



CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION: **Inquest into the deaths of
Marcus Peter Volke and
Mayang Prasetyo**

TITLE OF COURT: Coroners Court

JURISDICTION: Brisbane

FILE NO(s): COR 2014/3688; 3692

DELIVERED ON: 19 May 2017

DELIVERED AT: Brisbane

HEARING DATE(s): 31 January 2017; 15-16 May 2017

FINDINGS OF: Mr Terry Ryan, State Coroner

CATCHWORDS: CORONERS: Death in custody; avoiding being placed in custody; suicide; domestic homicide.

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Commissioner of Police:	Ms Melissa Cable
Senior Constable Bryan Reid; Constable Liam McWhinney; Senior Constable Robert Richardson; Detective Sergeant Tom Jakes; Senior Sergeant Sean McKay:	Mr Troy Schmidt i/b Queensland Police Union of Employees Legal Group

Introduction

1. Marcus Peter Volke and Mayang Prasetyo, an Indonesian citizen, were both 27 years of age and living together in a unit complex at Teneriffe at the time of their deaths, which occurred over the period 3 - 4 October 2014.
2. The couple had been heard arguing loudly in their unit over the evening of 2 October 2014. From the morning of 3 October 2014, other residents of the unit complex noticed a foul smell, which seemed to be coming from the couple's unit. During 3-4 October 2014, Mr Volke had purchased supplies from local stores including a large cooking pot, rubber gloves and various cleaning products. On 3 October 2014, he went to the Royal Brisbane and Women's Hospital (RBWH) to have a severe cut on his left hand treated.
3. By the evening of 4 October 2014, the smell emanating from the unit had become noticeably worse. Mr Volke called an electrician to repair a power outage which he attributed to an oven fault at his unit. This resulted in the unit managers being called, as the electrician required access to the main switchboard of the unit complex. While inside Mr Volke's unit, the unit manager noticed blood on the carpet and other damage, which led to the police being called.
4. Police officers arrived at the unit and spoke to Mr Volke outside in the hallway. Mr Volke indicated he did not know where Ms Prasetyo was. When police told Mr Volke they would need to enter the unit, he asked if he could have a moment to secure his dogs, which were currently running around inside. Police agreed to this request. Mr Volke re-entered the unit and locked the door behind him. He was subsequently seen by the unit manager running from the rear of the unit. A search ensued for Mr Volke, and involved officers on foot as well as members of the dog squad.
5. At the same time, police gained access to the locked unit and found Ms Prasetyo's dismembered body. Her feet were protruding from a large stockpot which was placed on the floor of the kitchen. Other body parts were found in a garbage bag contained in the washing machine.
6. Police located Mr Volke soon after in a nearby underground carpark with the help of police dogs. He was found inside an industrial bin with significant injuries to both sides of his throat and wrists. The Queensland Ambulance Service (QAS) was called, but the extent of his injuries meant that he could not be resuscitated.

Coronial jurisdiction

7. It is important to note that the primary function of an inquest is to seek out and record as many of the facts concerning a death as the public interest requires. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred. Where appropriate, a coroner may also comment on matters connected with the death that relate to public

health and safety, the administration of justice, and ways to prevent similar deaths from happening.

8. To make clear the distinction in roles the *Coroners Act 2003* specifically states that a coroner must not include in the findings or any comments, a statement that a person is or maybe guilty of an offence or is or maybe civilly liable for something.
9. In the context of this inquest, while I have concluded, on the balance of probabilities, that Mr Volke's actions caused Ms Prasetyo's death, I make no finding as to whether his actions would have constituted an offence under the criminal law of Queensland.
10. These findings:
 - confirm the identities of the deceased persons, how they died, and the time, place and medical causes of their deaths;
 - consider whether any third party contributed to the deaths; and
 - consider whether the police officers involved in attempting to locate and detain Mr Volke shortly before his death adhered to QPS policy and procedure.

The investigation

11. An investigation into the circumstances leading to Mr Volke's death was conducted by Detective Sergeant Joshua Walsh from the Queensland Police Service Ethical Standards Command (ESC) Internal Investigations Group. A separate homicide investigation into the circumstances leading to Ms Prasetyo's death was conducted by Detective Sergeant Jack Savage from the Fortitude Valley Criminal Investigation Branch.
12. After being notified of Mr Volke's death, the ESC attended the scene and an investigation ensued. The investigation was informed by statements and recorded interviews with:
 - all police officers involved;
 - attending QAS staff;
 - relevant persons from the unit complex and others who had contact with Mr Volke and Ms Prasetyo in the lead up to their deaths;
 - friends and associates of both deceased; and
 - Mr Volke's next of kin.
13. Relevant sections of the QPS Operational Procedures Manual were examined. Forensic analysis was conducted and photographs were taken. All the police investigation material was tendered at the inquest.

14. Full internal autopsy examinations with associated testing were conducted by Senior Forensic Pathologist, Dr Beng Ong. Further photographs were taken during these examinations. Identification of Ms Prasetyo was assisted by DNA comparisons with her biological mother in Indonesia
15. I am satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed. I extend my appreciation to Detective Sergeant Walsh for his comprehensive report.

The Inquest

16. Mr Volke's death was reported as a death in custody under the *Coroners Act 2003*. He died while he was trying to avoid being put into custody. In those circumstances an inquest was mandatory. The focus of the inquest was the actions of the relevant police officers involved in the events leading up to the death of Mr Volke.
17. As noted above, the dismembered body of Ms Prasetyo was located inside the unit where the two were living shortly before Mr Volke's body was found in Dath Street, Teneriffe. Ms Prasetyo's death was the subject of a separate homicide investigation which concluded that Mr Volke caused the death.
18. As the deaths were connected, I considered it appropriate to hold a joint inquest. The inquest was held in Brisbane over 15 – 16 May 2017. All the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. I accepted the submission from counsel assisting, Miss Cooper, that all evidence be tendered and that oral evidence be heard from the following witnesses:
 - Detective Sergeant Joshua Walsh;
 - Senior Constable Bryan Reid;
 - Constable Liam McWhinney;
 - Senior Constable Robert Richardson;
 - Detective Sergeant Tom Jakes; and
 - Senior Sergeant Sean McKay.
19. I consider that the evidence tendered in addition to the oral evidence from these witnesses was sufficient for me to make the requisite findings. I acknowledge the comprehensive submissions from counsel assisting, Ms Cooper, which provided the basis for my findings.

The evidence

Personal circumstances

20. Mr Volke was an Australian citizen and was born in Geelong. He had three siblings. He had trained with his brother as a chef. He had been involved in a long term de facto relationship and had purchased a unit in Ballarat.
21. Ms Prasetyo was an Indonesian citizen. Information provided from various associates suggests that Mr Volke met her in 2013 after he commenced working as a male escort within adult clubs in Melbourne.¹ They had married in Denmark on 1 August 2013.² The investigation material confirmed the pair had been travelling throughout Asia and Europe working within the sex industry throughout 2013 and 2014.³
22. Mr Volke advertised through Rent Boys Australia while visiting Australia in early 2014, and worked within both Queensland and his home State of Victoria. Mr Volke returned from Bali with Ms Prasetyo to live in Brisbane in September 2014.⁴ He also worked as a chef at a restaurant in Bulimba, and had done so since 24 September 2014.⁵
23. Mr Volke's parents, who resided in Victoria, communicated with their son via emails and Skype, the last time being on 29 September 2014. They believed that Marcus worked on cruise ships as a chef and was travelling the world. They did not know any details of his relationship with Ms Prasetyo and thought they had met on a cruise ship. Mr Volke was described as generally withdrawn and not inclined to disclose information to his parents, particularly in relation to his feelings.
24. A consistent theme among the material tendered at the inquest was that Mr Volke was very intelligent and health conscious. He did not smoke or drink and had a very good knowledge of nutrition and fitness. He had suffered from stomach, bowel and skin conditions and often chose naturopathic treatments. He frequently engaged in online discussions about these matters. There was no suggestion that he was abusive or had used violence in previous relationships. It was also clear that he was ambivalent about his work as an escort and his relationship with Ms Prasetyo, and the potential embarrassment these would cause his family.
25. Mr Volke had accumulated a significant amount of credit card debt throughout 2013 and 2014.⁶ Emails between Mr Volke and his former partner confirmed this, and that he was using loans to pay off other loans.⁷ Information provided by associates of Mr Volke described the relationship between him and Ms Prasetyo as 'financial'. Several emails between Mr

¹ Exhibit E6.

² Exhibit C8.

³ Exhibit C1, particularly emails (15) (50).

⁴ Exhibit C1 (2).

⁵ Exhibit E5.

⁶ Exhibit C7.

⁷ Exhibit C1 (56).

Volke and his former partner also suggested that his marriage with Ms Prasetyo was a business arrangement, and that his intention was to stop escort work and become a dog breeder.⁸

26. The emails further confirmed that Ms Prasetyo was assisting Mr Volke with the repayment of his debt.⁹ The emails also suggest that, in return for that financial assistance, Mr Volke had sponsored Ms Prasetyo in obtaining a visa to allow her to stay in Australia.¹⁰ The emails confirmed a somewhat volatile relationship between Mr Volke and Ms Prasetyo. Ms Prasetyo had threatened Mr Volke that she would tell his family of their arrangement if he did not carry out his side of the agreement or chose to leave her.¹¹ She also monitored his social media usage and email accounts, and was unhappy that he maintained contact with his former partner.
27. There was also evidence to indicate that Mr Volke and Ms Prasetyo lived together in a spousal relationship on a genuine domestic basis. They travelled together as a couple and had visited Ms Prasetyo's mother in Indonesia. They had joint bank accounts. They posted photographs together on Facebook, where they disclosed that they were married in Amsterdam in 2013. Mr Volke had referred to Ms Prasetyo as his 'crazy girlfriend' in discussions with work colleagues in the weeks before his death. He also listed her as his next of kin and girlfriend in his patient registration form with Teneriffe Family Doctors on 19 September 2014, when he also listed his marital status as 'de facto'.¹²
28. On 6 September 2014, Mr Volke and Ms Prasetyo met with Debrena Hughes, a building manager employed by 'Doubleone 3 Building Management Services Pty Ltd'. Mrs Hughes was the unit manager for a block of units at 113 Commercial Road, Teneriffe.¹³ Statements from Mrs Hughes, and her husband Kevin Hughes, were tendered at the inquest.¹⁴ Mrs Hughes showed the pair around several units. Mr Volke referred to Ms Prasetyo as his partner, and did most of the talking throughout the meeting. Mrs Hughes noted that Ms Prasetyo had a good command of English. Mrs Hughes was informed that Ms Prasetyo did not work, and that Mr Volke was a chef who was currently looking for employment.
29. Mrs Hughes noticed that, at times, Mr Volke and Ms Prasetyo were holding hands. They were very softly spoken people and seemed quiet. She was not sure how long they had been together. They wanted to lease a unit straight away as they were living in short-term accommodation and required a place that allowed dogs. A rental agreement for a ground floor, one bedroom unit with a courtyard was subsequently completed.¹⁵ They entered into a six month lease and moved in on 13 September 2014.

⁸ Exhibit C1 (12).

⁹ Exhibit C1 (65).

¹⁰ Exhibit C1 (32).

¹¹ Exhibit C2.

¹² Exhibit D5

¹³ Exhibit B29.

¹⁴ Exhibits B29 – B29.7; B30 – B30.1.

¹⁵ Exhibits B29.1 – B29.5.

30. The investigation material confirmed that Mr Volke and Ms Prasetyo both used the apartment at Teneriffe to live in and conduct their work as escorts.¹⁶ Information provided to the inquest revealed that Ms Prasetyo was actively advertising sexual services on the mobile application 'Tinder', under the name 'Mayang', up until and including the evening of 2 October 2014.¹⁷
31. The investigation revealed little information about Ms Prasetyo. It appeared that she felt isolated, was unhappy about living in Brisbane, and missed her family in Indonesia. Ms Prasetyo had worked to support her mother and her younger siblings in Indonesia. Representatives of the Indonesian Consulate General attended the inquest on behalf of Ms Prasetyo's mother.
32. I express my sincere condolences to the families and friends of both deceased.

Assessment of mental health

33. The police investigation established that Mr Volke had a mental health history in Victoria, spanning from about 2005.¹⁸ Mr Volke's parents and former partner disclosed a suicide attempt made by him in January 2006 when he took an overdose of paracetamol tablets. He reportedly recovered from this quite well, with his mother describing him as having received a 'shock' from the experience, after which he was determined to have a good life.¹⁹
34. Mr Volke was subsequently referred for treatment at the Ballarat Psychiatric Service in June 2007 due to concerns that he had longstanding anxiety and depressive features that were not improving. He was assessed as having moderate depression accompanied by a marked sleep disturbance.²⁰ He had lost 10-15kg over a month and was concerned his digestive system was not working properly. He was commenced on an antidepressant and significant improvements in his mood, sleep and appetite were noted within a month. He then commenced treatment with a private psychiatrist and his file was closed at the Ballarat Psychiatric Service in January 2008. At that time, there were indications that Mr Volke continued to have a 'mild body image disturbance' but he had returned to his usual activities, including karate.
35. While Mr Volke engaged voluntarily with a range of health practitioners while living in Victoria it is not clear if he sought treatment to manage his mental illness while travelling overseas. An email to his former partner dated 21 April 2014 disclosed that he was distressed about his

¹⁶ Exhibit B50; B50.1.

¹⁷ Exhibit B2 – B2.1.

¹⁸ Exhibit D4.

¹⁹ Exhibit E2.2.

²⁰ Exhibit D4

circumstances while he was living with Ms Prasetyo and that he was feeling suicidal.

36. While Mr Volke was living in Ballarat, a number of protective factors were in place that would have had a positive impact on his mental health. He had a supportive family, had been employed by his brother, was in a long term relationship, had a network of friends and was engaged in sporting activities. The loss of these supports after he moved from Ballarat is likely to have contributed to a deterioration in his mental health and reduced his capacity to handle stressful events.
37. Medical records from General Practitioner, Dr Paul Paterson, were tendered at the inquest.²¹ These records confirmed that Mr Volke was seen by Dr Paterson on 19 September 2014. Mr Volke had advised that he had just returned from overseas, and had a history of anxiety and depression. His complaint at that time was poor sleep, day time lethargy, mild depression and anxiety.
38. Mr Volke had requested medication for ‘thinking better’ throughout the day as he was about to commence working as a chef. He was prescribed Endep, a tricyclic antidepressant with sedative properties, to be taken daily before bed. He told Dr Paterson that he had previously found Endep helpful. The use of this medication is consistent with Mr Volke’s toxicology results.²²
39. The investigation produced no evidence to confirm whether Ms Prasetyo had a mental health history of any kind.

Events leading to death

40. Late in the afternoon of 2 October 2014, Mr Volke received a phone call at the unit from Ms Prasetyo. He was in the company of a client.²³ Mr Volke then left the unit with his client as Ms Prasetyo had called him to say she was on her way to the unit with a client of her own. On receiving this call Mr Volke referred to Ms Prasetyo as his ‘flatmate’.
41. After leaving the unit Mr Volke received a second call from Ms Prasetyo. His client heard Ms Prasetyo screaming at Mr Volke on the other end of the line. He described the conversation as stilted, and clinical. As soon as Mr Volke answered the phone, he became a different person and was no longer talking freely, openly, or honestly. Mr Volke said “*we’re walking down the river, we’re just going for a walk, oh ok*”, and then hung up.²⁴ Mr Volke said to the client “*I’ve got to go back, my flatmate wants me to help clean the dogs.*” Mr Volke then left his client to return home.²⁵ The client told police that he saw five small dogs within the unit. The dogs were kept in a small enclosure, and the unit smelled strongly because the dogs had soiled the carpet.

²¹ Exhibit D5.

²² Exhibit A4.

²³ Exhibit B50.

²⁴ Exhibit B50, page 4.

²⁵ Ibid.

42. Between 11:30pm and midnight on 2 October 2014, people in a neighbouring apartment overheard an argument coming from 113 Commercial Road.²⁶ It lasted about 30 – 40 minutes and it started to escalate to a point where the person, later identified to be Ms Prasetyo, was noted to be screaming. The male person, later identified to be Mr Volke, was seen to be sitting on the couch and staring straight ahead, not reacting at all to the screaming that was going on. Ms Prasetyo was heard to say things like “*fuck you*” and was calling Mr Volke “*stupid*”. Ms Prasetyo was also saying things like “*I can’t believe you.*”²⁷ The argument then stopped.
43. The neighbour awoke at 1:30am and could hear Ms Prasetyo and Mr Volke arguing again. This time it was not as loud, and Mr Volke’s voice could not be heard at all. This argument lasted about half an hour.²⁸ The neighbour did not hear any further arguing occurring from that unit over the ensuing hours or days.
44. On the morning of 3 October 2014, the unit manager, Mrs Hughes, started to smell something in the hall outside Mr Volke and Ms Prasetyo’s unit. Mrs Hughes was walking past the unit over the course of the day to use the lifts, and could tell that the smell was coming from that unit.²⁹ The smell was bad enough to require the use of air freshener in the hallway.
45. At 6:00pm that evening, Mr Volke attended a supermarket at Newstead and purchased, among other things, gloves, bleach, a scrubbing brush, garbage bags, wipes, and laundry soaker.³⁰ These items were later located inside the unit by police. Soon after this, Mr Volke caught a taxi to the RBWH, the time stamp being recorded as 6:16pm.³¹ Mr Volke told the taxi driver that he had a cut on his hand, and the taxi driver observed him to be wrapping one of his fingers with a small piece of cloth. There was blood on the cloth. Mr Volke told the taxi driver “*he had been cutting onions and the knife slipped. It’s very deep.*”³²
46. The hospital records confirmed that Mr Volke attended the RBWH emergency department and left, with his hand bandaged, at about 9:30pm that night.³³ The records state the reason for Mr Volke’s presentation was a cut hand, suffered in a fight with his girlfriend at 5:00pm that day. He said that she was holding a large chef’s knife. Mr Volke had grabbed the knife when an altercation ensued. During this altercation, his girlfriend pulled the knife from his dominant left hand.³⁴ Hospital records indicate that Mr Volke was to be admitted to have tendons in his hand repaired.

²⁶ Exhibit B1.

²⁷ Exhibit B1 paragraphs 17 onwards.

²⁸ Exhibit B1, paragraphs 22-23.

²⁹ Exhibit B29, paragraph 25.

³⁰ Exhibit C14.

³¹ Exhibit B60.

³² Exhibit B60, paragraphs 12 onwards.

³³ Exhibit D3.

³⁴ Exhibit D3, page 2.

47. Early on 4 October 2014, Mrs Hughes saw Mr Volke outside the unit complex and noticed his bandaged hand. Mr Volke told Mrs Hughes that he required surgery on his injured hand.³⁵ Mrs Hughes also noticed that the smell emanating from the unit was worse than the day before. At 2:00pm that day she sent Mr Volke a text message to tell him he needed to do something about it.
48. At 12:15pm that day, Mr Volke had attended a city store and purchased a meat cleaver.³⁶ At about 3:30pm, Mrs Hughes noticed a burning smell emanating from the unit. She knocked on the unit door, and noticed that Mr Volke appeared to have just arrived home. In relation to the burning smell, Mr Volke said *"I just went out and left my pot of stock on and it must have burnt dry."*³⁷
49. Later that evening, Mr Volke engaged the services of an emergency electrician, Bradley Coyne. A statement from Mr Coyne was tendered at the inquest.³⁸ Mr Coyne received a call from Mr Volke at 6:18pm. Mr Volke advised that he had no power to his unit, and needed help with the oven. Mr Coyne attended, and noticed Mr Volke had a bandage wrapped around his left hand. In relation to his hand, Mr Volke said words to the effect *"my psycho ex-girlfriend tried to attack me with a knife which I grabbed and cut my hand."*³⁹
50. Mr Coyne entered the unit, and Mr Volke said to him words to the effect *"you'll have to excuse the smell, I am cooking some pig's broth."*⁴⁰ Mr Coyne thought this was odd given the time of year, and described the smell as pungent and putrid, *"a bit like dog food"*.⁴¹ As Mr Coyne required access to the main switchboard to deal with the problem, Mrs Hughes was contacted to facilitate this. At about 8:15pm, Mrs Hughes and her husband met with Mr Volke and Mr Coyne in the foyer of the unit complex. Mr Volke told Mrs Hughes that his pot had overflowed and had shorted out the power. They proceeded to the main switch board, and then went upstairs to the unit.
51. Mr Volke opened the door for Mr Coyne to enter the unit. He tried to stop Mrs Hughes from entering, saying *"no, you have to give me seven days' notice"*. Mrs Hughes replied to the effect that she could enter the unit given the electrical fault was a safety issue.⁴² She noticed blood and other damage throughout the unit. Mr Hughes took a series of photographs of the damage. Mr Volke told her the blood on the carpet was from the cut on his hand. It was after this that Mrs Hughes contacted police and requested they attend at the unit. This call was taken by police communications at approximately 9:00pm.⁴³ The job was classified as a 'welfare check'.⁴⁴

³⁵ Exhibit B29, paragraph 27.

³⁶ Exhibit C18.

³⁷ Exhibit B29, paragraph 29.

³⁸ Exhibit B11.

³⁹ Exhibit B11, paragraph 19.

⁴⁰ Exhibit B11, paragraph 22.

⁴¹ Exhibit B11, paragraph 23.

⁴² Exhibit B29, paragraph 32.

⁴³ Exhibit A10, paragraph 2.60.

⁴⁴ Exhibit B59 at paragraph 3.

52. The first response officers were Senior Constable Bryan Reid and Constable Liam McWhinney, both from the Fortitude Valley police station. Both officers gave evidence at the inquest, in addition to their disciplinary interviews.⁴⁵ The officers attended at the unit some ten minutes after receiving the call to attend. They spoke initially with Mrs Hughes at the front of the complex. They then attended at the unit and spoke to Mr Volke outside the front door to his unit, in the hallway.
53. The events which follow were clearly captured by both officers, who had activated their body-worn cameras. This footage was tendered at the inquest.⁴⁶ The footage showed a conversation between the officers and Mr Volke about Ms Prasetyo's whereabouts. Mr Volke said that he had a fight with Ms Prasetyo, who had run away and had not returned. Mr Volke advised police that his guess was Ms Prasetyo had gone back to Indonesia. He said that she was here on a 'visitor visa' but was applying for a 'partner visa'.⁴⁷
54. The officers informed Mr Volke that they intended to enter the unit without a warrant, due to the odd odour and the reports of blood in the unit. Mr Volke's response was that she was '*obviously not in there*'. He told the officers that the unit managers had already looked inside the unit. Mr Volke then asked police if, before they entered, he would be able to secure his dogs that were inside the unit running around.⁴⁸ Based on the information the officers had at the time, they saw no issue with this.
55. The officers both recalled a strong smell emanating from the unit. Both were familiar with the smell of decomposing bodies and their evidence was that the smell was not consistent with that.
56. Mr Volke then re-entered the unit. The body worn camera footage depicts Mr Volke quickly locking the door behind him as he re-enters the unit. Officers McWhinney and Reid were questioned during their evidence about what factors they considered when they allowed Mr Volke to re-enter his unit, and whether there was anything else they could have done at that time to prevent Mr Volke doing so.
57. Senior Constable Reid said that although Mr Volke's demeanour quickly changed when told the officers needed to enter his unit, he appeared to be giving an honest account in the hallway. His explanation about the presence of blood and the source of the smell was not unreasonable. Senior Constable Reid was not aware of the number or size of the dogs. He considered it would be preferable to gain voluntary compliance from Mr Volke rather than having to force entry to the unit. While his suspicions had increased when Mr Volke gave the officers reasons they did not need to enter the unit, his objective was to keep him on side and see what happened.

⁴⁵ Exhibits B51 – B51.1; B43 – B43.2.

⁴⁶ Exhibits F1; F2 – F2.1.

⁴⁷ Exhibits F1; F2.1.

⁴⁸ Exhibit F1, from 00:06:00.

58. Similarly, Constable McWhinney stated that he did not want to be confronted by the dogs on entry to the unit, and there were no signs that Mr Volke would decamp or was hostile during their conversation with him.
59. After Mr Volke re-entered the unit, the officers waited in the hallway. Senior Constable Reid could hear metallic sounds from within the unit, which he thought may have been from the dog enclosure. Soon after, Mr Hughes informed the officers that Mr Volke had run from the rear of the unit on foot and gone over the back fence. The officers then proceeded to run to the rear exit of the building, where they took up with Mrs Hughes. Mrs Hughes gave them general directions about where Mr Volke had gone. A search for Mr Volke ensued in the surrounding streets. Senior Constable Reid's body worn camera footage continued to run throughout the initial search outside of the unit. However, as there was very little external lighting the quality of the footage is poor.⁴⁹
60. The search for Mr Volke was expanded to include various dog squad officers, and other back up police crews. Officers McWhinney and Reid returned to the unit, and gained entry via a master key provided by Mrs Hughes.⁵⁰ The search of unit is depicted on the footage provided by both officers.⁵¹
61. Upon entering the unit, Senior Constable Reid located a large black garbage bag inside the washing machine. A large metal pot was located on the kitchen floor, containing liquid from which toes from two human feet were protruding. Constable McWhinney told the inquest that he initially thought it was a sick prank. However, he also saw a large pool of fresh blood on the floor of the kitchen and determined there were human remains at the scene. The officers immediately exited the unit, alerted police communications of a potential homicide, and secured the crime scene. The contents of the black garbage bag, and the human feet were later identified as the dismembered body of Ms Prasetyo.
62. While the search took place inside the unit, efforts to locate Mr Volke were continuing in the local neighbourhood. At the inquest, I heard evidence from a dog squad officer, Senior Constable Robert Richardson.⁵² Senior Constable Richardson recalled receiving the call for the job just before 9:30pm, and he arrived at Commercial Rd some five minutes later. Soon after, he received information that a deceased person had been located in the unit from which Mr Volke had decamped. He was shown a still picture of Mr Volke from Constable McWhinney's body worn camera.
63. At 9:51pm he deployed his police dog, 'Zuma', who strongly indicated the presence of a track. He commenced tracking along Dath St, towards Vernon Terrace. Another dog squad officer tracked along the other side of the street.

⁴⁹ Exhibit F2, from 00:08:10.

⁵⁰ Exhibit B30, paragraph 56.

⁵¹ Exhibits F1 from 00:16:00; Exhibit F2.

⁵² Exhibits B52 – B52.1.

64. Police dog Zuma followed the track to an underground carpark, up a short ramp and to a door which was closed.⁵³ After clearing behind vehicles in the carpark Zuma made his way to Dath Street, and entered a small room via an open door. This was the same room that contained the closed door into the carpark. The room contained a number of industrial bins and Zuma indicated strongly to the first bin to the right as he entered the room. After clearing the remaining bins Senior Constable Richardson opened the bin indicated by Zuma and saw Mr Volke laying inside with a significant wound to his neck. After there was no response from Mr Volke, Senior Constable Richardson called for assistance, including the QAS, and secured the room.
65. Senior Constable Richardson's evidence was that shortly after he was joined by other police, including Detective Sergeant Tom Jakes, who I heard from at the inquest.⁵⁴ Detective Sergeant Jakes was in company with Detective Sergeant Brett Taylor.⁵⁵ Detective Sergeants Jakes and Taylor, Senior Constable Richardson and some other police officers entered through the open doorway.
66. Detective Sergeant Jakes drew his firearm and called '*Police. Armed police*' as the bin was opened. This is depicted on the footage provided by Senior Constable Simon Shilton.⁵⁶ As there continued to be no response from Mr Volke, the bin was wheeled out of the enclosed space onto Dath Street and it was tipped over. Detective Sergeant Jakes covered the bin with his firearm until it became apparent that Mr Volke posed no threat to officer safety.
67. These events are also caught in graphic detail on the body-worn camera footage provided by Senior Constable Bruno Masot, which was also tendered.⁵⁷ Mr Volke's body was extracted from the bin but he appeared to be unresponsive. He was covered in blood and had significant injuries to both sides of his throat and wrists. A 35cm kitchen knife was also extracted from the bin. QPS officers immediately commenced resuscitation efforts. The QAS was called at 10:00pm and they arrived on scene at 10:06pm.⁵⁸ Attempts to revive Mr Volke were futile, and he was declared deceased at the scene by paramedics at 10:18pm.

⁵³ CCTV footage depicts Mr Volke running into the carpark carrying a knife.

⁵⁴ Exhibit B33.

⁵⁵ Exhibit B59.

⁵⁶ Exhibit F6.

⁵⁷ Exhibit F4.

⁵⁸ Exhibit D1.

Autopsy results

Marcus Volke

68. A full internal autopsy examination was conducted by senior forensic pathologist Dr Beng Ong on 6 October 2014. A copy of the report was tendered at the inquest.⁵⁹
69. Acute injuries had been inflicted at or near the time of death. These injuries included incised wounds on the neck and the front of both forearms. The incised wound on the right side of the neck had partially cut the internal jugular vein, resulting in an air embolism. The embolism was ultimately responsible for the death. Dr Ong explained that death in these circumstances is almost instantaneous and that Mr Volke would have succumbed to the embolism, rather than the loss of blood. Dr Ong also noted other multiple superimposed incisions over the same area, which were consistent with the injuries having been self-inflicted.
70. There was another cluster of injuries including incised wounds on the hands and some bruises and abrasions on the upper and lower limbs. Dr Ong considered that these injuries were at least a few hours, and possibly a few days old. The injuries could have been sustained in an altercation (involving a sharp weapon), or could have been self-inflicted.
71. Dr Ong was satisfied that the formal cause of death could be stated as from an air embolism, due to or as a consequence of incised wounds to the neck.

Mayang Prasetyo

72. A full internal autopsy examination was conducted by senior forensic pathologist Dr Beng Ong on 7 October 2014. A copy of the report was also tendered at the inquest.⁶⁰
73. It was observed that Ms Prasetyo's body had been divided into portions, with the torso in three major parts - head and upper neck, lower neck and upper torso without any limbs, and lower torso without any limbs. Dr Ong noted that the body parts physically fitted together, in keeping with being from the same person.
74. Multiple bones and tissue fragments from the long bones of the limbs were present. The bones were soft, splintered and fragmented in keeping with attempts to soften them. The bones were from both the right and left upper and lower limbs. There were other, smaller fragmented bones that could not be identified.

⁵⁹ Exhibit A2.

⁶⁰ Exhibit A7.

75. Dr Ong noted that the margins where the body was dismembered showed no associated haemorrhage. This was in keeping with the deceased having died beforehand. In some margins, there were numerous associated superficial incised wounds, indicating multiple attempts during the process of dismemberment. There was a large horizontal incision across the back of the chest which appeared to be an aborted attempt of division of the torso. More than one weapon had been used in the attempts to dismember the deceased.
76. The main injuries identified ante-mortem were described as follows:
- Stab wound on the front of the neck with another small incised wound next to it. This stab wound was the fatal injury as major structures had been incised, namely the trachea and left common carotid artery;
 - Stab and incised wounds on the right cheek, right occipital region and the back of the head; these wounds did not damage any major organs or vessels so were unlikely to be responsible for death; and
 - Numerous bruises on the head and neck.
77. Dr Ong determined that the formal cause of death was due to the stab wound to the neck. He concluded that numerous additional injuries were inflicted after death, particularly the stab wounds to the face which were inflicted rather forcefully. Dr Ong confirmed that the body was dismembered after death with attempts to dispose of the body made by cooking and dissolving the body parts.

Investigation findings

78. The ESC investigation relevantly addressed two issues:
1. Was Detective Sergeant Jakes justified in the production of his firearm upon the location of Mr Volke; and
 2. Could the sudden death of Mr Volke have been avoided; concentrating on the actions of Senior Constable Reid, Constable McWhinney, Senior Constable Richardson and Sergeant Baxendall.
79. With respect to the first issue, the investigation considered information provided by the QPS Firearms Training Section, Education Training Command, which is responsible for the QPS firearms training curriculum state-wide. The QPS Situational Use of Force model contained in section 14.3.2 of the Operational Procedures Manual (OPM) was considered, as were the relevant sections of the *Police Powers and Responsibilities Act 2000*.⁶¹

⁶¹ Exhibit A10 from page 38.

80. The investigation confirmed the current QPS policy on lethal use of force, namely that "*the intentional lethal use of firearms may only be made when strictly unavoidable in order to protect life.*"⁶² The ESC investigation found that Detective Sergeant Jakes was of the opinion that Mr Volke had committed a life imprisonment offence, thus had the ability to cause serious injury or death to both police and members of the public. These factors caused Detective Sergeant Jakes to perceive Mr Volke to be a high threat. The presentation of his firearm was to ensure the safety of not only himself, but also fellow officers and members of the community.
81. As soon as he identified that Mr Volke posed no significant risk to himself, other officers or members of the public, Detective Sergeant Jakes holstered his firearm. In accordance with the OPM, he subsequently completed a Use of Force occurrence within QPRIME.
82. The ESC investigation found that, at the time of presenting his firearm, Detective Sergeant Jakes' actions in so doing were authorised, justified and supported by all applicable legislation. In this instance, it was found that Detective Sergeant Jakes use of force was legally and procedurally justified. I agree with this conclusion.
83. With respect to the second issue, ESC investigators assessed the facts which were known to Officers McWhinney and Reid when they attended Mr Volke's unit. It was found that the initial information was provided by Mrs Hughes, namely that she had entered Mr Volke's unit during the evening and had observed damage to the furniture (which was believed to have been caused by animals), blood on the floor, and the unit in a messy state. Mrs Hughes further advised there was a 'rancid' smell within the unit and Ms Prasetyo had not been seen for several days.
84. Mrs Hughes told police that Mr Volke had said he had been involved in an argument with his partner (Ms Prasetyo), who had fled from the unit a short time later. At the time of contacting police, Mrs Hughes had requested that police conduct a welfare check on Ms Prasetyo. She also said that Mr Volke was the only person present within the unit at the time.
85. Constable Kyle Malherbe of the Fortitude Valley police station then contacted Police Communications to register the job, and provided the details as given by Mrs Hughes. Officers Reid and McWhinney subsequently received the job details (as a welfare check) and attended the unit complex.
86. Prior to speaking with Mr Volke at the unit door, Senior Constable Reid spoke with Mrs Hughes whilst Constable McWhinney made inquiries for QPRIME searches be conducted. There was no information on QPRIME or Crimtrac with respect to either Ms Prasetyo or Mr Volke, apart from minor traffic infringements from Victoria in the name of Mr Volke.

⁶² Exhibit A10, page 39, paragraph 5.7.

87. During their interviews with ESC investigators, Officers Reid and McWhinney confirmed that there was a strong smell coming from the unit. However, they both described the smell as 'cooking' or 'off meat'. Both officers stated it was not the same as the smell of a deceased or a decomposing person. When questioned regarding the smell, Mr Volke said the smell was from pig's broth he was cooking, which had boiled over on the stove.
88. The officers observed that Mr Volke appeared genuine when he spoke to police about arguing with Ms Prasetyo. Mr Volke explained that the blood located within the unit was from the injury he had sustained during the altercation with Ms Prasetyo. He said that he attempted to clean up the blood using bleach, which added to the smell. Mr Volke explained that he had not reported the incident to police as he was more concerned about having his injuries attended to, explaining that surgery was required to repair the injured tendons in his hand.
89. The ESC investigation found that the decision of the officers to inform Mr Volke that they would need to enter the unit was justified, and authorised by law. The officers were not aware of Mr Volke's mental state, nor were the officers aware that Ms Prasetyo had been killed and partially dismembered within the unit.
90. Both officers accepted in their evidence both to the ESC investigators and at the inquest that, with the benefit of hindsight, they should not have allowed Mr Volke to re-enter the unit where he was able to lock the door. However, both officers believed it was Mr Volke's intention to secure the dogs, rather than run from the unit. At the time, the officers had no evidence available to them to suggest that Mr Volke had committed a serious offence and was about to commit self-harm. As Senior Constable Reid told the inquest, it is also possible that they could have been attacked by Mr Volke had they entered the unit.
91. The ESC investigation found that their actions in this respect were justified in the circumstances, and supported by relevant legislation. The ESC investigation concluded that there was no misconduct displayed by any of the officers involved and further concluded that no disciplinary proceedings were required.
92. At the inquest, I heard from Senior Sergeant Sean McKay, who was the District Duty Officer at the relevant time and attended at both aspects of the incident location.⁶³ His evidence centred on the measures which he ensured were in place to ensure the preserving of evidence, and the integrity of both investigations.

⁶³ Exhibit B42.

93. Senior Sergeant McKay ensured the scene at the unit was appropriately secured and a crime scene log had been commenced with respect to it. He contacted Detective Sergeant Jack Savage of the Fortitude Valley CIB and briefed him on what had occurred, such that the subsequent homicide investigation could be commenced. He liaised with the COMCO and ensured scenes of crime officers had been notified and were en route.
94. Senior Sergeant McKay was present when Mr Volke was retrieved from the industrial bin. Senior Sergeant McKay remained at the location and ensured a crime scene log was commenced. He also ensured that scene of crime officers appreciated the scale of the scene, and that it extended along Dath Street. Senior Sergeant McKay remained at the scene until after the government undertaker had left.
95. I accept and adopt the conclusions of Detective Sergeant Walsh. I am also satisfied that the integrity of the evidence was suitably preserved.

Conclusions

96. Ms Prasetyo was last seen alive in the unit she shared with Mr Volke early on 3 October 2014. I am satisfied after considering all the evidence that Mr Volke killed Ms Prasetyo early on the morning of 3 October 2014 by repeatedly stabbing her following a protracted argument. The wound that caused her death was a stab wound to the front of her neck.
97. Mr Volke suffered injuries to his left hand either during this argument with Ms Prasetyo or in his attempts to dismember her body. He then gave inconsistent statements to treating doctors and other witnesses about the cause of his injuries.
98. Over 3-4 October 2014, Mr Volke purchased a range of items that he used in his efforts to dispose of Ms Prasetyo's body, including rubber gloves, bleach, a meat cleaver, a 36.5 litre stockpot and strainer.
99. Over the same period, Mr Volke dismembered Ms Prasetyo's body. He tried to dissolve her remains using chemicals, including caustic soda heated on a stove top. When confronted about the smell emanating from his unit Mr Volke attempted to explain that it was from a pig's broth which had boiled over. He also said that he had used bleach to clean up blood from the wound on his left hand.
100. The blood found throughout his unit was explained by Mr Volke as being from the cut on his hand. Forensic examinations of the unit found drag marks and footprints in blood, together with a large blood stain on the carpet, and blood spatter covering most of the lounge room wall. DNA samples indicated that the only source of this blood was Ms Prasetyo.

101. I conclude that Mr Volke died from his own actions after inflicting multiple stab wounds to his neck within an industrial bin. He had run away from his unit when it became inevitable that police officers would discover Ms Prasetyo's remains within the unit. He also had incised wounds to both wrists that were self-inflicted inside the unit immediately after police officers attended. I find that none of the police officers or other persons at the Teneriffe unit block caused or contributed to his death in any way.
102. I am satisfied that the actions and decisions made by the attending police officers in the immediate lead up to Mr Volke's death were appropriate and timely. I am satisfied that the officers were justified in not forcing entry to the unit after they initially spoke with Mr Volke in the hallway. Mr Volke's death could not have reasonably been prevented by the attending officers.
103. I am satisfied that the investigation conducted into Mr Volke's death by the Ethical Standards Command was appropriate, thorough, and covered all relevant areas of investigation. I am satisfied that the protocols established to investigate deaths in custody in accordance with the *Coroners Act 2003*, and Queensland Police Operational Procedures Manual were complied with.

Findings required by s45

104. I am required to find, as far as is possible, the medical cause of death, who the deceased persons were and when, where and how they came by their deaths. After considering all the evidence, including the material contained in the exhibits, I am able to make the following findings:

Marcus Volke

Identity of the deceased – The deceased person was Marcus Peter Volke.

How he died - Mr Volke died as a result of his own actions. After police attended at his unit to conduct a welfare check on his spouse he decamped. He ran to a large waste bin in a nearby residential complex. He entered the bin and caused an incised wound to his neck with a large cooking knife which penetrated the right internal jugular vein.

Place of death – Mr Volke died at Teneriffe in the State of Queensland.

Date of death – He died on 4 October 2014.

Cause of death – Mr Volke died as a result of an air embolism, due to an incised wound to the neck.

Mayang Prasetyo

Identity of the deceased – The deceased person was Mayang Prasetyo, also known as Febri Andriansyah.

How she died - Ms Prasetyo was killed by her spouse, Marcus Peter Volke, after he inflicted a stab wound to the front of her neck. The wound penetrated the trachea and the left common carotid artery. Mr Volke then proceeded to dismember Ms Prasetyo's body, and attempted to dispose of the body parts by dissolving them with chemicals.

Place of death – Ms Prasetyo died at Teneriffe in the State of Queensland.

Date of death – Ms Prasetyo died on 3 October 2014.

Cause of death – Ms Prasetyo died as a result of a stab wound to the neck.

Comments and recommendations

105. Section 46 of the *Coroners Act*, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

106. In this case I have found that there are no grounds for criticism of the police officers involved. They responded professionally and in accordance with their training in a situation which they could not have reasonably foreseen would have unfolded in the way it did.

107. Ms Prasetyo's death was clearly a domestic violence death. However, as she and Mr Volke had moved to Queensland only a short time before their deaths there was very limited information available about the nature of their relationship. They had limited interaction with formal and informal support networks which may have been able to respond to risk factors in their relationship. I have been unable to identify any opportunities for intervention that were missed by formal service providers.

108. The report of the Special Taskforce on Domestic and Family Violence in Queensland, *Not Now, Not Ever: Putting an end to domestic and family* noted that the true nature and extent of domestic violence suffered by lesbian, gay, bisexual, transgender, and intersex (LGBTI) members of the community remains largely hidden. The Report noted that there are particular stressors and factors that are unique for the LGBTI community. It also noted a lack of awareness of what domestic violence looks like in this particular context. The Queensland Government's Response to the Taskforce Report and the Domestic and Family Violence Prevention Strategy 2016-26 also acknowledge the particular needs of LGBTI people.
109. The Taskforce made specific reference to Ms Prasetyo's death⁶⁴, noting that it was "*a devastating reminder of the existence and reality of domestic violence for LGBTI people, and the barriers we face as a community in addressing it. It is critical that the wider community continues to seek out, hear and respond to the voices and experiences of those in our LGBTI community who experience domestic violence, to ensure their stories are not lost.*"
110. In the circumstances, I do not consider that there are any recommendations I could reasonably make to prevent similar deaths from occurring in the future.
111. I close the inquest.

Terry Ryan
State Coroner
Brisbane
19 May 2017

⁶⁴ At page 141