IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 005548

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Sarah Gebert
Deceased:	Jason [redacted]
Date of birth:	[redacted]
Date of death:	18 October 2021
Cause of death:	1(a) Neck compression 1(b) Hanging
Place of death:	A bridge near Boundary Street, Kerang, Victoria
Keywords:	Family violence; suicide; mental health; Aboriginal

Aboriginal and Torres Strait Islander readers are advised that this content contains the name of a deceased Aboriginal person.
Readers are warned that there may be words and descriptions that may be culturally distressing.

INTRODUCTION

1. At the age of 30 years, Jason [redacted] discovered his Aboriginality and that his Great Grandfather was from around the Gulf of Carpentaria.

2. On 18 October 2021, Jason was 50 years when he was found deceased in Kerang in circumstances which suggested he had taken his own life.

3. He was a fly in fly out worker travelling between Kerang, Victoria, and South Australia at the time of his passing.

4. Jason had four sons with his wife, Kellie [redacted], and one daughter to a previous partner. He was still married but separated at the time of the fatal incident[1] and had been in a relationship with P [redacted] ('P')from February 2020 to 9 August 2021.

5. Jason grew up in Queensland and had a troubled adolescence including excessive alcohol consumption, drug use, and gambling.[2] Jason met Kellie when he was 16 years old, and they formed a relationship shortly after meeting.

6. Jason was reported to have an extensive history of perpetrating physical violence. As a child, Kellie said that Jason himself was the subject of family violence at the hands of his father, who later took his own life. When consuming alcohol, Jason was reported to become violent and aggressive and was imprisoned on at least two occasions for serious assaults.[3]

7. Jason had reportedly attempted suicide on two occasions in the past, once after the birth of his second child in 1998 when he attempted to light himself on fire and a second time in 2000 when he attempted to overdose on anti-depressant medications.[4]

8. From 2019, Jason completed qualifications to be a Health and Safety Advisor in the construction industry and commenced ‘fly in and fly out’ contracts with a renewable energy provider in South Australia. Jason would travel interstate for work and return for periods to stay in Kerang with 'P' prior to their separation in late 2021.

9. Jason consulted a general practitioner at the Port Auguster Medical Centre over 2020 and 2021 with his last consultation on 2 September 2021. He had been prescribed the antidepressant

[1] The separation followed an incident in June 2020 when Kellie travelled to Kerang with their children to surprise Jason, but discovered him with 'P' in Echuca. Jason did not see his children after this incident.

[2] Coronial Brief, Statement of Kellie [redacted] 22

[3] Coronial Brief, Statement of 'P' 14-15; Statement Kellie [redacted], 22-23

[4] Coronial Brief, Statement of Kellie [redacted], 24

Effexor in the past and was concerned about depression (noted as long term depression), mood swings and anger management.

THE CORONIAL INVESTIGATION

10. Jason's passing 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.

11. 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.

12. 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.

13. Victoria Police assigned Senior Constable Joelyen Lloyd to be the Coroner's Investigator for the investigation of Jason's passing. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

14. I also requested a copy of Jason's Medicare and Pharmaceutical Benefits Scheme (**PBS**) claims history for the period from 18 October 2020 to 18 October 2021, and subsequently obtained his medical records from the Port Augusta Medical Centre.

15. This finding draws on the totality of the coronial investigation into Jason's passing 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.[5]

[5] 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.

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

Circumstances in which the passing occurred

16. On 9 August 2021, 'P' and Jason separated. Despite 'P's wishes, Jason continued to contact her after this date. This occurred even though a Family Violence Intervention Order (**FVIO**)[6] (with no contact conditions) was in place having been made in February 2021.[7]

17. In the lead up to the fatal incident, Jason had pending charges against him for breaching the FVIO and stalking 'P'.[8] He was on bail with conditions similar to the FVIO and was due to face the Kerang Magistrates' Court for FVIO contravention charges on 21 October 2021.[9]

18. From 11.30pm on 17 October 2021 to approximately 4.30am on 18 October 2021, Jason was present at 'P's home. He forced his way into the residence where he prevented 'P' from leaving and was physically violent towards her, over approximately five hours.[10] 'P' reported that she activated her personal safety watch (**alarm**) three times during the ordeal, but police did not attend.

19. Following 'P's activation of the alarm, a security monitoring service received audio and location data from 'P's watch but triaged the notification as a non-family violence event.[11] The service attempted to contact 'P' but were unable to reach her. The service then contacted the Mallee Domestic Violence On-Call Service who advised them to contact the police however, this did not occur.[12]

20. Jason left 'P's residence at around 4.30am through the back door and was observed to be carrying a rope with a noose. Sometime between 5.40am and 5.50am, Jason walked over to a footbridge approximately 900 metres away from 'P's residence and used the rope he had carried with him to hang himself from the footbridge.

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[6] A Family Violence Intervention Order is a civil order which aims to provide an affected family member (including children) and their property with protection. Conditions can include stopping family violence behaviour, not contacting or communicating with a protected person, or get someone else to do it for them and not to go or stay near the protected person, or get someone else to do it for them.

[7] DFFH L17 portal records, 16

[8] Ibid, 2

[9] Ibid

[10] Coronial Brief, Statement of 'P', 16-17

[11] Coronial Brief, Commsync notes, 110-112

[12] Ibid

21. Several members of the public observed Jason's body shortly after and a report was made to police. Ambulance paramedics and police members arrived at the scene at around 6.20am and confirmed that Jason was deceased.

22. Police found no evidence of suspicious circumstances surrounding Jason's passing following their investigation.

23. Kellie said that COVID had a significant effect on Jason as he became isolated and confined to one spot which he hated, and had to rely more heavily on those around him. She stated, *Jason really did have too much going on in the end. The COVID thing did his head in. I think he was off his medication which had been prescribed to him by a doctor in Port Augusta. He was most likely drinking too much alcohol, he was obviously struggling with his relationship with 'P', and he had just lost a healthy relationship with his sons. All of this along with his previous mental health problems no doubt played a role in him taking his own life. It was like the perfect storm for Jason.*

Identity of the deceased

24. On 20 October 2021, Jason [redacted], born [redacted], was identified by fingerprint record comparisons.

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

Medical cause of death

26. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on Jason's body on 19 October 2021 and provided a written report of her findings dated 19 October 2021.

27. The post-mortem examination was consistent with the circumstances in which Jason was discovered. There were no significant post mortem CT scan findings.

28. Toxicological analysis of post-mortem samples identified the presence of alcohol at a concentration level of 0.02g/100mL. No common drugs or poisons were otherwise detected.

29. Dr Fronczek provided an opinion that the medical cause of death was *"1(a) Neck compression"* secondary to *"1(b) Hanging".*

30. I accept Dr Fronzcek's opinion.

FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

31. In light of Jason's passing occurring in circumstances involving recent family violence[13], I asked the Coroners Prevention Unit (**CPU**)[14] to examine his case as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[15] In particular, I was concerned that a safety measure put in place to protect 'P', proved ineffective. The in-depth family violence investigation process identified a number of concerns which I will make comment on below.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with Jason's passing.

32. Whilst I make observations concerning the service engagement with Jason, the available evidence does not support a finding that there is any causal connection between the circumstances highlighted in the observations made below and Jason's passing.

Orange Door – Incomplete family violence perpetrator police referrals

33. Family Safety Victoria is operationally responsible for the Orange Doors which have been rolled out across the state of Victoria. The Orange Door is an access point which provides advice and assistance for women, children and young people who are experiencing family violence.

34. Perpetrator support services make up part of the services provided by the Orange Door and are responsible for contacting respondents[16] referred to their service by way of an L17 referral. L17 referrals consist of a Risk Assessment and Management Report that police members complete when family violence incidents are reported to police. When an L17 is received by the Orange Door, the service aims to connect the respondent to relevant services including men's behavioural change programs and similar supports. In this case, the local Orange Door

[13] For the purposes of the *Family Violence Protection Act 2008*, the relationship between Jason and 'P' was one that fell within the definition of '*de-facto partner*'[13] under that Act. In addition, the available evidence suggests that Jason perpetrated '*family violence*'[13] against 'P' in the lead up to the fatal incident.

[14] The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

[15] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community

[16] A respondent is a person who is the subject of an application for protection (either protection under a Family Violence Intervention Order or Family Violence Safety Notice) by an individual or police member.

received at least three L17 referral requests in February, August, and October of 2021, identifying Jason as the respondent.

35. The available evidence in this case indicates that following each referral, an Orange Door worker attempted to contact Victoria Police to check if a FVIO had been served on Jason (to ensure the safety of the affected family member), but were unable to reach police and closed the referral.[17] This meant that Jason was never contacted and offered support. Several other coronial investigations have noted similar circumstances in which a respondent was not contacted or supported following referral to a support service by police.

36. Family Safety Victoria provided the following policies to the Court in October 2023: *Responding to Victoria Police incomplete referrals for respondents – Statewide operational guidance* and *Adults using family violence risk assessment – Interim statewide practice direction*. These two documents appear to indicate that all referrals to the Orange Door must receive an "Assessment and Planning" response. This response requires workers to implement risk management strategies before closing a referral.

37. The key document, *Responding to Victoria Police incomplete referrals for respondents – Statewide operational guidance*, came into operation from August 2022 (after the fatal incident) and includes the following prerequisite actions before an incomplete referral can be closed by the Orange Door:

    (a) Proactive email follow up with Victoria Police within 48 hours of receiving the incomplete referral and a subsequent phone call to the reporting police member/station as soon as the initial follow up has been sent;

    (b) Orange Door workers will seek to proactively engage with other services internally within the Orange Door who may be working with the affected family member, including seeking consent to contact the respondent when there is an agreement with a team leader on the approach and safety of the affected family member;

    (c) If the respondent is engaged with an external service/justice response, the Orange Door will proactively share information as per the Information Sharing scheme and send a reminder email to Victoria Police one week after receiving an incomplete referral if no response from Victoria Police has been received regarding service of an FVIO/FVSN;

[17] Orange Door statement dated 24 October 2023, 2

(d) Before closing an incomplete referral practitioners must consult with any Orange Door practitioners who may be working with the affected family member and/or consult with a Practice Leader or team leader. The referral will be closed after two weeks unless the affected family member or other services request that the referral remains open. The referral will only be closed if assessed as appropriate and no other strategies can be implemented.

38. I believe these new requirements outlined above are substantive and address the gaps evidenced in this case and others investigated by the Court.

The operation of the Personal Safety Initiative in Victoria

39. In April 2017, the Personal Safety Initiative (**PSI**) was rolled out across the State, as a government funded initiative to allow women and children who have experienced family violence to access a Personal Safety Device, safety audits by security specialists, installation of personal or home safety technologies, and 24/7 monitoring and support.

40. 'P' received a Personal Safety Device watch through the PSI operated by the Mallee Sexual Assault Unit Inc Mallee Domestic Violence Services (**MSAU-MDVS**).[18] This watch was monitored by Commsync, a registered security monitoring service. A MSAU-MDSVS practitioner worked with 'P' and developed a safety plan. The safety plan was emailed to Commsync on 21 September 2021 and 'P' was issued a watch on 23 September 2021.[19]

41. The safety plan developed by MSAU-MDVS in consultation with 'P' required contact to be made via SMS or email to 'P's designated contacts, which included 'P's mother and MSAU-MDVS staff, if an alert was activated.[20]

42. Just hours prior to the fatal incident, Jason perpetrated significant and extensive family violence towards 'P' over a period of approximately five hours. During this ordeal, it was reported that Jason tried to suffocate 'P' and hang her with rope over her bedroom door. 'P' managed to fight Jason off during this assault and he left the premises and took his own life shortly after.

43. 'P' notes that she activated the alarm on her personal safety watch three times during this incident, however, Commsync did not call police.

[18] Mallee Sexual Assault Unit Inc Mallee Domestic Violence Services records provided to the Court, 44-45
[19] Commsync statement dated 12 July 2022, 1
[20] Ibid

44. Commsync have confirmed that they received audio and location data from 'P's watch but triaged the alert as a 'no family violence evident'.

45. Following 'P's activation of the watch, Commsync listened to the audio captured during the activation and noted that no concerning audio was heard. This contradicts evidence from 'P', who reported that she initially spoke into the watch and said "*please help me*" at least twice, on two separate occasions during the ordeal. The Court requested audio evidence, but Commsync confirmed that this was not available.[21]

46. After listening to this audio recording staff then attempted to contact 'P' and were unable to reach her. Commsync then contacted the Mallee Domestic Violence On-Call Service (part of MSAU-MDVS) who advised the security service to contact the police. They did not contact police despite this advice.[22]

47. To clarify the operation of the PSI, I requested that Family Safety Victoria provide a response to address both the standards applicable to their Personal Safety Initiative and the lack of response to referrals for respondents of family violence.

48. Family Safety Victoria provided the following policies to the Court in October 2023: *Personal Safety Initiative – Minimum Technology Standards* and *Personal Safety Initiative – Minimum requirements for auditing, installation and monitoring services*. These policies outline the minimum requirements for safety technology and security providers who are contracted to provide services under the PSI. Neither of these documents provide instruction for how security providers must validate an activation of a personal safety device, when police must be contacted or whether a safety plan should be developed to guide provider responses.

49. Instead, these documents note that providers need to comply with the *National Police Alarm Activation Response Guidelines* (**Guidelines**). These guidelines stipulate that monitored personal safety alarm service providers are only to contact police upon 'validation' of an activation by an alarm user. Validation occurs "*by attempting to contact the MPSA [Monitored Personal Safety Alarm] user. If unable to contact the MPSA user, contact to be made with user's supervisor or employer for direction"*.

50. These guidelines do not clarify what information is sufficient for validation and do not provide guidance on specific considerations that should be given to incidents of family violence. These

[21] Ibid, 2
[22] Mallee Sexual Assault Unit Inc Mallee Domestic Violence Services records provided to the Court, 32

Guidelines also fail to provide specific provisions or requirements for providers to adhere to a safety plan or require providers to adhere to the instructions of user's designated contacts.

51. Family Safety Victoria confirm that they have consulted the family violence sector in developing both policy documents noted above and have had an independent security consultant review the policies.[23]

52. The available evidence suggests that there is a significant gap in the operation of personal safety device monitoring, evidenced by the circumstances of this case. It is important for personal safety alarm providers to have well established, comprehensive guidelines for staff to follow when responding to alarms triggered by victim-survivors of family violence. It is especially important for these services to recognise the unique circumstances of victim-survivors of family violence and the unreliability of incoming audio to decern risk.

53. Whilst there are clear benefits to the implementation of the PSI, the circumstances of this case demonstrate the need for further training and development of policies to adapt to the dynamics of family violence environments. This includes training and policies that work with victim survivors according to their individual safety plans and unique circumstances.

RECOMMENDATIONS

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

1. With the aim of promoting public health and safety and preventing similar deaths, I recommend that **Family Safety Victoria**:

    (a) in consultation with the sector, develop a standardised safety plan template that must be completed with the victim-survivor and provided to security providers responsible for monitoring personal safety devices funded by the Personal Safety Initiative (**PSI**). This template must, at a minimum:

        i. provide instruction on how the security provider should respond to the activation of a personal safety alarm when the victim-survivor and/or their contacts are unable to be reached; and

        ii. a copy of the safety plan should also be provided to the victim-survivor and reviewed at regular intervals.

[23] Orange Door statement dated 24 October 2023, 1

(b) make changes to the *Minimum requirements for auditing, installation and monitoring services* to ensure that all security providers that are contracted to deliver monitoring services under the Personal Safety Initiative are required to have a copy of a victim survivor's completed safety plan template on file, as outlined in Recommendation 1(a) and that this must be followed by the security provider when a personal safety alarm is activated;

(c) coordinate with the Australian Security Industry Association Limited (**ASIAL**) to develop an update to the *National Police Alarm Response Guideline* to provide clear instructions on when security providers are required to contact police following the activation of a Monitored Personal Safety Alarm by a user who has an alarm for family violence related reasons. Amendments to this document should include:

i. clear guidance on when activation of a Monitored Personal Safety Alarm should be considered 'validated', including in circumstances where the user cannot be contacted;

ii. the limitations of reviewing audio captured by a Monitored Personal Safety Alarm to determine risk to the users who are victim-survivors of family violence;

iii. explicit instructions that silent or non-violent audio captured by an activated Monitored Personal Safety Alarm is ***not*** an indication that the activation was invalid, and that further investigation is required to determine whether police should be contacted; and

iv. requirements for security providers to check if a safety plan exists when a personal safety device is activated and to comply with the requirements of the safety plan, including contacting police even if there is no 'validated' response from the user;

(d) review and update the policies *Personal Safety Initiative – Minimum Technology Standards* and *Personal Safety Initiative – Minimum requirements for auditing, installation and monitoring services* in accordance with the suggested amendments outlined above; and

(e) work with Statewide Personal Safety Initiative Coordinators to ensure that PSI coordinators are provided with guidance on the above amendments. The Statewide

Personal Safety Initiative Coordinator should also collaborate with the PSI coordinators to ensure that case managers supporting victim-survivors to access personal safety alarms are aware of the limitations of the device and the limited circumstances in which security providers can call police upon activation of the alarm.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Jason [redacted], born [redacted]; and

    (b) his passing occurred on 18 October 2021 along Boundary Street, Kerang, Victoria, 3579, in the circumstances described above.

55. I accept the cause of death as determined by Forensic Pathologist, Dr Fronczek and find that Jason [redacted] died from neck compression secondary to hanging, in circumstances where he intended to take his own life.

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

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

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

Kellie [redacted], Senior Next of Kin

'P' (care of Arnold Thomas & Becker Lawyers)

Eleri Butler, CEO, Family Safety Victoria

Bryan de Caires, CEO, Australian Security Industry Association Limited

Assistant Commissioner Ian Parrott (SA Police), Executive Chair, National Emergency Communications Working Group – Australian and New Zealand

Christopher Boyle, Executive Director, StandbyU Foundation

Assistant Commissioner Lauren Callaway, Family Violence Command, Victoria Police

Senior Constable Joelyen Lloyd, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 7 August 2024

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.