wife that she take him to hospital if he deteriorated, though when she indicated that this was not an option, it would have been reasonable for Dr Ganesh to provide her with additional strategies to obtain crisis help.

Coordination of care between Dr Ganesh and Bruce Perham

77. The CPU have advised that in an optimal setting there would have been further collaboration and communication between Mr Perham and Dr Ganesh. However, WB's needs did not

[57] No mental state examination nor risk assessment was documented to support this opinion.

necessarily require coordinated care, and so I commend Mr Perham and Dr Ganesh for communicating regarding his welfare.

78. Mr Perham was aware that WB was frequently seeing Dr Ganesh for mental health issues but indicated that it was not normal to liaise with a client's GP when they had been referred through an EAP provider.[58] Mr Perham did, at the third session, obtain consent to contact Dr Ganesh but it was a brief conversation with no ongoing expectations for either practitioner and no planning for further coordination of care.

WB'S ACCESS TO FIREARMS

OSTT suspension

79. WB held an active Operational Safety Tactics Training (**OSTT**) qualification in Active Shooter AAO Frontline Phase 3, obtained on 2 August 2018.[59] An OSTT qualification is a requirement to be issued with a firearm.

80. The Victoria Police Manual (**VPM**) provides for when a member's OSTT qualification must or should be suspended, which would prohibit them from signing out a firearm. The VPM notes that a qualification may be suspended *'to provide a time limited opportunity to review their welfare needs, initiate an assessment by an appropriately qualified Victoria Police mental health clinician and provide initial support'.*[60]

81. Relevant to the circumstances of WB's death, a member's OSTT qualification must be suspended when a member has recently self-harmed or threatened harm to themselves or another. A suspension should be considered when a member self-reports 'serious concerns' about their psychological wellbeing, or a third party (including a Victoria Police employee) reports serious concerns about a member's psychological wellbeing and these can be reasonable substantiated.

82. As discussed, Mr Perham did not inform Victoria Police of his concern's for WB's safety, and his risk of suicide or self-harm was not identified during any contact WB had with Victoria Police Wellbeing Services.[61] I also accept the evidence of WB's colleagues that while they knew he was experiencing low mood and was under stress, they believed he was being

[58] Statement of Bruce Perham dated 8 December 2021.
[59] CB Exhibit 14, OST Training History Summary.
60 CB Appendix 6, Victoria Police Manual – Operational Safety & Tactics Training Qualifications.
61 CB, Statement of Dr Alexandra West, dated 28 June 2019.

appropriately cared for by a doctor, and so their concerns for his wellbeing would not have risen to the level of 'serious concerns'.

83. Further, I accept that it was reasonable to not suspend his OSTT qualification given WB was on leave at the time of his death and therefore would not be in the presence of firearms. As he obtained the firearm through other means (being afterhours access of Olinda), suspension of his OSTT qualification would not have prevented the outcome. It is the issue of his access to firearms centres on his access to Olinda Police Station via his Schlage card and his knowledge of the pin code allowing him access to the safe containing keys to firearm storage, that is of greater concern.

Schlage card access

84. WB had access to Olinda via his previous temporary duties at the station. Olinda (and Monbulk) form part of the 'Belgrave station cluster' and can be viewed as an 'extended station' to Belgrave.[62]

85. Superintendent Anthony Glenane advised when employees are assigned to temporary duties at a police station, they are given temporary Schlage card access for the period of time they are assigned. Belgrave and Monbulk Station Sergeants and Senior Sergeants also have access to Olinda.[63]

86. It is unclear why, as WB's temporary duties at Olinda ceased on 18 August 2018, he still had access to the station. Superintendent Glenane conceded that 'without knowing further … access to Olinda Police Station probably should have been revoked'.[64]

87. The fact WB's Schlage card access was not revoked may have merely been an oversight and like the situation of his OSTT qualifications, Victoria Police were unaware of the risk to his welfare such as to immediately revoke his access. However, I consider this a missed opportunity and one that could be relatively easily rectified – that is, access can be revoked remotely and immediately where a member has no need for it.

88. Victoria Police informed me that they can suspend or remove a member's access with immediate effect if required. A member's access is not suspended when taking personal or

[62] CB, Statement of Senior Sergeant Douglas Berglund, dated 3 January 2019.

[63] Statement of Superintendent Anthony Glenane, dated 24 February 2022.

[64] Ibid.

annual leave, but their access is removed upon their exit from the organisation or where their OSTT qualification is suspended. Additionally, an Officer in Charge (**OIC**) of a police station has the ability to "block" a Schlage card in event it is lost or stolen.[65]

RESTORATIVE MEASURES

SMG Health

89. Since WB's death, SMG Health have implemented policies and procedures to ensure all contractors and employees providing EAP services to Victoria Police Members are aware of the reporting requirements and have released guidance on managing high risk clients.

90. These include the *Protocol for Risk Management of Victoria Police EAP Clients/Requests for Case Management Plans*, [66] *Procedure for Managing High Risk-EAP Clients,*[67] and *Suicide Risk Assessment.*[68]

91. SMG Health has also released an *EAP Clinician Handbook*. This is a comprehensive document which incorporates the above procedures and guidelines.

92. In addition to implementing policies and procedures relevant to the reporting requirements, SMG Health made changes to their systems and training, including

    - Inclusion of the mandatory reporting requirement in the induction process for new clinicians
    - Provision of training for clinicians on the assessment and referral process for clinicians seeing Victoria Police clients
    - Placement of a flag on referrals of police to EAP clinicians reminding them of the mandatory reporting requirement to the PPU

93. Appropriately, the *EAP Client Specific Procedures* acknowledges that police members may be uncomfortable with their service provider reporting them to the PPU and provides guidance on how this situation can be sensitively managed by the clinician. A key inclusion in the

[65] Letter from Victoria Police Civil Litigation Unit to the Court, dated 19 September 2024.

66 CB Exhibit 23, SMG Health letter, 'Protocol for Risk Management of Victoria Police EAP Clients/Requests for Case Management Plans, dated 2 May 2019

[67] CB Exhibit 27, SMG Health SOP – Procedure for Managing High-Risk EAP Clients dated 1 July 2019.

[68] CB Exhibit 28, SMH Health EAP Clinician Handbook dated 17 February 2020.

document is the information that the client can remain anonymous in initial discussions between the EAP provider and the PPU, at least until there is clarity about the degree of risk. The document also includes guidance on how a clinician might determine if their client is at high risk and consequently meet criteria for mandatory reporting.

94. I consider that the changes made by SMG Health should ensure new service providers are made aware of mandatory reporting requirements.

COMMENTS

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

Management of WB's mental health

1. I consider that the response of WB's colleagues to his mental health concerns was at all times reasonable and appropriate, and as I have noted above, in instances they went above and beyond in acting on their concerns. I also consider the response of Victoria Police Wellbeing Services to be reasonable and appropriate, particularly in light of the fact that the PPU were unaware of WB's risk of suicide or self-harm.

2. While Mr Perham was aware that WB was at high risk of suicide, safety planning centred around keeping him on leave in the mistaken belief that this would prevent access to a firearm. A more comprehensive exploration of WB's suicidal thoughts, plans and intent may have identified the limitations of this approach, but I acknowledge that it is impossible to speculate as to whether WB would have disclosed his plans had this occurred, and it is impossible to speculate as to whether this would have changed the fatal outcome.

3. I do not criticise Mr Perham for not reporting back to the PPU about WB's risk given he was unaware of the requirement to do so. I consider the fact that he was not informed to be a missed opportunity, however, acknowledge that SMG Health have since taken steps to ensure all contractors and employees providing EAP services to Victoria Police members are aware of the mandatory reporting requirements.

4. As in the case of Mr Perham, while there is insufficient information to know if Dr Ganesh undertook adequate assessment of WB's mental state or suicide risk but even if she had, there is no certainty that he would have informed her of his plans and intent, and I am unable to speculate as to whether any changes in her management of WB would have changed the outcome.

5. Given WB's risk, earlier collaboration between the practitioners could have facilitated information sharing on risk and mental state, however, it is again impossible to conclude whether this would have changed the outcome, particularly given both assumed he had no access to a firearm.

6. I consider that the assumption of Mr Perham and Dr Ganesh that because WB was on leave he was unable to access a firearm to be a reasonable assumption for them to have made. Their assumptions were based on what WB himself had told them (including that he did not want to return to work because that would give him access to a firearm), and assumedly their general knowledge of police practices.

7. Whilst throughout my finding I have identified what could be perceived as shortcomings in the care of WB, or what optimal practice would have looked like, I appreciate and acknowledge the difficulty for clinicians when faced with a complex situation such as WB's, which was labile, dynamic and occurred over a very short period of time. Ultimately, each clinician acted appropriately within the scope and limitations of their practice, and any suggestion of what more could have been done would purely have been in an ideal world and does not take into account the realities of practice in such a complex situation.

WB's access to firearms

8. The fact WB's Schlage card access was not revoked may have merely been an oversight and like the situation of his OSTT qualifications, Victoria Police were unaware of the risk to his welfare such as to immediately revoke his access. However, I consider this a missed opportunity and one that could be relatively easily rectified – that is, access can be revoked remotely and immediately where a member has no need for it.

9. Revoking and reinstating Schlage card access for any member on leave may be too onerous for an OIC as to be feasible, given the nature of leave – it is often unplanned and labile, and there may be reasons where a member must access their place of work while on leave. I consider though, that for member's welfare and the security of police stations, access should be revoked immediately following the cessation of temporary duties or otherwise where a member has no operational reason to require access to a station. I will make a pertinent recommendation to this effect.

Quality of the medical records

10. As I have previously noted, it was difficult to review the care provided to WB due to the illegibility of the notes made by Dr Ganesh and Mr Perham. This is unfortunately not at all uncommon.

11. Clinical documentation is not only a communication tool and integral to patient care, but it is a legal document, an aide-mémoire and protects the clinician in the event of an adverse event. Illegible documentation allows for misinterpretation and errors and may contribute to substandard patient care.

12. SMG Health's EAP Clinician Handbook provides that *for all sessions a Clinician must have sufficiently detailed clinical* notes, and notes that *clinician must also be mindful that their notes can be obtained by external parties through subpoenas or requests by a client for a copy of their clinical notes.* It follows logically that those notes must be in a legible format. Further. the Australian Association of Social Workers Code of Ethics[69] refers to record management at section 5.5 and provides that *social workers will record complete and accurate records of their work as soon as possible after the relevant activity.*

13. The Australian Commission on Safety and Quality in Health Care notes that documentation is an essential component of effective healthcare communication, and in its guiding principles for high-quality documentation, says that documentation should be readable – *documents are legible and able to be understood* and enduring – *documents are materially durable (not loose paper that is likely to be lost).*

14. I make no suggestion that the illegibility of the notes in this case was at all contributory to WB's death. I do, however, feel it is important to note the difficulty it causes to entities such as the Court who are required to interrogate someone's care and management, determine any shortcomings and identify any areas for prevention.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendation connected with the death:

1. With the aim of preventing like deaths and promoting public health and safety, I recommend that Victoria Police implement an audit or checking system to ensure that (a) member's Schlage card access to police stations is revoked as soon as they no longer have a need to

[69] Australian Association of Social Workers Code of Ethics 2020, at 5.5.1.

access that station and (b) codes for digital locks at stations are changed on a regular basis including where staff changeover has occurred.

FINDINGS AND CONCLUSION

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

   a) the identity of the deceased was WB, born [redacted];

   b) the death occurred on 9 November 2018 at Olinda Police Station, 549A Mount Dandenong Tourist, Olinda, Victoria, 3788;

   c) I accept and adopt the medical cause of death ascribed by Dr Matthew Joseph Lynch and I find that WB died from a gunshot wound to the head in circumstances where I find he intended to take his own life;

2. AND, having considered the available evidence, I find that financial stressors leading to anxiety and hopelessness was the predominant precipitating factor influencing the course of action WB ultimately chose;

3. AND FURTHER, while I have described actions that Mr Bruce Perham and Dr Suntharavalli Ganeshanandan could have taken in the most optimal provision of care, I do not consider that their management of WB was at all causal or contributory to his death.

4. AND FURTHER, I find that had WB been unable to access Olinda Police Station and obtain a firearm from the safe, his death would have been preventable in the circumstances in which they occurred, and it follows that the vicarious trauma of police members responding to the scene at their place of work may have been prevented. However, given his access to other lethal means, I am unable to make a finding that his death was preventable in its entirety.

Pursuant to section 73(1) of the Act, I direct that this finding is published on the internet in accordance with the rules.

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

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

Senior Next of Kin

Hall & Wilcox on behalf of the Chief Commissioner of Police

Wotton Kearney on behalf of Dr Suntharavalli Ganeshanandan

Bruce Perham

TELUS Health (SMG Australia) Pty Ltd

Australian Health Practitioner Regulation Agency

Australian Association of Social Workers

Inspector Scott Dwyer, Coroner's Investigator

Signature:

AUDREY JAMIESON

CORONER

Date: 24 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.