IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 6084

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of BH

Delivered On:	17 DECEMBER 2021
Delivered At:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK
Hearing Dates:	4 – 5 OCTOBER 2021
Findings of:	CORONER PHILLIP BYRNE
Counsel Assisting the Coroner:	MR RISHI NATHWANI, INSTRUCTED BY RACHEL QUINN, CORONER'S SOLICITOR
Representation:	MS CATHERINE FITZGERALD, ON BEHALF THE CHIEF COMMISSIONER OF POLICE, INSTRUCTED BY MS KATHERINE GOLDBERG OF NORTON ROSE FULBRIGHT

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2017 6084**

FINDING INTO DEATH WITH INQUEST

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

I, PHILLIP BYRNE, Coroner having investigated the death of BH
AND having held an inquest in relation to this death on 4 – 5 OCTOBER 2021
find that the identity of the deceased was BH
born on 24 May 1968
and the death occurred on 2 December 2017
at East Geelong Victoria 3219

from:

I (a) HANGING

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

BACKGROUND

1. BH, 45 years of age at the time of his death, resided with his stepdaughter CS and her husband DS at East Geelong. He was married to Ms DH for some 20 years but due to matrimonial discord the couple were separated. BH and DH have one child together, MH, and each has children from previous marriages.
2. BH had quite long term mental health issues, including Post Traumatic Stress Disorder, a recurrent Major Depressive Disorder and anxiety, reportedly due in large measure to his previous employment as an ambulance pandemic in Western Australia between 2003 – 2015.
3. After leaving WA and coming to Victoria, BH was under treatment from several clinicians including his general practitioner Dr Shelley Gray, clinical psychologists Yeudda Sio, and Dr Cheryl Campbell of the Veterans and Veterans Families Counselling Service, and consultant psychiatrist Dr Arthur Velokoulis. BH had spent some time as a voluntary patient

in the psychiatric ward at the Alfred Hospital followed by a period as a patient at the Melbourne Clinic Richmond. BH had on occasions experienced suicidation, but in a session with Dr Campbell on 1 December 2017 he advised he continued to experience suicidal thoughts, but specifically denied he would act on them.

BROAD CIRCUMSTANCES SURROUNDING DEATH

4. On 8 November Senior Constable Blackmore of Fawkner Sexual Offences and Child-abuse Investigation Team (**SOCIT**) received a report from North Division of the Department of Health and Human Services (**DHHS**) in relation to information relating to alleged historical sexual assault of his daughter MH by BH.

5. On 13 November DH attended the Northcote police station and saw First Constable Keith Thompson. She reported emotional and psychological abuse of her and the children by BH. On behalf of DH First Constable Thompson completed an application for intervention order. The application was heard at the Melbourne Magistrates' Court on 21 November 2017 at which time an interim intervention order was made in favour of DH and MH. BH made no concessions and the matter was adjourned over for hearing to 19 December 2017.

6. On 15 November 2017 DH and MH accompanied by a DHHS worker attended the Fawkner police station and spoke with Senior Constable Blackmore. No allegation of sexual abuse was made at this meeting.

7. On 27 November 2017 MH and CS exchanged a series of texts in which MH told CS that her father had sexually abused her as a child.

8. On 28 November Ms Tamara Lewis of DHHS called Senior Constable Blackmore stating that DH had advised her MH had disclosed she had been molested as a child by her father.

9. Having spoken to BH's GP Dr Shelly Gray about MH's allegation, it was suggested CS attend the Geelong police station to advise police of her concerns about her father's wellbeing should police attend in relation to the allegation.

10. CS attended the Geelong police station shortly after 4pm and relayed to First Constable Amanda Dickinson her concerns should police attend the residence, particularly as she and her husband were going to Perth so that her father would in their absence be alone at the residence.

11. In the evening of that same day, 30 November 2017, DH and MH attended the Fawkner police station where MH disclosed to Senior Constable Blackmore of Fawkner SOCIT that

BH had sexually abused her as a child while the family lived in Perth. Senior Constable Blackmore conducted a formal Video Audio Recorded Evidence (**VARE**) interview in accordance with the relevant Victoria Police Manual Procedures. In the interview MH confirmed her allegation of historical sexual abuse by her father.

12. Following the interview of the previous day, on 1 December Senior Constable Blackmore arranged for an application and warrant seeking variation of the interim intervention order made on 21 November 2017 to include full exclusion of contact with DH and MH. Senior Constable Blackmore prepared a briefing note to accompany the application and warrant to the Geelong police station for service upon BH. The application/warrant and Briefing Note was forwarded to Geelong for service. <u>The basis for the application to vary the interim intervention order in place was specified in the application as historical sexual abuse of MH</u>.

13. When they commenced duty on 2 December 2017 Senior Constables Kane Brown and Lachlan Cartledge were tasked with serving the application and warrant on BH. Shortly prior to 9am Senior Constables Brown and Cartledge attended the East Geelong address, where BH was alone, and executed the warrant; advising what the basis of the process was. <u>To that time BH was not aware of MH's allegation of historical sexual abuse</u>.

14. Shortly after 9am on that morning Sergeant Gray of Geelong police attended the address and bailed BH to appear at Melbourne Magistrates' Court on 4 December 2017. Senior Constables Brown and Cartledge then left the address.

15. Shortly after 10:30am that morning BH sent an ominous email to CS, his GP Dr Shelly Gray, his psychologist Ms Cheryl Campbell, and his father Mr FH, in which he advised police had attended and served him with process in which it alleged historical sexual abuse. In his email he denied the allegation and made comments suggestive of an intention to self-harm.

16. BH's mother VH received the email BH had sent to his father and phoned CS, who as planned was in WA. CS phoned Shelley Gray and forwarded to her a copy of the email. Shortly after 1:30pm both Dr Gray and DS rang the 000 emergency number requesting a welfare check be undertaken.

17. Acting upon the request for a welfare check Senior Constable Adam Johnston and First Constable Dickinson attended East Geelong, gained entry and located BH hanging from a beam in the second bedroom. The police members cut the rope and lowered the body to the

floor. Subsequently, an Ambulance Victoria paramedic attended and at the scene declared BH deceased.

REPORT TO THE CORONER

18. BH's death was reported to the coroner. I took carriage of the matter. Having considered the circumstances, having conferred with a forensic pathologist and noting the family were hopeful an autopsy would not need to be performed, I directed an external only post mortem examination and ancillary tests. The directed post mortem examination was undertaken at the Victorian Institute of Forensic Medicine by Forensic Pathologist Dr Gregory Young who subsequently provided an Inspection and Report dated 5 December 2017 confirming BH's death was due to:

    I(a) HANGING

    Toxicological analysis of a post mortem blood specimen was largely unremarkable demonstrating prescribed anti-depressant medication and Temazepam at therapeutic levels.

ASPECTS OF THE LAW PERTAINING TO THE ROLE/FUNCTION OF THE CORONER

19. Before turning to the evidence I consider it incumbent to say something about aspects of the law that bear on my role. In my view, there is considerable misunderstanding in the broader community about the role of the coroner. Section 67 of the Coroners Act 2008 provides the three core findings a coroner must, if possible, make. The first two are generally non-controversial, the third, the circumstances in which the death occurred, can quite often be difficult.

20. Quite often of recent times an "interested party," usually a family member of the deceased, will seek to blame another party for the death, alleging criminality or more often negligence; neither are findings a coroner is empowered to make.

21. Keown v Khan,[1] a decision of the Victorian Court of Appeal, represents a landmark judgement which, in my opinion, provided much needed guidance to Victorian (and other) coroners. His Honour Mr Justice Callaway adopting a statement contained in the Brodrick Committee (UK) Report[2] said:

[1] (1999) 1 VR 69

[2] Report of the Committee on Death Certification And Coroners (1971) (UK) ("The Brodrick Report" Cmnd. 4810)

"In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination or blame."[3]

22. Again quoting the Brodrick Committee (UK) Report, His Honour noted:

"In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceeding which affords to others the opportunity to judge an issue and one which appears to judge the issue itself."[4]

23. So while not laying or apportioning blame a Coroner should endeavour to establish the CAUSE, or CAUSES, of a death; the distinction is fine but real. As Callaway J.A. described it in Keown v Khan[5]:

"In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was in breach of a recognised duty, but that is the only sense in which para. (e) mandates an inquiry into culpability. Adopting the principal recommendation of the Norris Report, Parliament expressly prohibited any statement that a person is or may be guilty of an offence. The reasons for that prohibition apply, with even greater force, to a finding of moral responsibility or some other form of blame."

24. I have found it difficult to articulate the apparent contradiction between on one hand a conclusion that an act departed from a norm or standard, or an omission was in breach of a recognised duty representing a causal factor in the death under investigation, and, on the other hand, not laying or apportioning culpability/blame/fault. The only explanation I have found was provided by the New Zealand Court of Appeal in Coroners Court v Susan Newton & Fairfax New Zealand Ltd[6], where it was stated:

"It is no part of the coroner's function to apportion blame for the death. The coroner must however be able to go beyond the mere cause of death if the coroner is to serve a useful social function, and must establish so far as is possible, the circumstances of the death. The implicit attribution of blame may be unavoidable in

[3] (1999) 1 VR 69, 75
[4] (1999) 1 VR 69, 75
[5] (1999) 1 VR 69
[6] [2006] NZAR 312

order for the coroner to ascertain or explain how the death occurred in the wider events that were the real cause." (my emphasis)[7]

25. It should be understood the Coroners Act does not provide a general mechanism for an open-ended enquiry into the merits or otherwise of the performance of government agencies, private institutions or individuals. In Harmsworth v The State Coroner[8], Justice Nathan broached the subject of the limits of a coroner's power and observed that the power of investigation is not "free ranging", commenting that unless restricted to pertinent issues an inquest could become wide, prolix and indeterminate. Significantly he added:

    "Such an inquest would never end, but worse it could never arrive at the coherent, let alone concise, findings required by the Act, which are the causes of death, etc. Such an inquest could certainly provide material for such comment. Such discursive investigations are not envisaged nor empowered by the Act they are not within jurisdictional power."[9]

26. The relevant principle was relatively recently re-stated in the Full Court of the Supreme Court of the Australian Capital Territory in R v Coroner Maria Doogan; ex-parte Peter Lucas-Smith and ors[10], and in Doomadgee and Anor v Deputy State Coroner Clements[11], Justice Muir commented that coroners are "not roving Royal Commissioners," and added:

    "The evidence relied on by the Coroner must be relevant to the matters within the scope of the coronial enquiry."

27. Standard of proof is a fundamental issue requiring comment. Not surprisingly, the starting point is Briginshaw v Briginshaw[12] where Dixon J, as he then was, provided the classic statement on the issue; he stated:

    "...reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations, which must affect the answer to the question whether the issue had been proved to the reasonable satisfaction of the tribunal. In such matters

[7] [2006] NZAR 312, 320
[8] (1989) VR 989
[9] (1989) VR 989
[10] (2005) ACTSC 74 (8 August 2005)
[11] (2005) QSC 357
[12] (1938) 60 CLR 336 at pp. 362-3

'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences."

HINDSIGHT BIAS

28. In considering whether a party, by act or omission, has caused or contributed to the death under investigation I must do so without the benefit of hindsight. If one were to allow retrospection to "creep" into one's considerations, conclusions reached may well be very different from those reached without that benefit. I find it important to constantly remind myself that I should endeavour to put myself "in the shoes" of the person whose performance is being assessed with the knowledge he/she had, or should have had at the time; it can be quite a challenging mental exercise.

COURSE OF THE INVESTIGATION

29. As the matter met the criteria for referral to the Victorian Systemic Review of Family Violence Death (**VSRFVD**), Deputy State Coroner Iain West referred the matter to the review team within the Coroners Prevention Unit (**CPU**).

30. Subsequently, I received a Family Violence Case Review Report from the unit within the CPU. Not surprisingly, in light if their role within the Court, the primary focus of the unit's review was on issues relating to family violence. From my perspective my investigation was on the circumstances surrounding BH's death, although very obviously the issue of MH's allegations was front and centre in my considerations.

31. Having examined the report, which contained criticism of the performance of several police members, I revisited my coronial brief of evidence and carefully reviewed the various statements therein. In conjunction with the material provided by VSRFVD and my examination of the brief, I formed tentative and non-conclusive views on several relevant matters.

32. As a matter of procedural fairness I asked my coroner's solicitor Mr Darren McGee to write to Victoria Police indicating my tentative views on aspects of police involvement, and enquire whether the Chief Commissioner would seek to resist/challenge/counter those tentative views. Mr McGee wrote to the Civil Litigation Unit of Victoria Police in a letter of 25 February 2020 with an attachment identifying the issues upon which I had formed tentative views.

33. Norton Rose Fulbright, solicitors acting for the Chief Commissioner of Police, in a document dated 25 May 2020 lodged a comprehensive submission which in broad terms

resisted the various tentative conclusions I had reached. I carefully examined the submission. Having done so I was not persuaded to alter my previous views. Ordinarily, I would have listed the matter for an open court Mention/Directions hearing to endeavour to progress the matter. However, due to the impact of the COVID-19 pandemic on the business of the Court, I asked Mr McGee to write to Norton Rose Fulbright advising I was not persuaded to alter the tentative view conveyed in the earlier correspondence.

34. In a letter of 4 September 2020 to Ms Katherine Goldberg of Norton Rose Fulbright Mr McGee advised Norton Rose Fulbright of my unaltered position in an attached document titled 'Response to Submissions lodged on behalf of Chief Commissioner of Police.' In that response Mr McGee advised that I had acknowledged police were not investigating nor serving process in relation to the investigation of crime, historical sexual abuse of MH by BH, but executing a complaint and warrant in relation to an application to vary a family violence intervention order. However, from my perspective the critical issue, the fundamental basis of the complaint and warrant, was the alleged historical abuse of MH by her father, information that until service on the complaint was unknown to BH.

35. A very comprehensive Supplementary Submission on behalf of the Chief Commissioner of Police dated 17 November 2020, this time under the hand of Catherine Fitzgerald of Counsel, was lodged. It reinforced the Chief Commissioner's position to resist any adverse finding in relation to interaction, engagement by police members with CS and BH proximate to the death.

36. At paragraph 35 of her submission Ms Fitzgerald wrote:

> *"The Coroners Court is required to act fairly in its assessment of the witnesses and their conduct.[13] More specifically, a Coroner is required to accord natural justice, especially before making any adverse findings concerning any person.[14] While it is appreciated that the Chief Commissioner of Police has been provided an opportunity to respond to the Coroner's proposed findings, natural justice requires that individual witness have the substance of any adverse criticism of them as individuals put to them for comment – acceptance, rejection or explanation – whilst in the witness box.[15] Before deciding any fact, commenting or making a Finding under s 67(1) which reflects unfavourably on an individual, the Coroner must ensure that the requirements of procedural fairness have been met."*

[13] Specifically required by s 8 of the Act.
[14] *Annetts v McCann* (1990) 170 CLR 596, 608 (per Brennan J)
[15] In accordance with the long-standing requirements of *Browne v Dunn* (1893) 6 R 67.

It was for that very purpose that I advised I would take the matter to inquest.

37. The matter proceeded to formal inquest on 4 October 2021. Mr Rishi Nathwani appeared as Counsel assisting with Ms Fitzgerald briefed by Norton Rose Fulbright, solicitors, appeared on behalf of the Chief Commissioner of Police and the police members being called to give evidence. The primary focus of the inquest was the involvement of several police members who had engaged with DH, MH, CS and BH in the several days prior to BH's death. In order of involvement the principal players were Senior Constable Kirsty Blackmore of Fawkner SOCIT, First Constable Amanda Dickinson, Senior Constables Kane Brown and Lachlan Cartledge, and Sergeant Mark Gray.

38. Earlier in this finding I discussed the subject of the involvement of DHHS, Ms MH and Senior Constable Blackmore which led to the formal VARE interview and the decision by Senior Constable Blackmore to issue an <u>application for variation</u> of the interim intervention order previously made. I do not propose to revisit this events, but move on to the events of 30 November – 2 December 2017.

39. At approximately 4:10pm on 30 November 2017, being aware of MH's allegations of historical sexual abuse and having been advised to do so by psychologist Ms Cheryl Campbell, CS attended the Geelong police station where she spoke with First Constable Dickinson. There is contention in relation to what CS said to First Dickinson but it is clear she advised First Constable Dickinson her father was a suicide risk, she was aware of MH's allegation, her and her husband were going to WA the next day and BH would be home alone at the East Geelong address. There is contention whether CS specifically stated her father was at heightened risk of suicide if police attended. While I am unable to reach a conclusion on what <u>precisely</u> was conveyed to Fist Constable Dickinson, I am satisfied the mere attendance of CS at the police station, together with the information that her father would be at heightened risk of self-harm if police attended in her absence in WA, should have resulted in First Constable Dickinson understanding that if police did attend, BH was at heightened risk of self-harm. On the basis of the information that was conveyed First Constable Dickinson decided she would flag it on the Law Enforcement Assistance Program **(LEAP)**. When she accessed the program, noting there were personal warning red flags already on the program in relation to BH having mental health issues, was a suicide risk and had previously had panic attacks during police involvement, she decided not to pursue her previous intention and did <u>not</u> put an updated personal warning flag on LEAP.

40. In examination First Constable Dickinson stated that while she could not recall the exact wording, conceded that CS's concern was that her father would be at higher risk of suicide if police attended while she was away. She also conceded it is important to keep LEAP up to date; that of course is the very purpose of the program.

41. I include at this point an excerpt from the transcript of First Constable Dickinson's evidence. Mr Nathwani put to First Constable Dickinson:

> *"You were asked just then about whether or not – well, the purpose of your notes, including everything important, you agree your notes do not say he's an ongoing suicide risk?"*

First Constable Dickinson replied:

> *"Yes."*

He continued:

> *"Do you agree ongoing suicide risk was perhaps the most important information you were provided?"*

First Constable Dickinson replied:

> *"Yes."*

42. Further, Mr Nathwani asked:

> *"Do you agree you should've put the information on as giving the most recent, relevant information to anyone viewing the LEAP records?"*

First Constable Dickinson replied:

> *"Um, looking back, it probably should have been updated in this scenario."*

43. It is noteworthy that First Constable Dickinson accepted that looking back perhaps an undated personal warning flag should have been put on LEAP. Quite frankly, that was a concession that had to be made.

44. It is my firm view by not submitting a Form 292 for approval by a more senior officer was an omission by First Constable Dickinson. Whether this would have altered the tragic outcome I will discuss later in this finding.

45. I turn to the involvement of Senior Constable Blackmore of the Fawkner SOCIT. Earlier in this finding, in broad terms, I referred to Senior Constable Blackmore's involvement in the formal VARE interview where MH alleged historical sexual abuse by her father. I do not

propose to revisit those matters, but at this point focus upon the issue of the complaint and warrant to vary the previously made interim intervention.

46. After examining LEAP and noting the warning flags Senior Constable Blackmore prepared a briefing note to accompany the complaint and warrant which was to be forwarded to Geelong for service. In evidence, in response to questions put by Counsel Assisting, Senior Constable Blackmore accepted she, as an experienced SOCIT member, was aware there was a heightened risk of suicide when an individual was advised of an allegation against them of sexual assault of their child. Senior Constable Blackmore also accepted she was aware that on 12 November 2017 BH threatened self-harm resulting in police taking BH to hospital for a mental health assessment. It is unclear to me whether BH was taken voluntarily, or section 351 of the *Mental Health Act* was invoked and he was apprehended and conveyed to hospital.

47. Mr Nathwani summarised what CS had conveyed to First Constable Dickinson at Geelong police station the day before and asked whether she, Senior Constable Blackmore, accepted if that information had been on LEAP she believed she would have included it in her briefing note. Senior Constable Blackmore responded saying she believed she would have included it in her briefing note; confirming her answer in response to a question from me. Senior Constable Blackmore stated she would have included that information because it was "updated" information.

48. The briefing note advised the members serving the process that when served it would be the first time BH would be aware of the allegation of sexual abuse of MH.

49. Having regard to several questions put to Senior Constable Blackmore by Ms Fitzgerald for the Chief Commissioner of Police at the commencement of her examination of Senior Constable Blackmore, I indicated I took <u>no</u> issue with the decision to seek to vary the intervention order by way of complaint and warrant; having regard to the seriousness of the allegation I accept to proceed in that manner was entirely appropriate, and I do not recall it being suggested otherwise.

50. In relation to Senior Constable Blackmore's preparation of the briefing note, I accept she believed she was doing the right thing. However, I suggest it would have been appropriate for Senior Constable Blackmore to include in the briefing note reference to the incident of 12 November 2017 where BH threatened suicide. I suggest that incident could not adequately be described merely as <u>ongoing</u> risk of suicide; it went beyond a mere risk, it was a direct threat.

51. The critical issue, in my view, is the information conveyed to First Constable Dickinson by CS was not contained in the briefing note <u>because it has not been put on LEAP</u>.

52. Senior Constables Cartledge and Brown were tasked with executing the warrant and complaint in relation to the application to vary the intervention previously granted.

53. Senior Constables Cartledge and Brown discussed the nature of the process they were to execute and the content of the briefing note accompanying the process. In evidence Senior Constable Brown confirmed he read Senior Constable Blackmore's briefing note and discussed the content with Senior Constable Cartledge. Senior Constable Brown accepted that in the majority of situations if a briefing note was in existence it would be relied upon the provide information about the person they are to engage with.

54. Attending at East Geelong the two members were invited in, spoke with BH and executed the warrant. At that time BH was in custody awaiting Sergeant Gray to attend to bail him. In their statements both Senior Constables Cartledge and Brown said BH appeared shocked. Senior Constable Brown stated BH also appeared "slightly angered;" the anger directed towards the actions of his wife.

55. Mr Nathwani put to Senior Constable Brown that information of the events of 17 November 2017, together with information relating to CS's discussion with First Constable Dickinson, would have been relevant to the task he and Senior Constable Cartledge were about to perform. Not surprisingly, Senior Constable Brown accepted that sort of information would have been relevant.

56. Senior Constable Cartledge acknowledged he observed the document referred to as an "action plan" on the wall just inside the front door of East Geelong, but was not entirely clear as to what it was meant to convey. At the conclusion of his evidence Senior Constable Cartledge stated that at no time during the time spent in the company of BH did BH say or do anything to suggest to Senior Constable Cartledge that he was depressed or suicidal.

57. Sergeant Gray arrived during Senior Constables Cartledge and Brown's attendance at East Geelong for the purpose of bailing BH. In his statement Sergeant Gray expanded somewhat on Senior Constable Cartledge's assessment stating BH "did not appear interactive with us and was distant." All three members stated that when asked was he okay BH said he was alright. Sergeant Gray stated he was not convinced, stating:

> *"I wasn't overly convinced, but there was nothing in his actions, mannerisms or words to indicate to me that he was about to commit suicide. I took it he was quite*

depressed and enough to get my attention, to make the offers for assistance. We then left altogether. Outside in the street, I said to the 2 Geelong Van Crew members, it would not surprise me if we were called back here for an attempted suicide, based on my observations of him. At this stage there was no power of arrest under section 351, just a hunch with 28 years of policing experience."

Sergeant Gray added:

> *"At no stage did I have a power of arrest, nor enough concern to take BH under arrest due to 351. I felt I had given him every opportunity to disclose his feelings, which he chose not to. There is nothing I could have done in hindsight differently to effect the outcome, or prevent him from taking his own life."*

I accept there was no basis for any of those attending members to invoke s 351 of the *Mental Health Act 2014.*

58. In evidence Sergeant Gray accepted he personally did not access LEAP that morning, stating that if there was anything of importance on the LEAP record the crew would have advised him. He added the checks on LEAP should have already been done *en route* by the van crew. He stated that he did not know what the basis of the complaint was as his function was merely to attend the address and bail BH. He stated he did not see the briefing note. Sergeant Gray said he was not aware of an action plan on the wall, nor did Senior Constables Cartledge nor Brown discuss it with him.

59. Sergeant Gray, a vastly experienced police officer, was asked about BH's demeanour knowing that he had for the first time been advised of the basis of the complaint and warrant. He stated he felt "something wasn't right," but couldn't "put his finger" on what it was, stating BH was "staring into the distance" and "not engaging" as one would expect. Although initially Sergeant Gray said he could not recall saying he considered BH "depressed," but having been referred to his statement he accepted that is what he wrote at the time.

60. Sergeant Gray was referred to the discussion he had outside the residence when the members left where it was suggested he said he wouldn't be surprised if they were called back later in relation to the prospect of self-harm. Sergeant Gray said he was merely "thinking out loud," verbalising his thoughts because "something was just not sitting right."

61. I include here excerpts from Sergeant Gray's *viva voce* evidence which are, in my view, significant. Mr Nathwani asked:

"You concluded there was no power of arrest under s 351?"

Sergeant Gray responded:

> *"Absolutely not. There was no – even a threat of him harming himself, there was no indication. There was no external things that I was aware of that would indicate he was going to harm himself. The questions I had given him, he gave me the answers that were sufficient for me to be satisfied that he wasn't going to do anything."*

Mr Nathwani then put the following proposition to Sergeant Gray:

> *"Now, as far as the information – because you're obviously – and I don't criticise you because I really don't – and it's clear you were reliant on the information provided to you by the other officers present. Had you been aware of a number of facts I'm going to ask you about, whether that would have changed your position under 351 looking back now; not on the fact that he did ultimately commit suicide, but actually on the information available dealing with him at the time. Had you been aware that the day before his daughter had attended the police and been told a warning flag would be put on the system related to his ongoing risk of suicide which is enhanced or there's increased risk with police contact; would that have changed any way that you dealt with him or put into context the observations you had of him?"*

Sergeant Gray responded:

> *"It would have clarified in my mind I needed to probably question deeper and see if he could – he would elicit anything. But the questions I gave him he gave me the answers and indicated he wasn't going to harm himself. So it's always handy to have that extra information so I can make an assessment, of course."*

In my view that exchange demonstrates the significance of First Constable Dickinson's failure to submit a Form 292 in relation to what I am satisfied CS conveyed to her at the Geelong police station on 30 November 2017.

62. I am unclear whether an entry was made on LEAP relating to the incident some three weeks earlier where BH threatened suicide and held a knife to his stomach resulting in him accompanying police to Geelong Hospital for a mental health assessment. Apparently the issue was referred to in a police family violence report. In relation to that incident Mr Nathwani asked Sergeant Gray:

"How about if you'd had information that three weeks earlier he had – the police had been called to deal with him when he had a knife to his stomach, was threatening suicide and the police took him to the hospital? Would that have been information as part of a picture perhaps?"

Sergeant Gray responded:

"Of course. It doesn't change the fact whether I would have made the decision on the day as to whether I left him there or not based on the information I had and what I was dealing with. But yeah, it would help maybe formulate a picture and probably address the way we were working with him."

I have added the last exchange to demonstrate that the members attending would have had a clearer and more complete picture had they been in possession of more detail of these events when they attended on 2 December 2017.

ADDITIONAL COMMENTARY AND CONCLUSIONS

63. I should be clearly understood that it is <u>not</u> part of my role to make any assessment as to the veracity of the allegation of historical sexual abuse of MH by her father; it remains an untested, unproven claim that was vehemently denied by BH in his handwritten note addressed, "to who (sic) it may concern."

64. I think I have made it clear that I conclude First Constable Dickinson should have sought to <u>update</u> LEAP in relation to the information conveyed to her by CS; if I have not I now formalise that conclusion.

65. If that important information had been on LEAP, I have no doubt Senior Constable Blackmore would have included it in her briefing note, but it was not. In relation to Senior Constable Blackmore <u>if</u> she was aware of the events of 12 November 2017 when BH was conveyed to hospital for a mental health assessment, information that was in the family violence report, which I understand she was aware of, I believe that should also have been put on LEAP.

66. It is clear neither Senior Constable Kane and Cartledge accessed LEAP in the van on the way to East Geelong, but I conclude that is not as critical as one may think because the events of 12 November and the information conveyed to First Constable Dickinson by CS was not there. However, had Senior Constables Cartledge and Brown check LEAP the information logged there by Senior Constable Walls on 13 October 2016 it may, and I put it

no higher than that, have provided a clearer picture of how to engage with BH when they executed the warrant.

67. It is to be recalled that during the course of the investigation I expressed a tentative view that although it was not mandated by the Victorian Police Manual (**VPM**) Procedures and Guidelines in force at the time, attending members should have provided to BH the information and materials they would be required to provide if they were serving process in relation to a criminal offence involving allegations of this nature; allegations disclosed to the alleged perpetrator for the first time.

68. As I pen this finding it is enlightening to see how hearing *viva voce* evidence at formal inquest, rather than just relying "on the papers," provides a much clearer understanding of the events that occurred involving police members; it enhances the mosaic.

69. I now turn my mind to the issue of the action plan (referred to by Dr Shelley Gray as a "crisis plan") developed in consultation between BH, CS, Dr Cheryl Campbell and Dr Gray. The handwritten plan, a copy of which is contained in the coronial brief at page 127, was prepared by CS and attached to the wall inside the door at the East Geelong address. The intention was that if police attended BH would call those nominated: his therapist Dr Velokoulis; Dr Gray; Dr Campbell; or CS herself. In her statement CS stated:

> *"I hoped that if police were called to our house that they would see this list and ensure that Dad made the calls whilst they were still there with him."*

70. When the police members attended on 2 December 2017, CS's expectations were that police would stay with BH and "ensure" he made the calls. We know the members did not wait to "ensure" BH made the calls to the clinicians, and CS's expectation was not met. But the real question for me is what, if anything, should they have done? That important question depends to a large degree on what they knew, or should have known, and their observations of BH.

71. Again that takes me back to the fact LEAP was not updated in relation to the information conveyed to First Constable Dickinson by CS. That omission was perpetuated down the line, so that neither Senior Constable Brown, Senior Constable Cartledge, nor Sergeant Gray were fully cognizant of what the action plan proposed.

72. Although Sergeant Gray said he thought something was not right, I do not think it could be reasonably argued that BH's presentation while in the presence of the members warranted them waiting and ensuring BH made the calls to his treating clinicians. Furthermore the

members were not empowered to require BH to make the calls; the decision to call or not to call was a matter for him.

73. It is obvious I have retreated from my earlier tentative view that either Senior Constable Cartledge or Senior Constable Brown should have provided to BH the information/material required under the VPM Procedures and Guidelines for the investigation of sexual offences (my emphasis). I reiterate to do so was not mandated. I understand amendments to the relevant part of the VPM now requires members to provide the information and material to an individual being served with process in which it is alleged that a person sexually assaulted a family member.

74. I also note evidence of the attending members that when asked if he was alright, and wanted attending police members to do something, BH stated he was alright and did not require them to do anything.

75. If the members had been aware of the information conveyed to First Constable Dickinson by CS, and if it had been they would therefore have had a better understanding of the action plan, then I believe it would have been incumbent upon them to further discuss with BH the actions the plan suggested he take, but I reiterate they could not force the issue.

76. The tragedy is BH did not phone any of this treating clinicians as the action plan proposed, but shortly after police members left he intentionally took his own life. It is clear I suggest that becoming aware of MH's allegation for the first time was the catalyst for his actions, the "straw that broke the camel's back."

77. This matter demonstrates the difficulty in predicting when a person with mental health illness is at risk of crossing what I call the suicide threshold; basically the best these police officers could do, under the circumstances with the knowledge they had, was to undertake an assessment. The fact that BH suicided shortly after they left does not necessarily mean the assessment was flawed.

78. At the completion of evidence and oral submissions by counsel, Mr Nathwani read from a document lodged by CS which he described as a "personal message" to the Court. That poignant message appears at page 224 pf the transcript.

79. In the final analysis, I have asked myself what should/could the attending police members have done at East Geelong on the morning of 2 December 2017. I have concluded, having regard to BH's presentation, that the criteria for invoking section 351 were not met,

consequently police members were not empowered to apprehend BH and convey him to Geelong Hospital for a mental health assessment.

80. Attending members were not entitled to "ensure" BH contacted the clinicians referred to in the "action plan." Perhaps the members could have discussed with BH the prospect of him actioning the plan and calling the clinicians, but ultimately whether BH did or did not do so was ultimately a matter for him.

81. Save for the criticisms I have referred to earlier in this finding, which likely would have affected the way Senior Constables Cartledge and Brown and Sergeant Gray approached their task, I could not reasonably be critical of other aspects of the police contacts with BH proximate to his untimely death.

FINDING

82. I formally find BH, suffering mental illness and hearing for the first time that his daughter MH had accused him of historical sexual abuse, on 2 December 2017 at East Geelong intentionally took his own life.

COMMENT ON PROFESSIONAL STANDARDS

83. BH's death was in the context of what the Court considers a "police contact" death, having been formally under arrest and in the company of Senior Constables Cartledge and Brown on the morning of 2 December 2017. It is to be noted that the investigation on behalf of the Coroner, following established procedures/protocols, was oversighted by Detective Acting Senior Sergeant Christopher Alexander of the Professional Standards Command (Investigation Division of Victoria Police). Irrespective, I acknowledge the investigation of the event by Detective Senior Constable Simon Keogh of Geelong Crime Investigation Unit was comprehensive, thorough and objective. The coronial brief of evidence submitted by Detective Senior Constable Keogh was also comprehensive.

DISTRIBUTION OF FINDING

84. Pursuant to section 73(1) of the *Coroners Act 2008*, I order that Finding be published on the internet.

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

    DH, Senior Next of Kin;

    CS;

    AY;

    Mr Rishi Nathwani, Counsel Assisting;

    The Chief Commissioner of Police;

    Ms Catherine Fitzgerald;

    Ms Katherine Goldberg, Norton Rose Fulbright

    Detective Sergeant, Chris Alexander, Professional Standards Command

    Senior Constable Simon Keogh, Coroner's Investigator, Victoria Police

Signature:

PHILLIP BYRNE
CORONER
Date: 17 December 2021