IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2011 / 2479

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

(Paragraph 46(viii) amended pursuant to section 76 of the *Coroners Act 2008* on 12 January 2015

Inquest into the Death of: MICHAEL ATAKELT

Delivered On:	28 August 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Dates:	11, 12, 13 14, and 15 February 2013; 6 May 2013; 26, 27, 28, 29 and 30 August 2013; 25, 26 and 27 September 2013; 29 November 2013.
Findings of:	JUDGE IAN L. GRAY, STATE CORONER
Representation:	Ms J Dixon with Ms S Leighfield on behalf of Mrs Askalu Tella Mr P Lawrie on behalf of Chief Commissioner of Police Mr G A Seyoum Mr B Ihle on behalf of Detective Senior Constable T McKerracher
Counsel Assisting the Coroner	Mr J Burnside QC and Mr M Albert

I, JUDGE IAN L GRAY State Coroner, having investigated the death of MICHAEL ATAKELT

AND having held an inquest in relation to this death on 11, 12, 13 14, & 15 February 2013; 6 May 2013; 26, 27, 28, 29 & 30 August 2013; 25, 26 & 27 September 2013; 29 November 2013
at MELBOURNE
find that the identity of the deceased was Michael Atakelt or Solomon Atakelt Getachew-Seyoum; also known as Seged Atakelt Getachew-Seyoum.
born on 6 August 1988
and the death occurred or about the 26 June 2011
at Maribyrnong River in the vicinity of the Raleigh Road Bridge
from:

1 (a) CONSISTENT WITH DROWNING

in the following circumstances:

Background

1. Solomon Atakelt Getachew-Seyoum; also known as Seged Atakelt Getachew-Seyoum and Michael Atakelt **(Michael)** was the much loved son of Getachew Seyoum, biological father (Getachew) and Askalu Tella, biological mother (Askalu).
2. Michael was an Orthodox Christian and is described by his father Getachew as:-

> *"a very good boy. He had a very nice nature. For example, he was very friendly and polite to all those whom he encountered in his daily life e.g. family, friends, colleagues and those he met along the way. He was extremely charismatic and was able to build instant rapport with all those he encountered. Having said this, he was also stubborn and if provoked, gives back as good as he got."*[1]

Purpose Of A Coronial Investigation

3. The purpose of a coronial investigation into a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[2] In the context of a coronial investigation, it is the medical cause of death which is important (including where possible the mode or mechanism of death) and the context or background and surrounding circumstances of the death sufficiently proximate and causally

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[1] Submissions of Getachew Seyoum, p2.
[2] Section 67(1) of the Coroners Act 2008. All references which follow are to the provisions of this Act, unless otherwise stipulated.

relevant to the death, but not all circumstances which might form part of a narrative culminating in the death.[3]

4. The broader purpose of a coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[4] Coroners are also empowered to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[5] These are effectively the vehicles by which the prevention role may be advanced.[6]

5. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation.

6. I assumed control of the investigation into Michael's death in November 2012, after the previous State Coroner left the jurisdiction having indicated that the matter would proceed to inquest.

The Inquest

7. On 11, 12, 13 14, and 15 February 2013; 6 May 2013; 26, 27, 28, 29 and 30 August 2013; 25, 26 and 27 September 2013 and 29 November 2013 I conducted an inquest into Michael's death.

8. The areas of inquiry for the inquest were to investigate Michael's identity, his cause of death and the circumstances in which his death occurred.

9. The following witnesses gave evidence:
    - Askalu TELLA – mother of Michael
    - Getachew Atakelt SEYOUM – father of Michael
    - Muna Gidoni GEBREHAT – friend of mother
    - Marta GEBRAMEDHIN

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[3] This is the effect of the authorities- see for example Harmsworth v The State Coroner [1989] VR 989; Clancy v West (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[4] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act of the Coroners Act 1985 where this role was generally accepted as "implicit".

[5] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[6] See also sections 73(1) and 72{5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

- Samuel Khalifa DICHAK
- Yai CHOL
- Girmay MENGESHA
- Seaie Tekela NEGASH
- Surafel ALEMAYEHU
- Dr Noel WOODFORD
- Dr Byron COLLINS
- Voula STAIKOS
- Dr Linda ILES
- Rebecca COTTON
- Sergeant George DIXON
- Elsa GIDAY
- David Goldie PROVIS
- Constable Noah BEASLEY
- Constable Tim ROBINSON
- Constable BROCKWELL
- Constable MOM
- Constable Andrew PRIESTLEY
- Constable Natalie REMEDIOS
- Constable Sarah MAIDMENT
- Donna Louise DEGILLE
- Detective Senior Constable Craig WRIGHT
- Constable Adrian MILLS
- Detective Sergeant Peter BITTON
- Detective Senior Constable Tim McKERRACHER
- Detective Senior Sergeant Peter TATTER-RENDELMANN

10. All of the evidence was interpreted by a Tigrinian interpreter. All English spoken witnesses had their evidence interpreted into Tigria to allow the members of the Tigrinian community to understand the evidence and allow them to be involved in the inquest. Additionally, most of the statements were translated and provided to the Tigrinian community.

11. Interpreter Ibrahim Ali conscientiously and professionally interpreted the evidence at the inquest. Mr Ali's assistance was not only invaluable to me but also provided an important role in ensuring the Tigrinian community had access to the evidence and could be involved in the inquest.

12. At the conclusion of the inquest, I was shown a video of Michael's life. The video was touching and demonstrated how loved and popular Michael was.

Identity

13. Michael's father viewed the body of his son after it was recovered from the Maribyrnong River and identified it as his son, Michael.

14. Although partly decomposed, the images on the court records of Michael's body make it clear that it shared many common characteristics with photos of Michael taken shortly before his death.

15. I received, at the inquest, evidence from both of Michael's parents, Askalu and Getachew that his birth date was 6 August 1988, even though he had some identification documents with other birth dates on them.

16. I also received evidence, from Askalu and solicitor Stuart Webb (formerly of the Victoria Legal Aid), that Michael had identity documents in a number of names. These names included Michael and Seged as a first name, and Atakelt and Seyoum as a surname. I was informed that Michael was also known socially by a number of names.

17. I formally find the identity of the deceased to be Michael Atakelt, or Solomon Atakelt Getachew-Seyoum; also known as Seged Atakelt Getachew-Seyoum.

Medical Cause Of Death

VIFM Autopsy and autopsy report

18. On 12 July 2011, Chief Pathologist Shelley Robertson of the Victorian Institute of Forensic Medicine (VIFM) performed an autopsy on Michael's body. Dr Robertson prepared an unsigned autopsy report, however, due to her departure from VIFM, the report was reviewed, completed and signed by Dr Noel Woodford. Dr Woodford spoke to the report at the inquest.

19. The autopsy report gives the cause of death as 1(a) Consistent with Drowning.

20. The report provides the comments:-

> *"Development of post mortem decomposition changes is a variable phenomenon however the features identified at autopsy are consistent with death occurring around the time when the deceased was last seen alive.*
> *There was no natural disease identified of a type likely to have caused or contributed to death.*
> *There were no injuries identified of a type likely to have caused death.*
> *In the absence of another cause of death, allied to the fact that the deceased's body was found in water, in my opinion the cause of death is best considered as one of drowning.*
> *This report has been reviewed, completed and signed by Dr Noel Woodford, Head of Forensic Pathology, due to the departure of Dr Shelley Robertson from the VIFM. Any questions relating to the content of the report should be addressed to Dr Woodford.*
> *I have discussed this case with Dr Bryon Collins, consulting forensic pathologist."*[7]

[7] Autopsy Report Comments, paragraphs 3, 6, 7, 8, 11 & 12.

Autopsy conducted on behalf of the family

21. Consultant forensic pathologist Dr Bryon Collins also conducted a post-mortem examination. He also review the autopsy report of Dr Robertson and discussed it with Dr Woodford.

22. Dr Collins expressed the following opinion as to the cause of death:-

> *"Whilst I am in general agreement with the cause of death and the accompanying comments, as documented in the autopsy report, it would also be reasonable to have listed it as "UNASCERTAINED"- having regard to the progress of the investigations concerning the circumstances of the death, at the time of preparation of Dr Woodford's report.*
> *There are no features identifiable during an autopsy on a body found immersed in water, which are pathognomonic for the diagnosis of "death by drowning" and such a conclusion can only be reached by the process of exclusion of all reasonably possible alternative causes, in association with the knowledge that the individual was alive on entering the water, as follows:*
> *(i) pre-existing natural disease processes,*
> *(ii) adverse effects of drugs,*
> *(iii)trauma.*
> *In this particular case, the presence of decomposition changes involving the major organs has somewhat fettered the examination of the light microscope slides, however, there was no overt evidence of any significant disease process identified, which could have caused or contributed to the death."*[8]

Concurrent evidence by medical panel

23. I was assisted at the inquest by a medical panel (the Medical Panel) consisting of Dr Woodford, Dr Collins, Dr Linda Iles (VIFM pathologist) and Ms Voula Staikos (VIFM senior toxicologist). They answered a series of questions prepared by Mr Burnside QC counsel assisting (Mr Burnside QC). Question 5 was:

> *"What scientific and medical conclusions, if any, can be drawn from the condition of the body at the time it when it was retrieved from the river? Answer: A diagnosis of drowning as to the cause of death is one of exclusion and dependent upon consideration of autopsy findings and the circumstances. There were no injuries identified of the type that would have likely caused death. No natural disease processes were identified that would have likely caused or contributed to death.*
> *Having regard to these factors a cause of death could be given as "Consistent with drowning:" or "Unascertained". These causes of death are not mutually exclusive."*[9]

24. The Medical Panel and pathologists report all noted that the diagnosis of drowning as a cause of death is one of exclusion. The circumstances are vital in informing the diagnosis. In evidence at the inquest, the Medical Panel was asked whether they could exclude other possibilities other than drowning as a cause of death, and Dr Woodford responded:

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[8] Inquest brief, p 774, paragraphs 1 – 3.

[9] Exhibit P.

"It does and that's reflected in - most probable but for all the reasons that we've explored today about uncertainties, that perhaps might be better phrased as one of consistent with drowning and should maintain some consistency with the way the cause of death is given in the report, but yes, that remains my view."[10]

25. On the same point Dr Collins said at the inquest:

> *"Well, the "consistent with drowning" diagnosis is in relation to the fact that we didn't find any other appropriate cause of death and it's related to the circumstances. The word "unascertained" when you look at it strictly, we don't have a pathological cause of death in the absence of the circumstances and it depends heavily on the investigation of the circumstances as to whether that "unascertained" and "consistent with drowning" can be changed to "drowning"."*[11]

26. Michael's mother, Askalu, has submitted that I should find the medical cause of death to be "unascertained" rather than "drowning" or "consistent with drowning".

27. Depending on the circumstances, as found, the conclusions "unascertained", "consistent with drowning" and "drowning" are on a spectrum and distinguishing between them will be a matter of degree depending on the circumstances surrounding the death.

28. Here the critical circumstances are:

- Michael's lungs contained water,
- Michael's body showed signs of having been submerged in water for a significant time,
- There were no physical injuries on his body that would have caused death. [12]

29. In relation to the issue of physical injuries, I accept the submission made by Mr Burnside QC, and by Mr Lawrie for the Chief Commissioner of Police, that the injury on the left side Michael's forehead was unrelated to his death.

30. There were no natural disease processes that caused or contributed to his death.

Toxicology

31. In relation to alcohol and drugs it is clear, and not contested, that neither alcohol or cannabis can be found to have contributed to the death.

32. Askalu submitted that drugs may have contributed to the death:-

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[10] Transcript p 273 – 274.

[11] Transcript p 272 – 273.

[12] Closing submissions of Counsel Assisting, paragraph 9.

"In respect of the contribution of drug and alcohol to the medical cause of Michael's death, it seems clear that alcohol would not have been a contributing factor. It also seems unlikely that as a social user of cannabis, Michael would be so significantly affected by cannabis ingestion (on whatever day that occurred) as to lose control of his faculties, bearing in mind that small THC reading found at autopsy."[13]

33. In relation to other drugs, in particular Gamma Hydroxybutyrate (GHB), her submission was:-

    "It cannot be excluded that Michael's conscious state was altered by a covertly administered or ingested substance such as GHB which may have been administered to Michael against his will or knowledge (GHB being a drug of renown in this regard).[14]

34. Toxicology testing for GHB was done between the first and second sittings of the inquest. GHB was detected in blood and urine specimens but not in the vitreous humour specimen.

35. In her report toxicologist Voula Staikos said GHB was detected in Michael's blood and in urine of at concentrations 36 mg/L and 54 mg/L respectively. GHB was not detected in vitreous humour. In her opinion it is most likely that these levels of GHB in the blood and urine are endogenous, but she could not rule out that GHB detected is from exogenous ingestion.

36. The evidence does not exclude a drug or drugs from being a contributing factor directly or indirectly to the cause of death. The possibility that Michael ingested a drug such as GHB, or some other drug, potentially unknowingly, which could have been masked by decomposition changes cannot be excluded. During cross-examination, the Medical Panel of experts agreed that the possibility that Michael was affected by drugs which caused him to be unconscious and then die prior to being immersed in the water could not be completely excluded.

37. There is insufficient evidence to make a positive finding as to the contribution, (if any), of drugs to the death. However, I do not agree that, because the possibility of Michael being affected by drugs cannot be completely excluded, there should therefore be a finding of "unascertained" death.

38. I accept that there must remain a *possibility* that Michael's state was "*altered by a covertly administered or ingested substance such as GHB…administered against his will*"[15], as argued by Askalu. But there is no evidence to support this contention and it is not permissible to speculate about it. Her submission accepts that there is "*insufficient evidence to make a*

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[13] Submissions on behalf of Mrs Askalu Tella, paragraph 22.

[14] Ibid paragraph 21.

[15] Ibid.

positive finding about it"[16] but she argues "*the inability to exclude this possibility favours a finding of "unascertained" over "consistent with drowning" or "drowning".*"[17] I disagree.

Medical cause of death conclusion

39. Given all the known circumstances, and excluding other reasonably possible alternative causes, I am satisfied that the evidence supports a finding of "Consistent with Drowning" rather than a finding of "unascertained".

40. To the extent that there are differences of opinion, or shades of opinion between Dr Collins and Dr Woodford, I prefer the evidence of Dr Woodford. Ultimately, Dr Woodford was firm in his view that "*the cause of death is best considered as one of drowning*"[18].

41. Finally, on this issue I note the submission of Getachew. He has clearly always held the view that his son was murdered and he makes the point again at the end of his submission. One can understand his anguish, however it is clear that the medical and scientific evidence does not support his opinion.

Circumstances Leading Up To Michael's Death

42. On Saturday 25 June 2011, at approximately 3.00am, Senior Constable Bradley Johnson was performing foot patrol duties in the Melbourne central business district when he was approached by a male claiming that his friend had been head butted by an African male wearing red runners. Senior Constable Johnson observed that the male had a cut and some swelling to the bridge of his nose.

43. Senior Constable Johnson approached a person who fitted the description and identified Michael Atakelt. Senior Constable Johnson formed the belief that Michael was intoxicated as his speech was slightly slurred. Senior Constable Johnson observed that Michael was bleeding from the right side of his forehead[19] and also had sustained a cut to his left forehead. Michael was arrested for being drunk in a public place and was taken, by a divisional van, to the Melbourne Custody Centre where he was logged at 3.40am.

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[16] Ibid paragraph 23.

[17] Ibid.

[18] Transcript page 273.

[19] Inquest brief at p 260.

44. At 8.10am on the same day, Michael was assessed by Sergeant Paul Howden, given a penalty notice for being drunk in a public place, and released from custody.[20]

45. After Michael was released from custody, his movements on this day and the next are largely unknown, until he was seen by a friend at the West Footscray train station on the evening of Sunday 26 June 2011.

46. Close Circuit Television (CCTV) footage obtained from the West Footscray train station tracked Michael to several other train stations as follows:

    (i) at 4:07pm, Michael was identified at the Sunshine train station speaking to Elsa Giday, his ex-girlfriend, for approximately ten minutes near the bus stop area;

    (ii) at 4.19pm, Michael walked down the ramp towards the Sunshine train station platforms;

    (iii) at 6:21pm, Michael was identified at the Footscray train station with his friend and another unidentified African male on the overpass at the station;

    (iv) at 6:31pm, Michael boarded a train with his friend towards the West Footscray train station;

    (v) at 6:34pm, Michael forced open a train door and got off with a friend at West Footscray train station;

    (vi) at 6:48pm, Michael ran from a Sydenham bound train platform across to the city bound train platform and then boarded a train by himself heading towards the city;

    (vii) at 7:01pm, Michael got off the train at North Melbourne by himself;

    (viii) at 7:02pm, Michael got on an Craigieburn line train; and

    (ix) at 7:07pm, Michael got off the train at the Newmarket train station and walked onto the platform and then moved to the west side of train station.

Missing Persons Report

47. On 4 July 2011, Askalu attended the Footscray Police Station and spoke to Constable Andrew Priestly. She states that she wanted to report her son missing. Constable Andrew Priestley attended to Askalu on this day and he states that she enquired as to whether Michael was in

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[20] Inquest brief p 274.

custody at Footscray. He informed her that he was not in custody and made notes of the conversation.[21]

48. On Tuesday, 5 July 2011, Askalu returned to the Footscray Police Station to enquire whether Michael had been seen by police. Askalu was advised that there was nothing on the computer system. At around 11.45pm on this day Askalu telephoned 000 and asked to be put through to the Footscray Police Station and was advised that no missing person report had been filed.[22]

49. On 6 July 2011, at approximately 12.30pm, Askalu re-attended the Footscray Police Station and police filled out a missing person report. Constable Mills initially assisted Askalu to fill out the form and was later assisted by Constable Natalie Remedios, as Constable Mills was having some difficulty understanding her accent. Constable Remedios stated that while Constable Mills was filling in the missing persons report, she conducted the LEAP checks on Michael.[23]

50. On 7 July 2011, Askalu attended the Footscray Police Station requesting any updates as to the whereabouts of her son. Constable Remedios stated that she then telephoned all the hospitals including Footscray, Sunshine, Williamstown, St Vincent's and Royal Melbourne to enquire as to whether he was or had been a patient. Constable Remedios stated that she entered these enquiries onto the LEAP system.[24]

51. At approximately 2.25pm on Thursday 7 July 2011, police received a telephone call advising them that a body was floating in the river. Police attended at the Maribyrnong River and located the body and removed it from the water.

52. The Homicide Squad attended as the body appeared to have an injury on his forehead, being a cut approximately 1cm in size.

53. The body was found wearing a black and grey coloured track suit top, blue coloured jeans with a white belt with a distinct orange and black belt buckle with a pattern on it, red runners and an earring in his left ear.

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[21] Inquest brief pp 276-277.

[22] Inquest brief p 5.

[23] Inquest brief p 278-279.

[24] Inquest brief p 279.

54. Police searched his body and located a Maribyrnong Secondary College student identification card in the name of Michael Atakelt and a Victorian University student identification card in the name of Adhel Aleu Akechak in the right back pants pocket.

55. On the same day, at approximately 5.00 or 6.00pm an interpreter telephoned Askalu and advised her that the police would like her to attend the Footscray Police Station.

56. At approximately 6.30pm, Askalu attended at the Footscray Police Station where she was led into a room which had a number of police officers in attendance from the Homicide Squad and she was notified that her son had been found deceased in the Maribyrnong River.[25]

The Circumstances In Which The Death Occurred

57. Section 67(1)(c) of the *Coroners Act 2008* requires that I make findings, where possible, of the circumstances in which Michael's death occurred.

58. Whilst I have pursued all reasonable lines of inquiry it does not necessarily follow that I am able to make a finding with respect to every detail of the circumstances in which Michael's death occurred.

59. Despite an extensive investigation and inquest, the CCTV from the Newmarket train station is the last known sighting of Michael alive.

60. Eleven days later, on Thursday, 7 July 2011, Michael's body was found floating in the Maribyrnong River near the Raleigh Road bridge. What happened in those 11 days was a primary focus of the inquest.

61. Sadly, after an extensive investigation and inquest there is no conclusive evidence as to exactly when, or exactly where Michael entered the Maribyrnong River. However, the evidence allows some conclusions to be drawn on each question.

When Michael entered the Maribyrnong River

62. I agree with the submissions of Mr Lawrie on behalf of the Chief Commissioner of Police (CCP) and counsel assisting, Mr Burnside QC, that it is most likely that Michael went into the Maribyrnong River and died within hours after he was last seen at the Newmarket Railway Station at 7.07pm on Sunday, 26 June 2011.[26]

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[25] Inquest brief p291.

[26] Submission on behalf of the Chief Commissioner of Police, paragraph 5.

63. The entirety of the evidence is consistent with the fact that Michael was not seen by anyone after 7.07pm on 26 June 2011 and did not leave any other signs of normal day-to-day activity such as accessing his bank account.[27]

64. The Medical Panel agreed that there was no evidence from either toxicology or pathology to suggest that Michael had been dead for some time before he entered the water.

65. I agree with Mr Burnside QC's submission that the following evidence supports that conclusion:

> *"(a) The experts agreed that the state of Michael's body indicated that it had been submerged for "several days" by 7 July 2011.*
>
> *(b) The evidence of Michael's friends and housemates at the time of his death was that Michael had an active social life and saw his friends often by arrangement or in places that they usually met such as Romhay Café in Footscray His friends' evidence was that Michael was rarely home.*
>
> *(c) There was no evidence that Michael accessed his bank or Facebook account after he was last seen. The evidence received by this Court was that it was his ordinary pattern to access either or both account every few days in the months leading up to his death.*
>
> *(d) The clothes Michael was wearing when he left Newmarket station and those he was found wearing when his body was found appear to be the same (with the exception of the black glove).*
>
> *(e) It was his habit to sleep in homes belonging to friends or family. Michael was not seen after 26 June 2011 by anyone he had stayed with.*
>
> *(f) Michael was last seen on a Sunday night in winter at a location which is about 15 minutes on tram route 57 from the place he is likely to have entered the water.*
>
> *(g) Having conducted a broad, renewed investigation and pursued all reasonable lines of inquiry, the Court had been unable to locate anyone who saw Michael alive after he left Newmarket station."*[28]

66. On the whole of the evidence, I find that it is most likely that Michael went into the Maribyrnong River and died within hours after he was last seen at the Newmarket Railway station at 7.07pm on Sunday 26 June 2011.[29]

Where Michael entered the Maribyrnong River

67. The evidence given by Sgt Dixon, Dr Provis and Barry Gibson was of considerable assistance in understanding the movement of the water in the Maribyrnong River and the relevant currents.

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[27] Ibid, paragraph 13

[28] Closing submissions of Counsel Assisting, paragraph 18.

[29] Submission on behalf of the Chief Commissioner of Police, paragraph 5.

68. Sgt Dixon and Dr Provis agreed that it was most likely that Michael entered the Maribyrnong River in the vicinity of the Raleigh Road bridge. Moreover, Dr Provis stated that it was more likely that Michael entered up stream of the point of discovery.

69. As to exactly where Michael entered the water I am satisfied that he entered the Maribyrnong River within 200 metres either side of the Raleigh Road bridge and I agree with Mr Burnside QC's in his submission that states: -

> *"A number of people qualified to give their opinion on this topic gave evidence as to what could be deducted from the location where the body was found. Those people were George Dixon of the Water Police, Dr David Provis, an independent oceanographer, and Barry Gibson of Police Search and Rescue. In key respects, their evidence, although given separately, was to the same effect.*
>
> *Their evidence was that in the relevant part of the Maribyrnong River objects in the water move very little. The reason for this is that ordinary downstream flow of a river is largely neutralised by the upstream current from the bay at that point in the Maribyrnong River. This means that anything found floating in the river at that point is very likely to have entered the water in that vicinity. In their view, the downstream flow of the river was slightly stronger and thus it is more likely that a floating item would enter upstream from the point of discovery. The matter is complicated by the fact that surface water tends to flow downstream, but water below the surface tends to flow upstream.*
>
> *Dr Provis gave evidence that the most likely place Michael's body entered the water was 200 metres up- or down-stream of the Raleigh Road Bridge. He said that it was more likely that he entered upstream of the point of discovery. Mr Dixon's evidence was consistent with Dr Provis' evidence. He also said that, at most, Michael's body would have entered 1.5km upstream of where it was located, but it was probably closer than that."*[30]

70. In her submission, Askalu also agreed that it is not possible to identify the precise location at which Michael entered the water, "*save that it is most likely that it was within a few hundred metres of either side of the Raleigh Road Bridge*".[31]

71. On the whole of the evidence, and in particular the evidence of Sgt Dixon, Dr Provis and Barry Gibson, I find that Michael or Michael's body entered the water within 200 metres up or down stream of the Raleigh Road bridge.

Possible reasons for Michael's entry into the Maribyrnong River

72. I understand how important it is for Michael's family, and community to known *how* or *why* Michael entered the river.

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[30] Closing submissions of Counsel Assisting – paragraphs 21-23.
[31] Submissions on behalf of Mrs Askalu Tella, paragraph 60.

73. My investigation focused on lines of inquiry as to whether Michael's death was as a result of suicide, accident or foul play.

74. Mr Burnside QC summarised the relevant issues in his submissions under the headings "Relationships" and "Lifestyle" as follows:

> *"It is clear that Michael had many friends. The attendance of many of Michael's family and friend throughout this long inquest strongly suggests that he and his parents were held in high esteem, especially in the Ethiopian community."*[32]

I agree with this assessment.

> *"Michael had limited contact with his parents. By their consistent attendance and active participation in this inquest, it is clear that both Askalu and Getachew felt a strong connection with their son and are especially concerned to find out what happened to him. While he did not see his mother often, Askalu was very concerned for Michael's welfare.*
>
> *It was Askalu who first raised her concerns about Michael on 2 July 2011, when she asked some of his friends about his whereabouts. On the evidence, it is likely that he was dead by then.*
>
> *Michael had many good friends and he was known for his generosity and good company. He was also known to be gentle and caring to those around him. He shared his limited funds, his food and his good humour with many people. Constable Remedios, who met Michael when he was having a dispute with his landlord at 8 Gordon St Maribyrnong a few months before his death, described him as being obedient, polite and co-operative. One of his friend, Surafel, described him as being 'sensitive'.*
>
> *A number of his friends gave evidence that he had a temper and that that could quickly turn to acts of violence especially if he had been drinking. This is not unusual in young men. There were at least two occasions on which Michael had contact with police not long before his death – that involving Peter Kaye on 25 June 2011, and an earlier incident where he was stabbed at a share house along the 57 tram route in Mirams Street, Ascot Vale.*
>
> *There are three interactions in Michael's final few days which received significant attention in the evidence.*
>
> *The first was a conversation he had with his mother, Askalu. Michael visited her and stayed at her house on the night of 25 June 2011. During that visit, Askalu informed Michael that his paternal grandfather had died in Ethiopia in about July 2010. Michael had lived with his grandfather for about 10 years and was very close to him.*
>
> *The second conversation took place in Sunshine on the afternoon of 26 June 2011. Michael was in a close personal relationship with Elsa Giday. They met in Sunshine and discussed the state of their relationship. She made it clear that she did not want it to continue. He tried unsuccessfully to call her from public telephones late in the day. CCTV footage of that meeting suggests strongly that he was upset.*
>
> *Also that afternoon, he met with some of his associates at Romhay Café in Footscray. Sam Dichak had sold Michael's iPod that morning and gave him $50 from the proceeds. With his housemate, a friend, as well as Sam and one of Sam's friends, Michael went to get kebab in Footscray. Michael paid for everyone to have a kebab, but he did not eat.*

[32] Closing Submissions of Counsel Assisting, paragraph 31.

Sam challenged him on why he was not eating. An argument followed. As a result of that argument, his friend thought it was best to take Michael from Romhay café.
His friend and Michael then went to Footscray station and got a train to West Footscray station. At West Footscray station, the third conversation took place. It was the last conversation of which there is any evidence.
His friend asked Michael why he was upset. Michael was hesitant to answer. Michael then told his friend about the death of his grandfather and problems in his relationship with his girlfriend.
His friend's evidence was that Michael cried when he told his friend about this. His friend said it was rare for Michael to cry. Michael then ran off from this friend and boarded a train towards the city. The last thing he said to this friend was 'I am going for a long walk tonight.'"[33]
"Michael's friends confirmed that Michael regularly smoked marijuana with them. His friend gave evidence that Michael got his marijuana from Ascot Vale, but he did not know where. Surafel gave evidence that Michael bought marijuana in Footscray.
The evidence of many witnesses was that Michael drank alcohol sometimes but not often. Two of his childhood friends gave evidence that Michael could swim reasonably well. There was no evidence of him swimming often or at all in the Maribyrnong river.
Some of his friends gave evidence that they had smoked marijuana with him heavily on the night of 24 June 2011. The toxicology report of Michael's body confirmed a high concentration of cannabis in his system at the time of death. This is consistent with either recent consumption or/and regular consumption. It is not possible to know whether the reading suggest recent use or chronic use, but recent use would have affected Michael's coordination and could explain his going into the river and being unable to rescue himself: (see joint expert report, exh.P).
At the time he died, Michael was effectively homeless, although there was no evidence he was sleeping in open spaces or refuges."[34]

75. I accept this as a thorough and accurate summary of the evidence.

Suicide

76. A finding of suicide can be exceptionally distressing for the family of the deceased person and such a finding should only be made upon clear and cogent evidence.

77. In relation to the possibility of suicide, Mr Burnside QC made the following points:

- *Michael was angry; CCTV footage at Footscray station;*
- *He was upset (Elsa Giday p. 237; Surafel p.224; Ibsa Gutu p.248; Seare Negash p.251). His meeting with Elsa Giday ends with him looking despondent (the CCTV footage, Sunshine stations);*
- *He had just learned of the death of his grandfather, with whom he had a very close relationship (Askalu Tella p.4);*
- *He never spoke about harming himself (Girmay Mengesha p.18; Ibsa Gutu p.249; Sam Dichack T.125);*
- *He was generally a well-liked person. It is clear that he had a large number of friends. For example (a witness) who was in other respects a very reluctant witness)*

[33] Ibid, paragraphs 31- 42.

[34] Ibid, paragraphs 47 – 51.

said: Michael , he was a good friend of mine, always – he had a lot of friends, not only me. Michael was a good kid, Michael never walk around dirty, Michael was always clean, Michael was always friends with everybody in Footscray, Michael always laugh with anyone, doesn't have any enemies. (T.962)."[35]

78. D/S/C McKerracher expressed his opinion on what lead to Michael's death as follows:

> *"After leaving that train station in the emotional state that he was in, from the footage we saw him at West Footscray train station, and a combination of all the factors we've spoken about; he didn't have a job, he was - no place to live, he had recently found out about his grandfather's passing, he had recently broken up with his girlfriend, his friends have all stated or majority of them have stated that he was a different person in those weeks leading up to his passing, and the last thing he said to the person that saw him was – his friend, that he was going to go for a long walk. A combination of those factors may have resulted in him going down towards the river somewhere and he could have accidentally fallen into the river, he may have been substance-affected and that's how he come to be in the river."*[36]

79. In this context it is important to note Getachew's submission:

> *"The fact that my son was an Orthodox Christian has also been ignored. This is important because our Orthodox Faith teaches us that the only two sins that will never be forgiven are 1) to blaspheme against the Holy Spirit and 2) to commit suicide. Like all of my children, Michael was well aware of this and we never had any one of our family ties who commits suicide."*[37]

80. A judgment has to be reached inferentially in considering whether Michael's death was as a result of him intentionally taking his own life.

81. There is no definitive evidence bearing on this issue. Taking into account Michael's religious beliefs and considering the circumstances of his death, I accept Askalu's submission that the "*evidence is not a sufficient type or strength to support a finding of suicide*". Whilst it could be said that Michael was sad, upset and possibly angry, he clearly also had a lot to live for.

82. I do not find that Michael's death was a result of him intentionally taking his own life.

Accidental entry into the Maribyrnong River

83. I agree with Askalu's submission that in the absence of knowing exactly where Michael entered the river, it is impossible to ascertain the likelihood of him entering the water by accident and not being able to get back out.

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[35] Ibid, paragraph 55

[36] Transcript page 1060.

[37] Submission by the father of the deceased, page 2.

84. Substantial sections of the river have bluestone laid at the side of the river leading to the water being of a shallow depth for at least a metre from the river's edge in some areas but being of significantly greater depths in others.

85. I do not consider it a reasonable theory that Michael was so affected by anger or depression that he fell into the river. This is simply not supported on the evidence. Whilst Michael may have been upset when he left his friend, he did not appear to still be so on the CCTV footage at Newmarket station. It is also of some note that the footpath along the river is in most places a number of meters from the edge of the river and hence it is a somewhat unlikely scenario that Michael would have simply slipped from the path.

86. It is possible that Michael may have been affected by some unknown substance, or by some process which rendered him disoriented and caused him to enter the water accidentally. This could have been as a result of something done to him either without his knowledge or against his will. His inability to save himself in those circumstances would certainly be more understandable.

87. However, in the absence of further evidence, it is not possible to make a positive finding of accidental death.[38]

88. The physical features of the banks of the Maribyrnong river in the area of the Raleigh Road Bridge (referred to in paragraph 70 of Askalu's submission) are of particular note. Those features make accidental falling or stumbling into the river less, rather than more, likely. However, accidental death remains a possible explanation.

Foul play or third party involvement

89. It is Askalu's view that the circumstances surrounding Michael's disappearance and death are more consistent with possible foul play than any other scenario. However, there is simply not enough evidence to be able to determine what, in fact, actually happened to Michael.[39]

90. Foul play is possible and cannot be excluded. It is common ground between the parties here that it is one of the possible explanations for Michael's drowning.

91. Askalu's submission puts it that it is *"just as good a theory (if not more plausible) as the theory of Michael accidentally falling into the river from the paths along the banks and then drowning."*[40]

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[38] Submissions on behalf of Mrs Askalu Tella, Paragraphs 69-72.

[39] Ibid, paragraph 73.

92. There was a substantial amount of evidence, and submissions made, in relation to the person referred to as the "Italian man."

93. Although it is understandable that the family and members of the Tigrinian community have held suspicions about this man, I agree with Mr Burnside QC's submission that the link between him and Michael's disappearance is "*tenuous*" and "*there is no evidence to connect him to the disappearance and subsequent death of Michael.*"[41]

94. I also agree with Mr Burnside QC's summary of the relevant evidence, in particular that of Ms DeGille. In his evidence about the Information Report, based on Ms DeGille's CrimeStopper report to police on 7 July 2011, Acting Senior Sergeant Tatter-Rendelmann said:-

> *"What the caller said doesn't give enough information to describe the person or doesn't give enough to compare it - the person with the Italian?---No, no, the information in the - well, the content of the Information Report, the description, and obviously I'll get a copy of this, the person that was described, I wouldn't say that was anywhere near what this gentleman, the Italian man, looks like."*[42]

95. I agree with Mr Burnside QC's submission that the appearance of the Italian man does not comfortably fit Ms DeGille's description in her witness statement and he certainly does not fit the description given by Ms De Gille in her CrimeStopper report.[43]

96. It is common ground that foul play cannot be excluded, and it remains the situation that Michael may in fact have been the victim of the action of a third person or persons. However, the evidence, as it currently exists, does not support a theory that the man known as the Italian Man was involved in Michael's death.

Conclusion as to the circumstances in which the death occurred

97. Askalu submitted that I should make an open finding in respect of the circumstances in which Michael's death occurred. Getachew submitted that I should find that Michael was murdered.

98. Sadly, despite a thorough investigation, I am unable to make a finding on all of the circumstances in which Michael's death occurred. The evidence does not permit a conclusion, on the balance of probabilities, as to exactly how or why Michael entered the Maribyrnong River.

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[40] Ibid, paragraph 90.

[41] Closing submissions of Counsel Assisting, paragraph 60.

[42] Transcript page 528.

[43] Closing submissions of Counsel Assisting, paragraph 64.

99. As I said several times during the hearing, and as was confirmed by the coroner's investigator, the file will remain open and the coronial investigation can be re-opened if necessary.[44]

100. There is no alternative other than an open finding as to how and why Michael ended up in the Maribyrnong River and drowned.

Comments

Police and Coronial Investigations

101. During the inquest, considerable concern was voiced by members of the Ethiopian community about the attitude of police to members of their community generally, to Askalu and as to the adequacy of the investigation into Michael's death.

102. Whilst a coroner investigating a death must notify the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with a death, it is important to understand that it is not the role of a coroner to investigate criminal offences. Moreover, a coroner must not include in a finding or comment any statement that a person is, or may be guilty of an offence.[45]

103. When a reportable death occurs, Victoria Police and the investigating coroner both commence separate investigations into the circumstances of the death. Coroners temporarily suspend their investigations to allow the Victoria Police to ensure there are no viable criminal offences that can be investigated.

104. In some cases, despite the Victoria Police holding a belief that criminal offences were connected to the death, they are unable to progress the matter any further. In such cases the Victoria Police criminal investigation and the coronial investigation can overlap, but the coronial investigation must be progressed to ensure it is not unnecessarily protracted. Delay can exacerbate the distress of the family, friends and others affected by the death.[46]

105. The role of a coroner's investigator should be distinguished from the role of a police member's investigating criminal offences. The Court does not employ its own investigators. Where a reportable or reviewable death requires a coronial brief, a coroner relies upon the Chief Commissioner of Police to nominate a member or members of the force to assist the coroner with their investigation.

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[44] Transcript page 1164.

[45] *Coroners Act 2008* section 69(1).

[46] *Coroners Act 2008* section 8(b).

106. In this case D/S/C McKerracher was nominated to prepare the coronial brief.

107. D/S/C McKerracher's submission deals with the critical need for the community to be aware of the role of coroner's investigators:-

> *"Respectfully, the Court should comment publicly and perhaps even formally document for future cases, on matters concerning the role and responsibilities of the coroner's investigator. Accordingly, a police officer assisting the Court as the coroner's investigator should not be singled out and become the subject of unwarranted criticism as was the case here. Greater awareness of the particular and unique role of the coroner's investigator, (as distinct from their ordinary and often overlapping role as a police investigator) could also be achieved by the clarification and articulation of the special role from the beginning of all Coronial inquiries as well as via guidance material endorsed by the Court and made available to the public either in hard copy (i.e. pamphlets) or on the Court's website."* [47]

108. I agree with this submission. Since this matter the Court has replaced the term 'Investigating Member' with 'Coroner's Investigator' and defined that it to be:

> *A member or members of the police force nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist them with his/her investigation into a reportable death. The coroner's investigator takes instructions directly from a coroner and carries out the role subject to the direction of a coroner.*

109. This definition is now included in a number of practice directions published on the Court's website.

110. It is important to understand that D/S/C McKerracher, in his role as the coroner's investigator in this matter, did not technically represent the Victoria Police or the Chief Commissioner of Police, but took his directions from the coroner.

111. On my request, Detective Senior Sergeant Peter Tatter-Rendelmann was later nominated by the Chief Commissioner of Police as an additional coroner's investigator to assist me with my coronial investigation.

"Non suspicious" death

112. The *Coroners Act 2008* does not refer to, or use, the terms "suspicious" or "non-suspicious", nor does the *Crimes Act 1958.*[48]

113. Michael's death being referred to by Victoria Police as "non-suspicious" was a clear point of contention for Michael's family, loved ones and community.

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[47] Written Submission of behalf of D/S/C Tim McKerracher, paragraph 15.

[48] Closing submissions of counsel assisting, paragraphs 78.

114. The use of the term "non-suspicious" in relation to a death such as Michael's, where the circumstances surrounding the death were unknown, can cause unnecessary confusion for family members and loved ones at a time when they are most vulnerable.

115. The term "non-suspicious" clearly has a well understood meaning for Victoria Police and perhaps is also well understood in some sections of the broader community. But this is clearly not so in the Tigrinian community and may well not be so in other culturally and linguistically diverse (CALD) communities

116. On the evidence, given the composition of the community involved and the obvious need for very clear and unambiguous language, it would have been far better for the death to be described in a way that was readily understood. This comment could be made in respect of most, if not all, CALD communities.

117. I agree with Mr Burnside QC's submissions that Victoria Police should review and re-train its members in the way they categorise and describe deaths. A more appropriate description of Michael's death would have been *'not consistent with homicide'* or an *'unexplained death'*.

Policing

118. In his submission, Mr Burnside QC made the following points:-

> *"Members of the Ethiopian community are concerned about attitude of police to members of the community. Some of them think the police single them out for special (adverse) attention. There is support for that perception: see, e.g. Girmay Mengesha exh. AC at paragraphs 20-27.*
> *The Ethiopian community raised their concerns about the adequacy of the investigation at two community meetings at which police attended soon after Michael's death. They were assured that the investigation would be thorough. They naturally doubt that assurance in light of the fact that surprising death remains unexplained.*
> *Their perception of police indifference to their circumstances is heightened by the fact that Askalu's attempt to report Michael missing was not successful. It had no consequences, because he was very likely dead by 4 July. It is not clear that she adequately communicated the basis for a concern about his welfare.*
> *Two submissions have been provided from community members. They may not accurately state the evidence, and in several respects they depart substantially from the evidence. But they are important because they give an idea of the extent to which the Ethiopian community feel that the police do not adequately understand them or protect them. Whether their concerns are well-founded in fact is less significant than the fact that they feel genuinely aggrieved.*
> *Initially, some of them thought the police had killed Michael. There is no evidence to support that theory, but the fact that people thought it reflects a serious level of mistrust which is important to note.*
> *This mistrust creates, in some members of the Ethiopian community, a reluctance to seek help from the police, and it probably inhibits proper communication between members of the community and members of the police force.*

In this instance, member of the community were reluctant to trust the results of the police investigation into Michael's death. Their reluctance was misplaced, but the simple fact that they were reluctant to trust police is a matter worth noticing."[49]

119. This is a good synopsis of the issue.

120. Askalu made submissions under the heading "Adequacy and conduct of investigation process".

121. The submissions put that there was a "*perceived conflict of interest*"[50] on the part of the first coronial investigator D/S/C McKerracher. For his part, in his submissions, D/S/C McKerracher strongly rejected this criticism.

122. Askalu's submissions refer to the two community meetings with Victoria Police. It is clear that the issue of community confidence in the initial police investigation was raised at those meetings. I accept also that the community raised with Assistant Commissioner Fontana at those meetings, their concerns and criticisms of some aspects of the investigation by the local police; and that they wanted the police investigation to be conducted by other than local police.

123. D/S/C McKerracher was assigned the investigation responsibility and, when it was no longer considered a homicide, he became the coroner's investigator. He was a local police officer and members of the community perceived a conflict of interest because there was a view in the community that local police were, or may have been, involved in the disappearance and death of Michael.

124. It needs to be stated clearly that there is absolutely no evidence that any police officers were involved in Michael's disappearance and death. However, the issue is the "perception" rather than the reality. Given that perception at the time (however mistaken), it would in my view have been wise to assign officers from outside the local area to conduct the investigation from the outset. This would have, early on, enhanced community confidence in the process. Any suggestion that D/S/C McKerracher was somehow conflicted or not independent, can only – and at its highest – be put as a suggestion of appearance or perception, rather than any lack of independence on his behalf. There is no evidence that D/S/C McKerracher was actually conflicted or compromised in the discharge of his duties as coroner's investigator.

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[49] Closing submissions of Counsel Assisting, paragraphs 66 -72.

[50] Submission on behalf of Mrs Askalu Tella, paragraph 151.

125. It is clear that D/S/C McKerracher was not, as a matter of fact, conflicted in the performance of his role and I accept his evidence and his submissions on the point. However, the assignment of the case to him, in the circumstances, put him in a particularly difficult position (perhaps an invidious one). Askalu's submission was:

> *"As indicated in the oral submission on behalf of Mrs Tella, it is not D/S/C McKerracher's fault that he was assigned this task within this position of perceived conflict of interest. There was obviously going to be community distrust and hostility towards the handling of the investigation of Michael's death by local police. This was the sort of case that, because of language and cultural barriers, cried out to be conducted by a police investigator who would be able to network respectfully and comfortably with young and old members of Michael's community. It is significant that D/S/C McKerracher, and for that matter a community liaison officer, were not directed to attend either of the community meetings. If D/S/C McKerracher had attended he might have better understood the challenges he was faced with and he might have also understood the extent to which greater networking within the community could have greatly benefited the investigation."*[51]

126. I agree. It would obviously have assisted D/S/C McKerracher to appreciate the community views and concerns, if he had attended the community meetings. In evidence he agreed with this and it is no criticism of him that he was not assigned to do so. In my view he should have been so assigned.

127. It is important to note the constraints operating on the original investigator and in making the observation above I do not criticise either the competence, commitment or conscientiousness of D/S/C McKerracher. In this context I note his submission about the community's attitude towards assisting him:-

> *"A lack of cooperation and information from Michael's mother and those that were assisting her throughout this process meant that potentially important information was not passed on as it should have been. This has, at least in one known respect, resulted in CCTV footage from Michael's mother's flat being lost before it was known by police to have contained potentially relevant images. D/S/C McKerracher lamented this lack of cooperation and explained how it frustrated his ability to best assist the Coroner."*[52]

128. D/S/C McKerracher's frustration is understandable but must be balanced with the evidence of Askalu's lack of trust and confidence arising from that experience with the missing person process and the community disquiet about the investigation being conducted by local police.

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[51] Submissions on behalf of Askalu Tella, paragraph 151.

[52] Written Submission of behalf of D/S/C Tim McKerracher, paragraph 7.

Community trust/confidence

129. It is not within scope to consider the broader policing issues and the relationship between Victoria Police and the Ethiopian/Tigrinian community at the time. It is sufficient to note that there was clearly a lack of trust and confidence in local police. This apparently led to the convening of community meetings at which at least one very senior police officer, Assistant Commissioner Fontana, spoke. I infer that this was done by Victoria Police to address the serious issue of lack of community trust and confidence in the investigation.

130. It is absolutely critical that the community at large can have confidence in the competence, thoroughness and fairness of police investigations and coronial investigations. It is equally critical that in a multicultural and multilingual society, segments of the community (in this case the Ethiopian/Tigrinian community) can have confidence that a police officer nominated by the Chief Commissioner of Police to be the coroner's investigator will treat them with equal commitment to understanding and protecting them and their communities.

131. It is probably trite to say that there is an obligation on agencies such as Victoria Police to ensure that they build and maintain the confidence of the communities they serve and with whom they work. There is also an obligation on members of those communities to provide police with assistance and cooperation in investigations such as this. There can be no question that coroners investigators should receive the full cooperation of the community. It is far more likely that this will occur when the community understands and has confidence in the processes involved.

132. It is also important that all segments of the wider, general community provide assistance to police in investigating deaths and disappearances. It is obvious that investigations of disappearances and deaths can be prejudiced or compromised, or rendered less effective, if sections of the community are reluctant to seek help from the police and/or to reluctant to give information to them.

133. In this case, there was "serious level of mistrust" on the part of some people based upon a perception of unfair treatment by police of members of the Ethiopian/Tigrinian community. This appears to have lead in turn, as Mr Burnside QC put it:-

    "a reluctance to seek help from the police, and it probably inhibits proper communication between members of the community and members of the police force."[53]

    This is a fair reflection of what happened.

[53] Closing submission of Counsel Assisting, paragraph 71.

134. On the evidence of D/S/C McKerracher it is clear that his role of coroner's investigator was made more difficult than it should have been. A lack of information from Askalu and those that were assisting her throughout this process meant that potentially important information was not passed on as it should have been. As D/S/C Mckerracher's submissions put it,

> *"this has, at least in one known respect, resulted in CCTV footage from Michael's mother's flat being lost before it was known by police to have contained potentially relevant images. D/S/C McKerracher lamented this lack of cooperation and explained how it frustrated his ability to best assist the Coroner."*[54]

135. It is clear that D/S/C McKerracher experienced genuine frustration. It is also apparent that Askalu, extremely concerned for her son's welfare, nonetheless did not sufficiently trust investigating police to provide them with relevant information as soon as possible. This is a great pity. As the submission put on behalf of D/S/C McKerracher states:

> *"The Court should also consider making comments which educate the public as to the deleterious impact that stereotype-based prejudices have on the ability of the Court (and its agents such as the Coroner's Investigators) to function. Appropriate comments and recommendations should be made specifically directed to Victoria Police, The Tigrinian Community, those that hold a place of special significance and trust within that and other communities (e.g. the Flemington Kensington Community Legal Centre) and the community at large that Coroner's Investigators should receive their full cooperation, without hindrance or presupposition."*[55]

136. I have made comments to this effect above.

137. I note the evidence given by D/S/C McKerracher about steps he took to deal with cultural issues. In his submission he put:-

> *"Where permitted, Michael's family were informed of the progress of the investigation. Further cultural sensitivities were sought to be proactively addressed through communication with the Ethiopian High Commissioner and the Human Rights Commission."*[56]

These were appropriate steps to take.

138. However, the perception of police bias made his job difficult generally and resulted in a hampering of the investigation.

139. I am invited to comment on the effects of "*stereotype-based prejudice and how it may tend to undermine that which we are all ultimately seeking to achieve.*"[57] One of the reasons for the inquest was an apparent concern among the Ethiopian community in Flemington that police

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[54] Written Submission of behalf of D/S/C Tim McKerracher, paragraph 7

[55] Ibid paragraph 16.

[56] Ibid, paragraph 5.

[57] Ibid paragraph 8.

were in some way involved in Michael's death. As stated earlier, there is no evidence to support that proposition.

140. In relation to the issue of community mistrust and the implications for the effectiveness of the investigation the following evidence was given by D/S/C McKerracher:

> *"You may recall that the family - or that Askalu Tella's solicitors have been asking that footage be obtained from the Racecourse Road flats where she lived where Michael had visited on the weekend that he went missing. That was never able to be obtained by the time it was sought, do you agree with that?---It was very unfortunate that Michael's mum wouldn't speak to me from the outset and I only become aware of the fact that Michael visited her just prior to him last being seen in November of 2011 when I was provided with her statement. So because I was unable to speak to her, I wasn't able to find out that information.*
> *Do you agree that as it's turned out, Michael's family and Michael's community had a lot of - and his friends and associates, had a lot of important information to bring forward to the investigation?---Absolutely.*
> *Not through any fault of yours, you were put in a difficult position of needing to network with that community, whereas you now know that there was a problem with community mistrust?---Yes. It's unfortunate that the community weren't able to come forward with some of this information at the earliest possible time so that I could have investigated it. I have - I placed posters around asking that they provide information to me, and a lot of people that had information didn't supply it to me at the time when this investigation first started and have only come out and given that information since this inquest hearing has started."*[58]

141. Ultimately, and unfortunately, perceptions which existed within the Ethiopian/Tingrinian community about policing have lead to a level of mistrust and reluctance to assist which has made the initial investigation of Michael's disappearance and death more difficult than it should have been. I do not find that earlier assistance or a better more harmonious relationship with Victoria Police, or a trusting relationship with Victoria Police, would *necessarily* have made any difference to the ultimate conclusions reached by the investigators. However it is a lesson to be learned from this experience, and this inquest, that all that can be done must be done to ensure that these relationships are built on trust and good clear communication. Victoria Police clearly has a significant responsibility to ensure that this happens. Trust and confidence in police by any part of the community will clearly be enhanced if local policing is perceived by the community to be fair and even handed. In this context I note the proposed recommendations at the conclusion of Askalu's submission.

[58] Transcript page 1050.

Missing persons reports

142. This was an important area for examination at the inquest and the subject of extensive questioning and submissions in particular on behalf of Askalu. Substantial submissions were also made on the issue by the CCP.

143. A missing person is defined in the Victoria Police Manual:-

> *"A missing person is:*
> - *Any person reported to police whose whereabouts are unknown; and*
> - *There are fears for the safety or concern for the welfare of that person, including a person from an institution (not including a prison or gaol).*[59]

144. The first and most important event was Askalu's attendance at the Footscray Police Station at 1.49pm on 4 July 2011. She spoke to Constable Andrew Priestly.

145. Sadly, it is clear from the evidence of the Medical Panel that Michael was highly likely to have been dead by 4 July 2011. As the Medical Panel said in their joint evidence:-

> *"the body of Michael Atakelt has been in the water for at least several days and the appearances are consistent with him being in the water from around the time he was last seen alive."*[60]

146. There is a conflict between the evidence of Constable Priestly and the evidence of Askalu and Muna Gebrehat, who attended the police station with her, to assist her with language. The details of conflicting evidence are fleshed out in the submissions of Askalu and the CCP. All three persons were clearly honest witnesses and in my view Constable Priestly was acting conscientiously in discharging his duties. There was no doubt that Askalu was worried about Michael's circumstances. Constable Priestly made detailed notes and a number of enquiries at the time.

147. Clearly, Askalu and Muna left the police station believing they had made an official missing persons report and that it would be acted upon.

148. Equally clear, Constable Priestly did not consider that the second limb of the test had been fulfilled, so he advised Askalu that if she could not find Michael, reports could be compiled if there were concerns for his welfare.

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[59] Exhibit AN – Victoria Police Manual – Procedures and Guidelines: Missing persons investigations at Inquest brief page 820.

[60] Joint report prepared by Dr Noel Woodford, Dr Linda Iles, Dr Byron Collins, and Voula Staikos, page 1.

149. As to the conflict in the evidence, I agree with Mr Burnside QC that Constable Priestly's notes "*seemed reliable; more reliable than the recollection of the witnesses*."[61] I also agree, that Askalu and Muna were "*stressed*."[62]

150. Given the criteria he had to apply it would not be reasonable to criticise Constable Priestly, and I agree with Mr Burnside QC that it is significant that Askalu told him she had not seen Michael for several years.[63] When asked if he would do anything differently now (in light of what he was told and ascertained at the time), Constable Prieslty said "*no I would not do anything different*".[64]

151. There were seven police contacts altogether within three days. Clearly, Askalu was becoming more and more worried and frustrated over this short period. On the evidence, I conclude that each police officer dealing with her applied the missing person criteria in good faith and conscientiously and none concluded that the second limb was satisfied, i.e. they did not conclude that "*there are fears for the safety or concern for the welfare of that person including a person from an institution (not including a prison or gaol)*."[65]

152. It is clear, on the evidence, that the approach the police officers took to the interpretation and application of the missing persons criteria was, that they themselves, having heard the information, should hold the relevant "*fears for the safety for the welfare of that person*" rather than simply assess it on the level of fear or concern held by the person making the report.

153. Finally, on 6 July 2011 at about midday, Constable Remedios made an official missing person report. She did so even though she also did not believe there were concerns for his welfare or safety within the meaning of the second part of the definition.

154. Askalu's submission sums up her evidence fairly:

> *"Constable Remedios also saw that Mrs Tella was upset and frustrated, and she could see that there had been some miscommunication that was making it difficult for her. Constable Remedios said that she did not believe that there were concerns for Michael's welfare and hence that the second part of the Victoria Police Manual Criteria had not been met. Her view was that in judging the criteria to concerns for welfare – it was the concerns of the police to be considered, rather than the concerns of the reporting*

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[61] Closing submissions of Counsel Assisting, paragraph 86.

[62] Ibid.

[63] Ibid, paragraph 87.

[64] Transcript p 580.

[65] Submissions on behalf of Mrs Askalu Tella, paragraph 127.

person. However Mrs Tella's dissatisfaction with the earlier responses of Constables Priestley and Robinson prompted the decision to take a missing persons report from Mrs Tella."[66]

155. The CCP's submission is in broad agreement:–

> *"Whatever were the communication difficulties between Askalu Tella and the police members she spoke to, there is a consistent picture that emerges from their evidence:*
> *(a) Michael was estranged from Askalu and had not lived at home with her for a considerable period of time'*
> *(b) Askalu had no contact details for Michael;*
> *(c) although Michael's whereabouts were unknown, he was an adult with no identified mental or physical health issues; and*
> *(d) otherwise, there was no tangible concern for his safety or welfare.*
> *It is submitted that the police members who spoke with Askalu between 4 July and 6 July 2011 responded appropriately based upon the information as they understood it. It was reasonable for the conclusion to be drawn that Michael was a person whose whereabouts were unknown but he was not a missing person as there were no material fears or concerns for his safety or welfare."*[67]

156. Leaving aside any problems with the criteria, in my view, Askalu's repeated attendances at police stations in a state of obvious anxiety about her son could have resulted in an earlier decision to formalise the missing persons report. Although the officers cannot be criticised, having conscientiously applied themselves to the task of checking the report against the criteria as they understood them, their approach was perhaps too formal and mechanistic. In my opinion, a more flexible and more sympathetic response would have been appropriate. In making this observation I am mindful of the need not to be retrospectively overly critical of persons in the positions of these officers that is persons discharging one of a number of functions in a busy police station.

157. Constable Remedios' response to Askalu's obvious frustration was appropriate, particularly in the light of the critically important language issue.

158. The system issues here are the application of the missing persons test, language and associated with training. I agree with the submissions made by Mr Burnside QC:-

> *" However, the confusion associated with reporting him missing deserves mention as a matter which could and should be addressed by police. Specifically, it would be useful to recommend that written material regarding procedures for reporting missing persons be made available in several languages. Material on the police website is useful only for people who can access the internet at the relevant time (see D/S/C McKerracher 3rd affidavit Exh BW at page 4)."*[68]

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[66]. Ibid, paragraph 113.

[67] Submissions on behalf of the Chief Commissioner of Police, paragraphs 38 & 39.

[68] Closing submissions of counsel assisting, paragraph 89.

This was accepted in turn by the CCP in his submission:

> *"Nonetheless, Victoria Police acknowledges the ongoing need to identify and employ aids to communication between police members and persons who do not speak English. Accordingly, there is merit in the recommendation suggested by Counsel Assisting."*[69]

159. I strongly agree with the submission of Askalu:–

> *"Another matter of considerable concern is the lack of information available to members of the general public in respect of how to make a missing persons report, the factors which are considered by the police in assessing the report, and the items of information that a reporting person needs to be armed with in order to satisfy the requirements for a missing persons report to be made. There are no pamphlets providing information to the public on making missing persons reports in English or any other language. Indeed it seems that the only information available to the general public is on the police website – which is only useful to those who have access to the internet at the relevant time, have the ability to locate the information, and can read and understand it. Even then, the information provided is not sufficient to overcome the kinds of issues faced by Mrs Tella in the present case.*
>
> *It is also of considerable importance, that a person attempting to report a loved one or associate as missing is clearly aware upon leaving the police station as to the status of their enquiry. In particular it is of considerable importance for them to know whether:*
>
> *(x) a report has actually been taken;*
>
> *(xi) if a report has been taken, what steps the police are going to undertake and what steps, if any, the reporting person needs to undertake;*
>
> *(xii) if a report has not been taken, why not; and*
>
> *(xiii) what a reporting person needs to provide, or what criteria needs to be satisfied, in order for a missing persons report to be taken in the future.*
>
> *Mrs Tella's inability to effectively report her son missing and follow through with that enquiry is a clear example of the problems that the current lack of information and public understanding of the process can create.*[70]

160. Whilst the scope of the inquest on this issue was limited, and noting that I expressly declined to undertake a system-wide examination of the missing person process, I accepte the importance of it from Askalu's point of view and from the point of view of the community. In addition, all parties have addressed this in submissions.

Delivering the death message

161. Whilst no criticism can be made of the way the death message was delivered in this case, given all the circumstances that had to be taken into account and accepting Detective Wright's explanation and evidence, there is merit in the proposed recommendations made in Askalu's submission that police members should receive training, and have information readily available to them, on cultural factors which might impact upon the method of delivering a

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[69] Submissions on behalf of the Chief Commissioner of Police, paragraphs 41.

[70] Submissions on behalf of Mrs Askalu Tella, paragraphs 131, 132 & 134.

death message and the importance of seeking accurate cultural guidance wherever possible prior to the delivery of the death message.[71]

The Adequacy of the Investigation

162. Two aspects in particular were singled out for criticism by Askalu:-

    1. The use of the term "non-suspicious" to describe Michael's death from a very early stage of the investigation. (I have dealt with this issue at paragraph's 112 – 117).

    2. An incorrect assumption on the part of the investigators to where Michael or his body entered the Maribyrnong River.

163. In respect of the incorrect assumption where Michael's body went into the river, Mr Burnside QC made the following points :-

> *"One aspect of the investigation was apparently mistaken: the initial theory was that Michael had turned down Smithfield Rd, entered the river somewhere north of Smithfield Road and drifted north. That theory was supported by CCTV footage showing Michael late on 26 June 2011 in Racecourse Road east of Smithfield Road, and the absence of any sighting of him in CCTV footage in Racecourse Road west of Smithfield Road.*
> *The theory was consistent with the fact that Smithfield Road led down to Ballarat Road where Michael was living.*
> *But the theory directed the way evidence (including CCTV evidence) was obtained. However it was a plausible theory, apart from the question whether a body would drift upstream far enough to account for the place where it was found."*[72]

164. D/S/C McKerracher also dealt with the issue:-

> *"During the inquest, it was suggested that D/S/C McKerracher's investigation proceeded on a false assumption, that being that Michael entered the river approximately 4 kilometres upstream somewhere between the Smithfield Road Bridge and Raleigh Road Bridge. Expert evidence later established that this hypothesis was unlikely and it was more probable that he entered 2 kilometres downstream from where his body was eventually located.*
> *Counsel Assisting the Coroner also submitted the D/S/C McKerracher's theory on where Michael entered the river was "persuasive and well-reasoned" but, in light of subsequent expert evidence, was probably wrong. In considering this potential factual inaccuracy, caution must be exercised in taking on overly critical retrospective analysis. The comments of Counsel Assisting that D/S/C McKerracher's theory was persuasive and well-reasoned is a fair and careful assessment of the detective's beliefs viewed in the context of the time, and with the knowledge that was then available to him."*[73]

165. I note the submissions made by Mr Burnside QC and Mr Ihle, counsel for D/S/C McKerracher on the point, however the working assumption as to where Michael or his body went into the

[71] Ibid, paragraph 147.

[72] Ibid, paragraphs 72 – 75.

[73] Written Submission of behalf of D/S/C Tim McKerracher, paragraphs 10 – 11.

river was incorrect. In my opinion, it would have been prudent from an investigative point of view to check very early on with Water Police or other experts as to the movement of currents and tides in the Maribyrnong River, as a fundamental consideration in assessing where he is likely to have gone in. Although as Mr Burnside QC put it, that the original theory was "plausible", those superior to D/S/C McKerracher charged and tasked with the responsibility of assisting and advising him should have recommended that he get expert advice at that point on that issue. As he said in evidence:-

> *"It's fair to say, isn't it, that a number of matters that have been inquired into by Sergeant Tatter were matters that could have been pursued at an earlier stage but nobody had suggested to you that you needed to get Water Police or Search and Rescue or a water expert, no-one within the police force had suggested that to you prior to you giving the inquest brief to the Coroner?---Correct."*[74]

166. I note also Askalu's submission on the point:-

> *"It is significant that the first time that the assistance of Water Police was requested in identifying Michael's possible entry point to the water was on the first day of the inquest – in February 2013, over 18 months after Michael's death and well after completion of the brief of evidence. It very quickly became apparent on speaking to Sergeant Dixon that the working assumption made by D/S/C McKerracher was wrong and that the investigation had been focused too far south. Indeed, the inquest needed to be adjourned to allow for further investigation to be undertaken. It is submitted that a fundamental error was made by police in not obtaining the expertise of police such as Sergeant Dixon, or a water flow expert at an early stage in the investigation."*[75]

167. Ultimately, I am satisfied that this is a fair criticism. Having made that comment, I am also satisfied that D/S/C McKerracher acted in good faith, did his best in his investigation and that he sought to discharge the duties of investigating the death originally as a potential homicide and then after that as the coroners investigator.

168. However it became necessary in February 2013, in the interests of ensuring confidence in the coronial investigative process, to bring in Acting Senior Sergeant Tatter-Rendelmann as an additional coroner's investigator to ensure that the Tigrinian Community had their confidence and trust in the process restored as much as possible.

Summary of findings and conclusions

169. The medical cause of death is "consistent with drowning".

170. The death occurred on or about 26 June 2011 in the Maribyrnong River in the vicinity of the Raleigh Road bridge.

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[74] Transcript p 1049.

[75] Submissions on behalf of Mrs Askalu Tella. Paragraph 157.

171. It is not possible to make conclusive findings as to exactly when, exactly where, or why Michael entered the Maribyrnong River. However, I find that he entered the water within 200 metres upstream, or downstream, of the Raleigh Road bridge. I also find that it is most likely that he went into the river and died within hours of being last seen at the Newmarket railway station at 7.07pm on Sunday 26 June 2011.

172. There was no police involvement in Michael's disappearance and death.

173. There is the possibility that foul play caused or contributed to the death.

174. I do not find that Michael intentionally took his own life.

Proposals by parties

175. In Askalu's submission, a number of constructive proposals are put in relation to coronial/investigative process:-

> *"It is submitted that to overcome the issues outlined above, the following recommendations should be made:*
>
> *(xiv) in cases involving considerable community interest, disquiet and/or concern about police contact and police relations, the Coroner's Court should, as part of its process:-*
> - *schedule a directions hearing or hearings at an early stage;*
> - *have the investigator provide, during the directions hearing/s, updates on the status of the investigation including identifying the non-controversial evidence already obtained or lines of investigation being pursued;*
> - *consider taking evidence in Court on non-controversial topics from witnesses at an early stage; and*
> - *maintain a strict oversight of the investigation;*
>
> *(xv) in cases involving an institutional, perceived or real conflict of interest on the part of the investigator, the Coroner's Court should, as part of its process:*
> - *consider the impact the institutional, perceived or real conflict of interest is having on the investigation (if any);*
> - *ensure that an independent, experienced and effective coronial investigator is appointed; and*
> - *in the event that the perceived conflict of interest is having an impact on the investigation, implement measures to overcome that perception whether through greater community consultation; greater communication by the Court of its role in the investigation process; the assignment of a new investigator,; or the introduction of a community liaison officer."*[76]

176. I thank Ms Dixon and Leighfield for these proposals. I note that a system of early Directions Hearings had already been implemented in respect of police contact deaths and I will carefully evaluate the balance of the proposals for future implementation.

[76] Ibid, paragraph 161.

The missing persons process

177. Submissions were made by Mr Burnside QC, Mr Lawrie and Askalu.

178. I set out Mr Burnside QC's and Mr Lawrie's earlier at paragraph 158.

179. Askalu put forward a very detailed proposal:-

> *"The first is to have available at Police stations information for the public – in multiple languages – which outlines the criteria for making a missing persons report; the kind of information required to make such a report; and the steps that will be taken once such a report has been made.*
> *Secondly, it is submitted that a receipting and recording process should be introduced. This process would involve a police member providing a document to a reporting person at the time of their attendance to the police station identifying the following factors:*
> *(i) the date and time of the contact/inquiry;*
> *(ii) the name of the person making the enquiry;*
> *(iii) the name of the person being reported missing or for whom concerns are held;*
> *(iv) a clear identification of whether a missing persons report has been filed;*
> *(v) if a missing persons report has been filed – the steps being undertaken by police; and those that can or should be undertaken by the reporting person;*
> *(vi) If a missing persons report has not been filed – the reasons why it has not been filed; and the steps that the reporting person needs to take;*
> *(vii) the name, rank and police ID of the member/s interacting with the reporting person;*
> *(viii) confirmation that a missing persons information pack has been provided to the reporting person (ie this may include a pamphlet as to missing persons procedures in an appropriate language; and*
> *(ix) confirmation that the response record has been explained and understood by the reporting person – including an indication as to whether an interpreter has been used where there are language difficulties.*
> *Thirdly, it is submitted that a system should be introduced to log all Inquiry Response Records where a missing persons report has not been taken, together with the reporting member's notes as to the contact person, in order to enable police members to more readily understand the concerns for a person's welfare – especially in circumstances where multiple reports are made by the same or different reporting persons."*[77] *And "(ii) that concern for the welfare or fears for the safety of a person be assessed by reference to concerns of the reporting person, rather than those of police members, provided the concerns are reasonable."*[78]

180. I thank the parties for their constructive proposals for recommendations and system change.

RECOMMENDATIONS

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

[77] Submissions on behalf of Mrs Askalu Tella. Paragraphs 136, 137 & 139.
[78] Ibid, paragraph 140 (ii.)

1. I recommend to Victoria Police that it consider implementation of the proposal set out in paragraph 179 above (which is in three parts). Appendix A of Askalu's submission set outs: "Example of Proposed Missing Persons Inquiry Response Record". I attach that to these findings and recommend that Victoria Police consider implementation of a system/process designed to achieve the same purpose.
2. That Victoria Police provide training and information to members on cultural factors which might impact upon the method of delivering a death message and the importance of seeking accurate cultural guidance wherever possible prior to the delivery of the death message
3. That Victoria Police review the language used to categorise and describe deaths to ensure that the terms used are clear and are likely to be understood by members of the family and/or community of the deceased person.

I extend my condolences to the family of Michael Atakelt.

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

Mr Getachew Seyoum

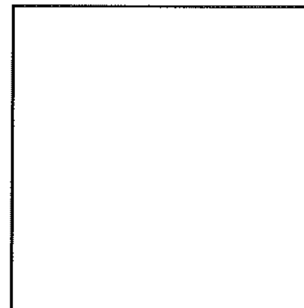
Mrs Askalu Tella

Chief Commissioner of Police, Ken Lay APM

D/S/C Tim McKerracher, Coroner's Investigator

Senior Sergeant Peter Tatter-Rendelmann, Coroner's Investigator

Signature:



JUDGE IAN L GRAY
STATE CORONER
Date: **28 August 2014**

AMENDED FINDING

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: 12/1/2015