



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001842

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Coroner David Ryan
Deceased:	Mrs R
Date of birth:	2 February 1967
Date of death:	Between 30 and 31 March 2024
Cause of death:	Asphyxia Inhalation of liquefied petroleum gas
Place of death:	Coronet Bay, Victoria
Keywords:	Mental health – Police welfare check

INTRODUCTION

1. On 31 March 2024, Mrs R was 57 years old when she was found deceased at her home. At the time of her death, Mrs R lived alone in Coronet Bay. She is survived by her husband, her four children, her grandchildren, her mother, and her two brothers.
2. Mrs R is warmly remembered and deeply mourned by family and friends.

BACKGROUND

3. Mrs R's medical history included bipolar disorder, borderline personality disorder and depression. She was prescribed medication by her general practitioner including escitalopram and quetiapine. Mrs R also had a gambling addiction and had experienced trauma as a child as a result of being sexually abused by a family friend.
4. In 1988, Mrs R and her husband were married. They subsequently had four children together but also suffered the trauma of a stillbirth in 1991. Their relationship was often challenging and volatile, involving incidents of family violence, breaches of trust and financial stress.
5. In 2017, Mrs R and her husband moved into a property at Coronet Bay. At around this time, Mrs R's brother became unwell and passed away which reportedly affected her deeply.
6. In 2021, Mrs R and her husband separated, and she stayed temporarily and at different times with one or other of her children. Their relationship became further strained and a series of Family Violence Intervention Orders were made which restricted the contact between them. At this time, Mrs R's mental health deteriorated, characterised by consuming paranoid thoughts and suicidal ideation, and she received treatment from mental health services.
7. In 2022, Mrs R moved back to the property in Coronet Bay with her husband.
8. In March 2023, Mrs R's father passed away. She was reportedly devastated by his death.

THE CORONIAL INVESTIGATION

9. Mrs R'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.
10. 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.

11. 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.
12. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mrs R's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. Further, evidence was also obtained by the Court directly from Victoria Police through its legal representatives.
13. This finding draws on the totality of the coronial investigation into Mrs R's death including evidence contained in the coronial brief and submissions made by Victoria Police's legal representatives. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.¹

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

Circumstances in which the death occurred

14. On 12 February 2024, Mrs R's husband was charged with offences relating to a family violence incident with Mrs R. An Intervention Order was also issued naming him as the respondent and he was required to move out of the house in Coronet Bay. He subsequently moved into a unit in Corinella.
15. On the evening of 29 March 2024, Mrs R's husband had dinner with a mutual family friend in Corinella. Mrs R had become paranoid that they were having an affair, and she attended the address and confronted Mrs R's husband in a public and abusive exchange. Mrs R's husband returned to his unit and Mrs R eventually returned home to Coronet Bay.

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

16. On 30 March 2024, Mrs R separately contacted her daughter and her friend Ms H and disclosed her ongoing concerns that Mrs R's husband was having an affair. They were concerned for Mrs R's wellbeing and sought to provide her support and reassurance. Mrs R's last text message sent to Ms H was at 8.57pm in which she stated, "*I struggled today, thanks [Ms H] x*".
17. During the morning on 31 March 2024, various members of Mrs R's family, including her daughter, sent her text messages wishing her a happy Easter. Mrs R did not respond to these messages. Her mother also telephoned her, but she did not answer. Mrs R was unable to be contacted throughout the day and Mrs R's daughter became very concerned for her mother's welfare. At her request, Mrs R's husband drove past their house in Coronet Bay and observed Mrs R's car parked in the carport with no lights on in the house.² He advised Mrs R's daughter of his observations who became increasingly concerned and contacted emergency services (Triple Zero) at 8.57pm to request a welfare check.
18. Mrs R's daughter disclosed to the Triple Zero operator that Mrs R:
 - a) Could not be contacted by family and "*it's Easter and that's not normal*";
 - b) Had a mental health history with prior involvement with the Crisis Assessment and Treatment Team (CATT);
 - c) Had recently separated from her husband;
 - d) Had "*a bit of a breakdown the other day*" and had been "*jumping fences and screaming*";
 - e) Had spoken with her yesterday and "*seemed really down*"; and
 - f) Appeared to be at home with her car in the driveway but no lights on in the house.
19. The Triple Zero call taker accurately reproduced the pertinent information from Mrs R's daughter's call into the relevant database,³ created an event coded a 573-WELFARE CHECK and assigned the job as "*Priority 3*" which required Victoria Police to "*attend when able*".⁴

² There was an existing Intervention Order against Mrs R's husband which prevented him from entering the Coronet Bay house.

³ The computer-aided dispatch (CAD) system.

⁴ VPMG – *Patrol responsibilities and communications*.

20. At 9.02pm, the Triple Zero dispatcher then broadcast the job over the D24 police radio to police units in the field and it was assigned to a Sergeant and Senior Constable who were rostered that evening to Police Divisional Van (**Cowes 354**). The Senior Constable also had access to the information recorded by the Triple Zero call taker via their portable IRIS device.
21. At 9.28pm, the Senior Constable telephoned Mrs R's daughter to clarify why she had sought a welfare check for her mother.⁵ Mrs R's daughter confirmed the following to the Senior Constable:
- a) Mrs R's recent breakdown involving Mrs R's husband and her recent unusual behaviour involving "*jumping up on fences, screaming...throwing clothes*" and "*banging down the door*";⁶
 - b) The family's inability to contact Mrs R that day;
 - c) Mrs R's previous involvement with CATT and that she had threatened suicide in the past; and
 - d) She had not conducted a welfare check herself as she was in Lakes Entrance and 26 weeks' pregnant.
22. As directed by the Sergeant, the Senior Constable then telephoned a Mental Health and Police Response Clinician to seek further available information in relation to Mrs R's mental health. The clinician stated that they advised the Senior Constable as follows:
- a) Mrs R had a diagnosis of borderline personality disorder, adjustment disorder, delusional disorder, suicidal ideation and a gambling addiction;
 - b) There was no record of Mrs R having contact with mental health services since 2022;
 - c) Mrs R's medical records identified previous suicide attempts involving carbon monoxide poisoning and cutting her wrists; and
 - d) To provide Mrs R's daughter the local mental health triage number to discuss any mental health concerns that were non-urgent.

⁵ The phone call was placed on speaker mode so that it could also be heard by the Sergeant.

⁶ Body Worn Camera footage of the Senior Constable.

23. Ultimately, the Sergeant determined that Cowes 354 would not be conducting a welfare check on Mrs R as he did not have a belief that she was at risk of imminent and serious harm. They also “*determined that a ‘general welfare check would not be appropriate either in the circumstances, as there was nothing indicating that [Mrs R] was at any risk, and the reason behind the call to 000 appeared to be because family/friends were not/could not attend to check on [Mrs R], even though no indication of unusual behaviour or self-harm’*”.
24. As directed by the Sergeant, the Senior Constable then telephoned Mrs R’s daughter to advise her that they would not be attending to conduct a welfare check on Mrs R and that she would need to try to get her mother “*linked into some mental health services if she has concerns for her mental health*” and “*if she still has concerns for her mother’s welfare to get another family member or friend to attend*” to conduct the welfare check.
25. At around 10.25pm, Ms H, her son and his partner, attended the Coronet Bay address and located Mrs R lying on a couch in the lounge room on the second floor. They could smell gas and observed an LPG gas bottle with the hose leading to and secured to Mrs R’s face and nose area with a face mask and a compression bandage. Mrs R was clearly deceased and Ms H stated that “*[Mrs R] was very cold to the touch*” and she could not recall “*any gas coming from the hose or the gas bottle*”. They contacted emergency services and moved the LPG gas bottle outside.
26. Victoria Police and Ambulance Victoria attended the scene and paramedics pronounced Mrs R deceased at 11.20pm.
27. Victoria Police during the subsequent investigation did not identify any evidence of suspicious circumstances.

Identity of the deceased

28. On 31 March 2024, Mrs R, born 2 February 1967, was visually identified by her friend, Ms H.
29. Identity is not in dispute and requires no further investigation.

Medical cause of death

30. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine conducted an examination on 3 April 2024 and provided a written report of his findings dated 8 April 2024.

31. Toxicological analysis of post-mortem samples identified the presence of citalopram,⁷ quetiapine⁸ and propane.
32. Dr Burke provided an opinion that the medical cause of death was *1(a) Asphyxia, 1(b) Inhalation of liquefied petroleum gas (LPG)*.
33. I accept Dr Burke's opinion.

SHOULD A WELFARE CHECK HAVE BEEN CONDUCTED BY VICTORIA POLICE

34. The following information was available to Cowes 354 when they decided not to conduct a welfare check at the Coronet Bay address:
 - a) Family had not been able to contact Mrs R since 30 March 2024 and they were very concerned for her welfare given this behaviour was out of character and not normal due to it being Easter;
 - b) Mrs R had a mental health history (borderline personality disorder, adjustment disorder, delusional disorder, suicidal ideation and a gambling addiction) with prior involvement with the CATT. There had been no contact with mental health services since 2022;
 - c) Mrs R had threatened and attempted suicide in the past;
 - d) Mrs R had recently separated from her husband and had recently experienced a breakdown with unusual behaviour;
 - e) Mrs R appeared to be at home with her car in the driveway but no lights on in the house; and
 - f) The family's ability to conduct a welfare check themselves was inhibited by Mrs R's daughter being 26 weeks' pregnant and in Lakes Entrance (three and a half hours away) and Mrs R's husband being subject to an Intervention Order which prohibited his contact with Mrs R.
35. Victoria Police have advised that there is no instruction in the Victoria Police Manual (**VPM**) or policy document which provides specific guidance in relation to when and how police conduct welfare checks and there are no specific training modules. They advised that

⁷ Citalopram is indicated for major depression and panic disorders.

⁸ Quetiapine is an antipsychotic drug.

ultimately, police members are expected to draw upon their training and experience and the “*police response should be appropriate to the circumstances and demonstrate sound judgment and reflect contemporary organisational and community expectations*”. They did however provide 17 different VPMs (268 pages in total) which they stated may be of assistance to the Court. It was not specified how they may be of assistance.

36. In my view, it is clear that Victoria Police ought to have proceeded to conduct a welfare check on Mrs R at the address in Coronet Bay after speaking with Mrs R’s daughter and the clinician. The absence of a recent direct threat by Mrs R to harm herself appears to have been the primary basis for Cowes 354 not conducting the welfare check, but there were other highly concerning factors present which nevertheless warranted that the check be carried out. In particular, Mrs R’s mental health history, her history of suicidal ideation and threats of self-harm, her recent breakdown and the inability of Mrs R’s husband or daughter to perform the check themselves nor contact her.
37. It appears that Cowes 354 considered that the reason for the request from Mrs R’s daughter for a welfare check was because she held concerns for her mother’s mental health and was seeking the engagement of support services. However, I am satisfied from the evidence that Mrs R’s daughter was requesting the welfare check because she was concerned for her mother’s immediate wellbeing.
38. In my view, police members should have readily accessible and available to them clear and specific guidance in the VPM to inform their judgment as to the circumstances in which welfare checks are required to be conducted. The fact that police members may need to have reference to 17 separate chapters of the VPM when deciding whether it may be appropriate to conduct a welfare check is clearly unsatisfactory.
39. I accept that my view that a welfare check ought to have been conducted by Victoria Police is made with the benefit of hindsight and that members of Victoria Police are required at times to weigh competing priorities when making difficult operational decisions. It is acknowledged that things can seem a lot clearer after the event, when we are pouring over events in painstaking detail, which in reality may have unfolded more rapidly and in challenging circumstances. However, this reinforces the need for clear and specific guidance to be available in the VPM to assist members in performing their challenging duties.

FINDINGS AND CONCLUSION

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

- a) the identity of the deceased was Mrs R, born 2 February 1967;
- b) the death occurred between 30 and 31 March 2024 at Coronet Bay, Victoria, from asphyxia and inhalation of liquefied petroleum gas;
- c) the death occurred in the circumstances described above.

41. Having considered all of the circumstances, I am satisfied that Mrs R intentionally took her own life. Although I am of the view that a welfare check should have been conducted by Victoria Police in this case, I am satisfied that it would not have prevented Mrs R's death in the circumstances as it is likely that she had already passed away at the time Mrs R's daughter requested the check. However, it would have relieved Mrs R's friends from the burden of locating her body in distressing and potentially unsafe circumstances.

RECOMMENDATIONS

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

- (i) The Chief Commissioner of Police develop a chapter for the Victoria Police Manual to provide clear and specific guidance to police members to inform their judgment as to the circumstances in which welfare checks are required to be conducted.

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

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

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

Senior Next of Kin

Chief Commissioner of Police

Professional Standards Commands, Victoria Police

Detective Sergeant Kaine Pawson, Coronial Investigator

Signature:



Coroner David Ryan

Date: 08 May 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.
