OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Leanne Melissa Thompson**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2006/26
DELIVERED ON:	3 May 2013
DELIVERED AT:	Brisbane
HEARING DATE(s):	4 & 20 December 2012, 8 February 2013, 22-24 April 2013, 26 April 2013
FINDINGS OF:	John Lock, Brisbane Coroner
CATCHWORDS:	Coroners: inquest, hanging, forensic evidence, Child Protection

REPRESENTATION:

Counsel Assisting: Ms J Sharp I/B Office of State Coroner

Counsel for Department of Communities: Ms K Carmody of Counsel

Counsel for Alexander O'Sachy: Mr C Chowdhury of Counsel I/B Legal Aid Queensland

Counsel for Daniel O'Sachy: Mr J Allen of Counsel I/B Legal Aid Queensland

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Introduction

1. Leanne Melissa Thompson was aged 15. At the time of her death she was the subject of a Child Protection Order. There had been substantial involvement with the Department of Child Safety. Leanne had been engaging in high risk behaviours and the Department had found it difficult to engage with Leanne. She had been living in a Youth Shelter but then began living with a 28 year old male Alexander (Alex) O'Sachy, a person with a criminal history and a known user of illicit drugs. His brother Daniel O'Sachy also lived at these premises. The Department was concerned with the circumstances of her residential circumstances and her relationship with Alex O'Sachy. It had encouraged her, and would have facilitated her to live elsewhere, but she refused. Leanne was a very troubled young person.

2. On the morning of 7 September 2006 Daniel O'Sachy had expressed concerns to the Department and in particular that his brother was assaulting Leanne and providing her with drugs. He wanted the Department to remove her from his brother's influence. He had also contacted police that afternoon on a number of occasions expressing concerns about Alex and Leanne. After one call about them creating a disturbance, Police arrived but Leanne was not seen by Police and they left. A short time later Leanne was found hanging from a beam underneath the house where she was living.

3. CPR was commenced by Daniel and Queensland Ambulance Services (QAS) attended and were able to obtain a return of cardiac function and she was taken to hospital. However Leanne had been without oxygen circulation for a sufficient time to cause hypoxic brain damage. An autopsy examination concluded she had suffered a hypoxic brain injury due to hanging.

4. Subsequently Alex O'Sachy was charged with assisting in her suicide. The charge went to trial, but the jury was unable to reach a verdict.

5. Almost 4 years after her death, a next door neighbour provided police with further information, which suggested this was a case of murder in that she says she saw Alex and Daniel applying a noose to Leanne's neck and suspending her. A further 18 month Police investigation was conducted. No further charges have been brought.

6. Further forensic opinion now questions whether the ligature marks found on Leanne's neck are wholly consistent with a suspended hanging suicide. The forensic evidence, and in particular relating to what must have been the time of her death, was inconsistent with the version of events detailed by the neighbour.

7. Leanne's father was a police officer. He believes Leanne committed suicide but has expressed concerns about the involvement of the Department of Child Safety. Leanne's mother maintains Leanne was murdered.

Issues

8. Given there was considerable uncertainty as to the circumstances in which Leanne died, a decision was made to hold an inquest. The issues determined at a pre-inquest hearing were;

   a) The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased person, when, where and particularly how she died and what caused her death;

   b) The circumstances leading to the death, in particular:
      - the adequacy of the initial police response to the O'Sachy residence on 7 September 2006; and
      - the adequacy of care and protection afforded to the deceased by the Department of Communities (Child Safety); and
      - the adequacy of the policies and procedures in place by the Department of Communities (Child Safety) to care for high risk children

   c) If there are ways to prevent a similar death occurring in the future, in particular, the adequacy of policies and procedures currently in place by the Department of Communities (Child Safety) to care for high risk children.

The scope of the Coroner's inquiry and findings

9. An inquest is not a trial between opposing parties but an inquiry into the death. The scope of an inquest goes beyond merely establishing the medical cause of death.

10. 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 and in appropriate cases with a view to reducing the likelihood of similar deaths.

11. As a result, a coroner can make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future. However, a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.

12. Proceedings in a coroner's court are not bound by the rules of evidence but that does not mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

13. A coroner should apply the civil standard of proof, namely the balance of probabilities. However the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, then

the clearer and more persuasive the evidence needs to be for a coroner to be sufficiently satisfied it has been proven to the civil standard.

14. If, from information obtained at an inquest or during the investigation, a coroner reasonably suspects a person has committed a criminal offence, the coroner must give the information to the Director of Public Prosecutions in the case of an indictable offence.

Summary of Family Background and Involvement of the Department of Child Safety

15. Leanne had lived with her parents, Dianne Thompson and Damien Rockett and her brother, up until the disintegration of that marriage. From that point onwards Leanne's behaviour became increasingly difficult for her parents to manage, and this was thought to have come about as a result of the marriage breakdown, which was and remains acrimonious.

16. On 31 March 2004, there was a disclosure made by Leanne to her school counsellor alleging physical harm. The school counsellor then informed the then Department of Child Safety ('the Department" now the Department of Communities). This was the first involvement of the Department with Leanne. The outcome of the call was that an Initial Assessment ('IA') was to be conducted. The IA concluded that Leanne was at risk of further harm.

17. Leanne made various other disclosures during the course of her involvement with the Department. The substance of these disclosures is referred to in the records of the Department and Child Death Review. It is not intended to detail the disclosures other than in a general fashion as they contain untested allegations naming certain people, including the difficulties she reported she had with both of her parents. It is sufficient to say they appeared serious and concerning from the Department's position and without doubt Leanne was exhibiting disturbing behaviour consistent with what she had been saying.

18. By September 2004, Leanne had told the Department she was too scared to go home, and was staying with a friend. She then moved in with her paternal grandmother but by the end of October 2004, Leanne moved out and was staying with friends. Despite some serious allegations being made as to why she moved out it was deemed insufficient for a Child Protection Notification to be made at this time.

19. Leanne's living situation was rectified by Christmas 2004 and she lived with her mother until the end of March 2005. This situation was viewed by the Department as being stable during this time. At this time Leanne was also assisting police in relation to her evidence in charges that had been brought against others in relation to drug and sex offences. In her 93A statement she outlined her involvement in drug use and prostitution.

20. On 29 March 2005 the Department was informed by Leanne that she was now staying with a friend. The Department investigated and were informed of a suicide attempt and general lack of school attendance.

21. Leanne was admitted to Wynnum Hospital in April 2005 for a self harming incident and was referred to Child and Youth Mental Health Service. She was offered counselling but she refused to engage with that service

22. On 28 July 2005, a Child Protection Notification was made due to Leanne placing herself at risk of harm and her parents being unable to protect her due to her living away from them since April 2005. It was at this time that Leanne was noted to be associated with the O'Sachy brothers, who were both known to the Department. Leanne was refusing to return to her parents' care and refusing to be accommodated in a youth shelter. She had not attended school for some 6 months.

23. Leanne was deemed by the Department to have a substantiated risk of future harm due to her refusal to return home and unwillingness to have contact with her parents or for information to be provided to her parents.

24. On 30 July 2005 Leanne was located by Queensland Police Service (QPS) and transported to her father's house. She was observed self harming by cutting her wrist and Leanne was transferred via ambulance to hospital. She was admitted to Mater Child and Youth Mental Health Service for five days. She was diagnosed with an adjustment disorder with mixed disturbance of emotions and conduct.

25. On 23 August 2005 there was a referral to SCAN by QPS with regard to Leanne's ongoing substance abuse problems and being supplied heroin, methamphetamine and cannabis.

26. On 2 September 2005 the SCAN meeting discussed that her parents were willing to help but had difficulty in doing so given her behavioural tendencies and her ongoing drug problem. A Child Protection Notification from 28 July 2005 remained unallocated.

27. On 28 October 2005 a SCAN review discussed that Leanne had been living at a Youth Shelter Service since the beginning of September. There were continuing allegations of difficulties with her parents.

28. On 2 November 2005 Leanne was interviewed at the Youth Shelter. She made many disclosures about problems with her parents, prostitution, cannabis use, and abuse of anti-depressants. The Youth Shelter had requested assistance in obtaining a bank account and Health Care Card for Leanne, and an expression of interest by Leanne in attending TAFE and doing hairdressing.

29. On 6 November 2005 Leanne was taken to hospital by a youth worker after taking heroin, speed and morphine the night before. It was believed she had become highly distraught after a telephone call with her father.

30. On 19 December 2005 a Child Protection Order was made granting custody of Leanne to the Chief Executive until 19 December 2007. The Stones Corner office was managing her case and Ann Duffield was the case officer.

31. On 28 February 2006 Leanne advised she was staying with a friend as she could not cope staying at the Youth Shelter. She advised she would return the next day. At this stage the Department suspected she was still in contact with Alex O'Sachy.

32. By mid June 2006 Leanne had left the Youth Shelter entirely after some months of inconsistent living and was residing with Alex O'Sachy. A number of alternative placement options were provided all of which she refused.

Discussions took place between the Department and QPS with regard to forcibly removing Leanne from her living arrangement with Alex O'Sachy, however, attempts to contact Leanne were unsuccessful.

33. On 14 July 2006 Leanne was contacted by the Department and was verbally abusive. She denied suffering any violence by Alex O'Sachy and said she was living with him so she could 'get off speed'. She denied being in a sexual relationship with Alex O'Sachy. QPS confirmed he had no history of violence. The Department acknowledged that they did not agree with Leanne's living plan, but there was no power to forcibly remove her given her refusal to cooperate. Leanne eventually consented to a Safety Plan, whereby she was required to make contact with the Department 3 times a week (in person and by phone). This Safety Plan was not complied with by Leanne.

34. Throughout August 2006 there was sporadic contact with Leanne by the Department with minimal developments.

35. Her father says that in the last telephone conversation he had with Leanne she asked him for permission to stay at the O'Sachy residence. He refused. She asked why. He said to her, "I know what they are like"(having local knowledge of them and their problems).

36. A further SCAN meeting was conducted on 1 September 2006 attended by representatives of the Department, Police, and Health. At that meeting the situation was discussed in detail. It was again noted the Department had no legislative authority to place Leanne in a secure facility and to remove her from that address. The SCAN team agreed to close the case as her immediate safety needs were addressed, presumably via the Safety Plan.

37. On 1 September 2006 Leanne rang her mother and as a result her mother collected her from the O'Sachy residence. On 2 September 2006 Leanne went out on the Saturday night but never returned. Her mother pleaded with her not to see Alex again and she said she would not. Her mother tried her mobile number on a number of occasions but received no answer. When Leanne was with her mother and after her death she saw a number of disturbing notes apparently written by Alexander O'Sachy, which were abusive and suggesting he would rape and kill her, or for her to kill herself. Despite this it is clear Leanne returned to the O'Sachy residence.

38. The last Department contact with Leanne was on 6 September 2006 when she was taken shopping by her Case Officer, Ann Duffield. Leanne did not appear depressed or exhibiting signs of self harming. An extension of the Child Protection Order was discussed as Leanne intended on living independently and needed assistance with the transition.

Issues concerning Department of Communities

Child Death Case Review

39. The review was completed on 20 February 2007. It identified 37 findings and made 4 recommendations. Essentially, issues of staffing numbers and lack of training, excessive workloads of child safety matters to staff, lengthy delays in response by the Child Safety Service Centres and lack of communication between the various centres and the youth shelter were identified.

40. It was also made clear that Leanne self-placed in a very unsafe environment and was uncooperative and unresponsive to attempts by numerous agencies, including the Department, to provide support and a safe place of residence. It was determined that a safety plan implemented by one of the Child Safety Service Centres was indeed appropriate, but it was not fully enforced or adequately monitored.

41. The SCAN team discussed Leanne's circumstances on numerous occasions and representatives demonstrated a committed and collaborated approach to Leanne's care and protection. Consensus was reached that without Leanne's cooperation there were no options available to the Department to ensure her safety from risk of harm.

42. The review also noted the absence of legislation that would have allowed departmental officers to forcibly remove Leanne from her chosen placement and detain her in order to ensure her safety. The review was also unable to suggest any implementation of any realistic legislative amendment that would allow such force and detainment.

43. The review made the following recommendations:
    1. That the Zonal Director disseminate the findings of the review to the staff members directly involved in Leanne's care so as to facilitate practice improvements and learnings
    2. That the Department review the systemic issue of excessive case loads affecting service delivery for the 'Child Under Orders Team', with a view to ensuring that the staff are able to adequately fulfil their legislative, ethical and professional responsibility to protect children from harm and risk of harm
    3. That the Department refer this report to the relevant Zonal Director and the Human Resource Branch for review as to whether disciplinary or performance management action is warranted
    4. That the Department identify and implement the most appropriate mechanism for informing staff at relevant Child Safety Service Centres, following a child death, of their responsibilities when subsequently compiling file records in order to ensure that all staff are aware of the requirements.

Response to recommendations to Child death Review and other Policy Initiatives

44. The Department has since been approached with respect to the implementation of these recommendations, or any further action/change that has taken place since Leanne's death.

45. Mr David Ponting, Manager of Case Review Unit provided a statement[1]. In relation to recommendation 1 this was endorsed by the death review committee without comment.

46. In relation to recommendation 2 it was conditionally endorsed however it was noted that the Department was implementing a number of initiatives aimed at addressing the impact of high workloads but also noted that the Department

[1] Exhibit F8

has to prioritise available resources given to it through government and the Stones Corner branch needed to manage its resource allocation accordingly.

47. In relation to recommendation 3 this was endorsed by the committee with a comment in particular in relation to a finding that a team leader had failed to advise police on allegations that she had been recently raped by an unnamed assailant. It was noted there are now provisions for staff to notify police regarding allegations of harm to children that may have involved the commission of a criminal offence relating to the child. Those procedures became transitionally operational on 16 September 2005 and fully operational on 31 October 2005, which was after the team leader received this information.

48. In relation to recommendation 4 this was endorsed by the committee with the comments that the department should amend the critical incident report system to provide a reminder to staff about their responsibilities in that regard. The amendments were made in August 2007.

49. Ms Mayfield[2] advised that revised policy and procedures for responding to self harm and suicide risk were endorsed and incorporated into the Child Safety Practice Manual on 3 August 2009. In addition Placement Services Units have been established in each region to assist child safety officers in locating placement options for young people in care who have specific and complex needs including difficult behaviours, alcohol and drug abuse and other physical health and development needs.

50. Ms Mayfield also stated that the Department had established three therapeutic residential care services as part of a continuum of placement and support services within out-of-home care service delivery. The purpose of these services is to provide residential care in the least restrictive environment, which is physically designed to minimise the risk of self harming and violence.

Queensland Child Protection Commission of Inquiry

51. The Queensland Child Protection Commission of Inquiry was established on 1 July 2012 to review Queensland's child protection system. The Commission of Inquiry is headed by the Hon Tim Carmody SC. The Inquiry's terms of reference included that it should review progress of outcomes related to the previous Forde Inquiry and Crime and Misconduct Inquiry.

52. One of the difficulties that the Department faced in dealing with Leanne's needs and placement was due to her challenging and high risk behaviours and lack of engagement and challenges with placement options.

53. It is noted in a Discussion Paper disseminated in February 2013, that amongst many other issues, the Commission is considering various out-of-home care models for older children with complex and high needs. These include the establishment of a therapeutic secure care model of placement or containment model as well as less controversial and alternative models.[3]

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[2] Exhibit F4.1

[3] See Chapter 5.4 Discussion Paper, February 2013

Concerns of Damien Rockett

54. Leanne's father, Damien Rockett believes Leanne's death to be a suicide and has raised concerns regarding the involvement of the Department and suggests this aspect of the case be referred to the current Queensland Child Protection Commission of Inquiry, chaired by Commissioner Tim Carmody SC.

55. He said the only way for the authorities to successfully intervene was for them to be given the power to remove a child to a safe and secure place so that she could get the medical and psychiatric care and rehabilitation from health care professionals to be able to make more informed and mature choices without being influenced by a need for drugs.

56. He said it was not in Leanne's best interests to be allowed to remain with the O'Sachys at that address. The child's best interests should be what the Department of Child Safety should be trying to achieve. A safe address where she is not at risk of harm should have been the primary consideration. The child's wishes in this instance should have been overruled by what was in her best interests. For Leanne to have any hope of a normal life she should have been removed from the dysfunctional residence she chose to reside at.

57. Her health and well being were compromised by the unsatisfactory state of the house she moved into and the mental health of the persons she lived with. Her father says this should not have been allowed to happen and the people who were responsible for her should not have allowed this situation to deteriorate so badly.

58. He notes that as a parent he did not have the ability or the authority to force her to stay home or stay away from undesirable persons.

Royal Australian and New Zealand College of Psychiatrists- Submission to the Commission of Inquiry

59. The Royal College made a submission to the inquiry noting a small group of young people who are on child protection orders who have disengaged from placements and services. The majority are adolescents and when placed tend to exhibit destructive behaviours. They also often engage in substance misuse and high risk behaviours. It notes that they are at an increased risk of premature death from misadventure, suicide or even at the hands of others. It noted that therapeutic management for such young people requires long-term placements in a therapeutic facility where their emotional, psychological and educational/learning needs can be met. Due to their lack of insight and absconding behaviour, these facilities must be secure. Currently, the only framework in Queensland for secure detention is in the criminal justice system.

60. The Royal College recommended the Inquiry consider alternative models for placement of young people, for example secure children's homes. The criteria for secure children's home placements are in relation to the child's risk and welfare, not their offending and the aim is explicitly therapeutic.

Response of Department to Concerns Raised and Further Developments

61. In 2006 there appears to have been substantial efforts by the Department to provide Leanne with assistance and it adopted a number of strategies. Ms Williams in her addendum statement[4] addressed the issue of the Department's policies and practice in 2006 to manage such young people who self place and have high risk behaviours. The strategies included building a positive working relationship with the young person through developing rapport and trust, regular communication with their support network that included holding placement meetings, encouraging the young person to accept referrals services that can either address the risk taking behaviours or the underlying causes of those behaviours, encouraging young people to engage in work or education, referral to SCAN meetings for a multidisciplinary approach to case management and the development of safety plans that were inclusive of the young person and their support network.

62. Since 2006 there have been further developments to practice and policy in those areas, but this would not address the concerns raised by Mr Rockett.

63. Ms Mayfield, the Director of Child Protection Development noted in her report[5] that the Department does not have the legislative authority to forcibly remove a young person who has self placed with an unapproved carer or premises where a responsible adult is not present.

64. In such cases the Department will attempt to engage with the young person to identify the reasons for self placement and will offer casework support and service referral. The department's framework for intervention is outlined in a practice paper *A framework for practice with high risk people 12 – 17 years.* The report also noted a number of Child Safety Practice Manual and Policies with the emphasis being on communication and building relationships to provide a foundation to effective engagement and involvement of the young person.

65. Ms Mayfield pointed out that subsequent to the Forde enquiry in 1998 recommendations for legislative reform were made which reflected on a growing understanding that detention was of little therapeutic value for children and young people in need of protection and may actually result in longer term harm. The Forde Inquiry emphasised the need for a therapeutic response for children experiencing emotional, mental health and social issues.

66. She noted that the implementation of a system of secure care would require a legislative scheme and considerable investment in infrastructure. She noted that secure care schemes have been implemented in some other Australian jurisdictions where the primary objective is the stabilisation of a crisis situation where there is an extreme risk of substantial harm that existing services cannot manage and all other placement and support options must have been exhausted. A number of specific policy considerations would need to be examined.

[4] Exhibit F7.1
[5] Exhibit F4.1

Conclusion on Issue of Child Protection Recommendations

67. The evidence supports a clear finding that Leanne, despite being on a Child Protection Order disengaged with the Department and continued to exhibit high risk behaviours placing her at a considerable risk of harm. Tragically those risks became all too true.

68. I accept there were undoubted staffing resource issues impacting on the Department's capacity to engage with someone like Leanne. In general the Department officers, as well as SCAN participants, did the best they could under difficult circumstances.

69. With the benefit of hindsight there were no doubt opportunities that could have resulted in some escalation of concerns. By example are the conversations Department staff had with Daniel O'Sachy on 1 and 7 September 2006. However Leanne was contacted on 1 September and denied any problems and it is difficult to say whether anything would have changed on 7 September since Police did become involved, albeit some hours later.

70. The Department and SCAN teams were expressing considerable frustration with what more they could do notwithstanding the very evident concerns that Leanne was at risk of harm. That impasse seems to have resulted in not a lot of pro-active thought about other strategies that could be adopted. The only substantive strategy put in place was a Safety Plan, which Leanne did not comply with and the Child Death Review found was not adequately monitored. Otherwise the Department endeavoured to keep in contact and engage with her by having her meet with her case officer to do her grocery shopping and access her $30.00 a week pocket money. I do not pretend to have a simple solution or answer as to what else could have been done, but the impression is it had got too difficult.

71. These events occurred in 2006, time has moved on and there have been changes since then within the Department. Objectively there have been some improvements to policies and procedures, although it is unclear as to whether this has any significant practical impact. I do not have any specific evidence to suggest staff resourcing issues are still impacting. I expect they are. The very equivocal response to recommendation 2 from the Child Death Review regarding staff resourcing was not comforting at all.

72. Given the current Commission of Inquiry is looking broadly at how the child protection system is being conducted and specifically considering various models of care and options for similar high risk young people, I consider it is appropriate to leave the Commission to make recommendations on those particular issues. The Commission has heard many months of evidence and received many submissions. It is much better placed to arrive at recommendations, which may be able to be implemented at both a policy and resource level. A copy of these findings will be sent to the Commission for its consideration.

Background to Events of 7 September 2006

73. At the time of her death, Leanne was living at a residence at 108 Wishart Rd, Wishart along with Alexander O'Sachy aged 28 and his brother Daniel O'Sachy and Daniel's 10 year old son N. The house is owned by George O'Sachy, Alex and Daniel's father.

74. Daniel and N lived in the upstairs of the house, whilst Alex and Leanne lived in the downstairs section of the house. It has been confirmed from DNA testing of swabs taken after Leanne died that Alex and Leanne were in a sexual relationship at the time. They both had consistently denied this to Police and the Department when asked.

75. It is evident from the statements of numerous witnesses that Alex in particular was a heavy drug user and was abusive and violent towards females, often his girlfriends. There is incontrovertible evidence that Alex was abusive and physically violent towards Leanne.

76. Daniel had his own considerable problems with a past heroin use and was using subutex. He admits he is an alcoholic and it was well known at the time he was drinking heavily.

77. On the morning of 7 September 2006 Daniel attended the Department of Child Safety office at Upper Mt Gravatt and told the Department that Leanne was in a bad way and that she should be removed from his house.

78. At 2:48 pm on 7 September 2006 Daniel telephoned Upper Mt Gravatt police to advise that Leanne was wandering the streets and was nearly knocked over by a motor vehicle. At 2:54 PM Daniel telephoned the same police and advised that Leanne had returned home and not to bother sending a vehicle and that he would keep an eye on her.

79. At 3:25 and 3:26 PM two telephone calls were made from unknown persons from the property at 108 Wishart Road. At 3:35 PM, N made a 000 call to police communications stating that Alex was hitting Leanne who was contemplating suicide. Half way through the telephone call Daniel interrupted stating that it was all quiet now, "that Alex was killing her but it's all gone quiet" and he won't let anything happen to her.

80. Another phone call from 108 Wishart Road was made to Upper Mt Gravatt police was made at 3:39 by an unknown caller.

81. At 3:44 police (Sergeant Paul Caton and Constable David Courtney) arrived at the scene. They had received warnings that Alex was a known drug user and had possession of weapons including a long bladed knife. They located Daniel and eventually Alex but Leanne was not located. The police were told by Daniel that Leanne had gone and he had last seen her in the toilet downstairs. The police went to the garage area and looked in the toilet but could not see her there.

82. Constable Courtney now says he walked into the storage area. It was dark with items up to the roof and he had a quick look but Leanne could not be seen.

Given he says he ventured in far enough to approach the concrete stump near to where certainly the electrical cord and possibly Leanne was then hanging, it is unclear why he did not see it or her, but I accept he did not.

83. The two police officers then walked out the back door to a granny flat adjacent to the house where they observed Alex. They observed that he was slurring his words and thought he was drug affected. He clearly was. Alex said words to the effect and directed at Daniel that he was "a dog" for calling the police. Police asked where was Leanne and Alex continually spoke about having had money ripped off him and kept on referring to $250 that he had just been paid. Alex was at this stage becoming distressed and agitated. At this stage the Duty District Officer, Acting Senior Sgt Herbert arrived.

84. It is evident the police did not search the premises extensively because Daniel had said to them that she had run away. With the benefit of hindsight perhaps they should have conducted a more thorough search, but their actions were understandable in the particular circumstances they faced. QPS subsequently left the house and commenced a search for Leanne in the nearby streets. It was estimated the Police were at the residence for a total of 5 minutes.

85. At 3:55 PM a telephone call is made to 000 by N advising that Leanne had cut her wrists. 3 minutes later, at 3:58 N rings 000 to say that she had been found hanging.

86. At 3:57pm the same QPS officers received a dispatch to go back to the address, as an ambulance had been called to the address with respect to an attempted suicide of a young girl (at that stage, it was reported to have been suspected slit wrists). The QPS officers re-attended and were informed by Daniel and Alex as to how they had allegedly discovered Leanne hanging from a beam in the store room downstairs. Daniel had commenced CPR on Leanne on the front lawn.

87. Leanne was still exhibiting a heart rate when the ambulance ('QAS') arrived at 4:00 pm. She was transferred to the Princess Alexandra Hospital ('PAH'). However, Leanne was severely hypoxic with gross pulmonary oedema and remained so after life sustaining measures were commenced at the PAH. Her life support was switched off and she was pronounced deceased at 11:58pm that same night.

Initial Investigation and Criminal Proceedings

88. QPS commenced an investigation, Operation Echo Mantle. This resulted in Alex O'Sachy being charged with aiding Leanne's suicide, under s311 of the Criminal Code. The evidence for this charge appears to be based on the observations by Daniel and N of the events of 7 September 2006. Reliance was also made on written material including notes that Alex had made and conversations he had with old and subsequent girlfriends, which indicated he had told Leanne to kill herself.

89. This charge proceeded through the committal process in the later stages of 2007. The evidence of Daniel and N was used to prove verbal arguments between Alex and Leanne on the day of her death.

90. The matter proceeded to trial in the Supreme Court from 16 – 18 September 2009; but the jury was unable to reach a verdict.

91. It was in the course of serving witnesses for a re-trial in July 2010, that new evidence was obtained from the next door neighbour, Linda Hart. This new evidence suggested that Leanne's death was a murder, thus a further 18 month QPS investigation ensued. The investigation was extensive and utilised various covert strategies and monitoring.

92. As a result of the new evidence, the Director of Public Prosecutions (DPP) discontinued the aiding suicide indictment against Alex O'Sachy.

93. Alex O'Sachy subsequently pleaded guilty to unlawful carnal knowledge with respect to Leanne. This confirmed his sexual relationship with Leanne which had previously been denied by him. He has also been convicted of unrelated trafficking of heroin charges.

94. No other criminal proceedings have been commenced with respect to Leanne's death.

95. The police investigation was extensive and numerous statements were taken from a variety of witnesses.

2nd QPS investigation –New Evidence from Linda Hart

96. At the relevant time, Linda Hart lived next door to Daniel and Alex, at 106 Wishart Rd, Wishart. She initially provided a rather non-contentious statement to police shortly after Leanne's death. In that statement she said that, on the day of Leanne's death, she had been home and had heard some arguing between Daniel and Alex, to the effect that Daniel wanted Leanne out of the house. She had heard a girl screaming during the day. She said that she had left the house at about 2pm, and didn't return until 6:50pm that night.

97. On 30 July 2010, police attended at Linda's address to serve her with a subpoena for the re-trial of the aiding suicide indictment against Alex. It was at this time that Linda informed police that she had not previously told them everything she knew about Leanne's death. As a result of this, a further 4 statements and a video re-enactment have been taken from Linda, and each time she would add further detail.

98. The further evidence comprises that the day before Leanne's death, on 6 September 2006, Linda was at home at 11:30am. At this time she heard Daniel and Alex arguing about Leanne. Daniel was saying to Alex that Leanne was a 'fucking slut' and a 'fucking cunt' and he no longer wanted to have her in the house. Daniel also said to Alex that he wanted Leanne out because he was sick of the cops always coming around looking for drugs.

99. On the day of Leanne's death, 7 September 2006, at about 2am Linda was at home working on her computer, which faces the O'Sachy's residence. She heard a female crying and heard Alex say 'just shut up. You're a fucking whore. You're a fucking whore'. Moments later Linda heard a noise that sounded like something being thrown into a wall and she then heard the female scream. The arguing continued until about 4am when Linda tried to get some sleep.

100. Linda woke up at 6am, the arguing was still ongoing. At 7:45am, Linda heard Alex yell 'you're a fucking pathetic loser. Get the fuck out. Just fuck off you whore. Just fucking kill yourself, you fucking bitch.' At 10am, similar statements were again yelled out by Alex. Linda says that both Alex and Daniel were saying similar sort of statements.

101. Linda found the arguing upsetting and distressful, so at about 10:30am she left the house to visit her parents. She returned at about midday, and the arguing was still ongoing.

102. Consistent with her previous evidence, at about 12:16pm Linda was on the phone to a friend. She could see through her window to underneath the O'Sachy's house. She says she saw Daniel, Alex and Leanne underneath the house. Leanne was on her knees with her head bowed and her hands covering her face. Daniel had a length of electrical cord in his hands. He looped the cord around Leanne's neck, at which time Linda heard Leanne scream out begging for help.

103. As the cord was being looped around Leanne's neck by Daniel, Linda observed Alex laughing, and Daniel was saying things to Leanne like calling her a 'fucking dog and a slut'. Daniel grabbed Leanne by her hair and pulled her head back violently. Leanne screamed out in pain. Daniel did this moments before looping the cord around Leanne's neck.

104. Linda then left the house in a distressed state, given what she had witnessed. As she was exiting her house she again noticed Daniel, Alex and Leanne underneath the house. She observed Daniel throw the electrical cord over the beam underneath the house. At this time Leanne was screaming. Alex was standing in front of Leanne. Linda then saw Leanne being pulled up via the electrical cord by Daniel on the beam. Alex was holding her legs. Leanne was struggling and her body was moving. Linda observed Leanne to get one of her legs free and kick Alex in the head. Linda then left her house.

105. Linda did nothing to assist Leanne at the time as she was fearful of the O'Sachy brothers and said she had been subject to death threats from them for a considerable period of time. Linda had lived at 108 Wishart Rd for approximately 5 years. Daniel O'Sachy was already living there when Linda moved in.

106. In late October 2006, Linda overheard a conversation between Alex and Daniel, where Alex was upset that N was speaking to a psychologist. Linda heard Alex saying words to the effect of 'well what the fuck is going to fucking happen if fucking N talks to the cops? What's he gonna say? He'll fuck it up and give it away. They'll fucking know what fucking happened.'

107. Linda moved out of her property on 10 November 2006, as she was receiving more verbal abuse from the O'Sachy's over her 'dogging on them to the police'. On the day Linda moved out, the O'Sachy's had thrown rocks at her house and accused her of 'dogging on them'. She says Daniel had yelled at her 'you're a fucking dog cunt. You fucking dogged on fucking me and my fucking brother to the fucking cops. I'm gonna kill you fucking cunt. We'll fucking make what we fucking did to Leanne look like a fucking accident, compared to what we'll do to you.'

108. It was not until after her video walk thru that she gave a further statement on 18 November 2010 which included details of Daniel assaulting Leanne about the face causing her to fall to her knees. She then says she observed Alex pull his pants down and force his penis into her mouth. She says she saw Daniel laughing and said "when you are finished with Alex you can do me too".

Evidence of other witnesses to disclosures by Linda Hart

109. Lisa O'Neill had a conversation with Linda on 7 September 2006. Telephone records confirm this was at 12.16 and was for 8 minutes. She says she could hear shouting and what sounded like an argument and asked Linda what was going on. She says Linda said it was "neighbours again. The young girl next door is having a hard time." She recalls Linda later told her that the girl next door had died and it wasn't by natural causes and she was fearful of her ex-neighbours.

110. In her statement of 30 July 2010 Linda said that on 10 November 2006 a friend, Allan Butcher was helping her strip wallpaper and was present when Daniel got angry and aggressive and was threatening her. Mr Butcher has confirmed that he had attended at her house on one occasion to assist with stripping wallpaper and heard rantings and ravings coming from the house next door and the words to the effect "get you, you fat bitch" in a loud male voice which he believed was directed at Linda.

111. Carmel Cattalini also recalls a conversation with Linda in 2006, before she sold her house, when she told her that a girl next door had been hung and that it looked like suicide but she said it was a murder. She does not recall if Linda told her she saw it or where she got the information from.

112. Julie Collins was acting as a real estate agent in the sale of her house and she recalls Linda telling her the boyfriend had strangled someone next door. She did not say exactly what she had seen the she recalls her saying someone had been murdered and she was a witness and she was involved.

113. Linda met with a registered psychologist, Diana Greenhalgh shortly after the death, and says she told Dr Greenhalgh the 'entire story' about what she saw. There is certainly a disclosure to Diana Greenhalgh, which goes some way towards supporting the truth of Linda's evidence. It is apparent that Linda still feels a lot of guilt over what she saw, and the fact that she did nothing to assist Leanne.

114. Ms Greenhalgh took detailed notes. At the first consultation on 20 September 2006, Linda listed 8 stressors that were currently concerning Linda, which largely were related to her work. The eighth stressor related to Linda telling her about neighbours who she named as Daniel and Alex arguing with each other and a young girl for a long period of time the night before and the next day. She said she had been abused and threatened by Daniel and Alex in the past and she was frightened of both of them. She said she heard the girl screaming for approximately 14 hours before she was murdered. She said that at 2 PM on the day of the girl died she couldn't stand the screaming, yelling and fighting going on any longer and left the home address to escape to a friend's house.

115. The disclosures to Ms Greenhalgh started on 20 September 2006 and continued until 16 November 2006, which was her last consultation. At no time

during the consultations did Linda say she had actually witnessed the person being killed. Given its importance for treatment options she would have recorded this if it had been said.

116. Linda also consulted with a psychiatrist, Dr Thomas Hogan. He consulted first with her on 27 August 2007. During the course of this consultation she told him she had witnessed the murder of a 15-year-old girl who had lived in a house next to where she was previously living and this had been carried out by two drug addicts who lived in the house and they beat her.

117. She was seeking his help with giving up smoking. During the course of the consultations it became evident to him her diagnosis of anxiety, depression and Post Traumatic Stress Disorder was long standing and related to past issues and had merged into work stressors.

118. Dr Hogan says more detail came out after she approached the Police in 2010. She said there had been many arguments occurring in the house next door and there had been many noisy incidents. She described that she had observed the males she referred to as Alex and Daniel abusing the girl Leanne. She said that the males had used a cord of some sort to strangle and hang the girl. She said that she was frightened of the two males and that they had threatened her on a number of occasions. They had mentioned they threatened to kill her because they believed she had spoken to police about their drug habits causing them to be raided by police.

119. Linda also spoke to him about workplace bullying she believed she was being subjected to as well as other unrelated matters.

120. Ms Hart provided to the court a spreadsheet of names of other persons who she had disclosed about the events of 7 September 2006. Some of those names had already been provided to police and statements obtained from those witnesses. Other statements were obtained after she gave evidence.

121. James Kay recalls she spoke of men yelling at her from the house which upset her and the incidents had been escalating. He makes no reference to her telling him that they had assaulted and hung the girl.

122. Stephen Hayden recalls Linda Hart telling him about the domestic situation at the neighbouring property and the violent physical abuse of a female that live there. She told him about the yelling, screaming and banging that would go on. She did not tell him specific details about the death that occurred next door to her house.

123. Toni Power does have a clear memory of one conversation with Linda when she told her she had witnessed a murder and the incident had ruined her life and she was unable to sleep without nightmares. She understood the incident that Linda observed was of a neighbour found hanging and she had observed other third parties there at the time but she is unsure if this knowledge came from Linda or from other people who spoke to her about this.

124. Craig Vandermeer recalls in 2008 Linda telling her about the drama she was having with her neighbours with drug use and noise complaints and threats of violence against her. She told him that as a result of that drug use a young girl of about 13 years of age had died. She said that she had witnessed the girl die and it was a possible suicide and that the girl had been hung or shot.

125. Karen Watson (See) also recalls a conversation with Linda when she advised her she had been witnessed a murder outside her house. She also told her she had suffered from post-traumatic stress disorder as a result of witnessing this death. There was little or no reference to how the death occurred.

126. Daniel Short worked with Linda and was her manager in 2006. He remembers Linda telling him about some interesting characters that left lived next door to her and he got the impression that drugs were involved and there was frequent violence. He was also aware that a major event occurred next door but he is not sure what happened. There was office gossip in 2007 about a murder or a very violent event that occurred at the house next door.

127. Katrina Kokkoris also recalls Linda telling her about a young girl being the girlfriend of one of the brothers next door and there was trouble with noise and the shouting. She said she was scared of the two brothers and recalls her talking to her about one of the brothers killing the girl but she is not sure if she said she saw what happened and she cannot remember if she told her how the girl was killed.

Evidence of Daniel O'Sachy

128. Daniel O'Sachy provided a taped interview on the night of 7 September 2006 and a further formal written statement. He has given evidence at the committal hearing and in the Supreme Court trial. He gave evidence at the inquest. He was directed by me to do so pursuant to section 39 of the Coroners Act 2003 on the basis that his evidence may incriminate him. Accordingly any evidence, which did incriminate him, could not be used in later criminal proceedings other than for perjury.

129. He stated that he presumed that Alex and Leanne were in a sexual relationship and he knew she was 15 years of age.

130. He said that Leanne idolised Alex however he would treat her really badly. By this he means the relationship was turbulent with many fights and arguments both physical and verbal. Not unusually in this type of relationship Daniel described that Alex controlled her. Although Leanne gave some back he was the dominant force.

131. The Department records indicate that on 1 September 2006 he spoke to the Department of Child Safety at Mt Gravatt where it is reported that he saw Alex hit Leanne on the back of the head, was screaming and yelling at her and was calling her a "fucking whore" and told her to get out the home. Daniel also said Alex had given her some speed.

132. As a result a telephone call was made to the Stones Corner office and Delia Williams received this information. She telephoned Leanne who denied Alex had hit or yelled at her and also denied he had given her speed. Ms Williams said that Leanne sounded confident and was surprised the allegations had been made. Ms Williams said in her evidence she did not telephone the police, and took at face value what Leanne had said.

133. In his evidence Daniel was not able to recall all that occurred on the night of 6 September and into the morning. It has to be understood that Daniel was an

alcoholic and almost certainly would have been drinking but he does recall they were fighting and it was something about money. This would almost certainly be about the $250.00 that Alex obsessively referred to the next day to Police.

134. .On the morning of 7 September 2006 at about 10.40 am Daniel was attending the Department of Child Safety office at Upper Mt Gravatt in relation to other matters relating to his own children. He said he reported to the Department that Leanne was in a bad way and that she should be removed from his house where she was living with Alex. He said he observed her mixing morphine in a spoon that morning but did not see her inject it.

135. This information is noted in the Department records and the meeting held with. Elaine Kelly and Emma Murray. Ms Murray provided a statement which said she did not recall the conversation however Ms Kelly does recall a conversation and she took notes. She says she did not take the comments by Daniel seriously because they occurred at the end of the meeting and she had formed the view he was only doing so in an attempt to take the focus off himself and his own parenting. Ms Kelly did not pass this information onto anyone nor did Ms Murray who was the Team Leader.

136. Daniel then says that after he returned from this meeting at about noon. This is consistent with the meeting taking 1 hour to 1.5 hours, with a brief stop to buy some beer. After he arrived he saw Alex punch Leanne in the back of the head. He said this was not unusual as Alex would often be violent towards her.

137. Daniel and his son then went out again to Woolworths and the bottle shop again. In his first record of interview there is reference to an ATM receipt for 2:17, so this does not exclude Daniel from being at the house when the events described by Linda Hart occurred.

138. It is uncertain when, but Daniel says he and his son then went on a walk to a park with their dog and he also went to Community Service to pick up his hat. Some time later he returned and he saw Leanne stumbling on the road near the house. He says he then had N telephone police. This took place at about 2:47 PM as confirmed with 000 records. He says Leanne returned a short time later so he spoke to police and told them she was back and not to worry about coming. Again this is confirmed from the 000 recording.

139. It was after this time that he says Alex said to Leanne "go and kill yourself". Daniel recalls there was a discussion about the Gateway Bridge. He heard Leanne say something about not having the money (it is presumed this refers to the $250 that was apparently missing) and a short time later Alex punched her again on the back of the head.

140. Daniel says that he then telephoned the police to report the disturbance between Alex and Leanne and this was the last time he saw her alive. He says that a short time later, possibly 2 to 3 minutes, two police officers attended at his house and they started to search for Leanne. He said Alex was delaying them by talking rubbish. They searched the toilet and a room adjacent to the toilet. The police then left the premises to search for Leanne.

141. Daniel then says he heard his brother callout "Oh she has necked herself" and he went back downstairs. Leanne was hanging from a beam in the garage near a fridge and Alex was just standing staring at her. Daniel believed that the police had not looked in their earlier.

142. He says he then went straight over and lifted Leanne up from the waist and was trying to get the electrical cord off her neck. Alex was still standing and watching him and he called him over to give a hand. They got Leanne down. He says he then put her on the floor of the garage and started performing CPR and yelled out to his son N to call 000.

143. In his statement he told police he had never seen the electrical cord. It is evident that the electrical cord had a serial number on it which links it with one of the white goods found downstairs. Other telephone monitoring evidence indicates that Daniel may have seen the cord before.

144. Daniel denied the allegations that were made against him by Linda Hart concerning the events of 7 September 2006. He conceded he called Linda Hart names (I accept they would have been abusive and crude) and would have yelled at her but he did not consider this was in a threatening manner. I accept Linda Hart would have found it threatening. He denied threatening to kill her.

145. Specifically Daniel denied he placed the noose around Leanne or saw Alex doing so. He said he had not gone into the storage area that day and did not assault Leanne with Alex.

146. There is ample evidence that suggests Daniel's parents did not want him to co-operate or say anything to the Police.

Evidence of N

147. N was ten at the time. He gave an interview with police on 7 September 2006 and a subsequent interview on 21 November 2006. He was re-interviewed on 9 November 2010 and he gave evidence at the inquest. It is most unfortunate he has had to relive those moments again. No child should have to live in the circumstances that he did. The court heard the harrowing 000 calls he was involved in. He performed remarkably well then as well as in Court.

148. N confirmed that Alex and Leanne slept in the same bedroom and bed downstairs. On the day Leanne died he confirms they went to the Department of Child Safety around 1130 (Daniel says it was 10:40 and this is consistent with the Department's usual appointment schedules). He recalls his father Daniel telling them they should come and get Leanne as she was talking about suicide. He also said his father mentioned she was taking lots of Xanax including eight or so that morning.

149. They went home and saw Leanne in the back yard. He said she looked tired and was walking in a weird swaying manner. He then went upstairs and watched television. He and his father then left with their dog to the park but before they left he says he went downstairs. Leanne was yelling at Alex and was packing her clothes. They were both swearing at each other at about him taking her money and Alex's money being stolen and he was going to make a complaint.

150. They were both shouting and swearing at each other. Alex kicked her. He could see it through the kitchen. She had sworn at him and then he went over and kicked her. At that stage he and his father went to the park.

151. He then described that from the park they walked over to Community Service to get his father's hat from the caretaker.

152. When they got home Leanne came on to the footpath and then crossed the road and nearly got hit by some cars. He then says his father got him to ring the police and at that stage he saw Alex was asleep on his bed.

153. N then watched more television and he describes that the police came and talked to Alex and they said Leanne was missing. He said his father told police that Alex and Leanne were fighting and she had taken Xanax. He says his father walked the police downstairs to where Alex was in his room. He heard Alex continually talk about money that was missing.

154. He then says that Alex and his father found her and they told him to ring the ambulance. He then confirms that he rang 000 a second time. He recalls telling the ambulance that he thought her wrists were cut or she was lying unconscious on the ground. He mentioned the wrists because he had seen her with cut wrists before. He also recalls his father calling the police station earlier.

155. In the second statement on 21 November 2006 he added further information including that of Alex telling her to go and commit suicide and otherwise abusing her. He believes this was before they left to go to Woolworths and they were swearing at each other and she was on the ground and he kicked her in the side. He told police that Alex used to say to Leanne to go commit suicide all the time.

156. N confirms that Alex was the one that found her and yelled out to his father. He said that Alex always talked about drugs but he had not seen him give Leanne any drugs but used to tell him to go outside the room.

157. The police then reinterviewed N on 9 November 2010. In that interview he confirms that he and his father went to Child Safety at about 9:30 AM. He heard his father tell Child Safety that he wanted Leanne out of the house because she gets bashed by Alex and Alex is giving her drugs. When they got home Alex and Leanne were fighting and Leanne took off and then came back. Later Alex yelled out that she had necked herself.

158. He further describes that Leanne and Alex would be okay for a few days and then they would fight particularly when Alex had no drugs. Alex would hit Leanne. He describes that they had a big fight the night before and he went downstairs with his father to check on her the next morning. He saw Leanne sitting on the bed and she had a spoon and a needle and said it was morphine.

159. He stated that when they got home from Child Safety they were still fighting and yelling and he saw Alex kick Leanne in the ribs.

Other Evidence about Encouragement to Suicide

160. N also told police that he remembers Alex tell Leanne to go and kill herself. N also told police that Alex told Leanne she should commit suicide on other occasions during fights in the weeks or so leading up to Leanne dying.

161. In one of her statements Alex's former girlfriend Lisa Palmos told police that Alex told her he would tell Leanne to go and kill herself all the time. In one

conversation they had in November 2008 Alex said to her "I know I told Leanne to go and knock herself and that I wouldn't be far behind her but I didn't mean her to go and do anything"

162. Another of Alex’s girlfriends, Nicole Bremner says Alex told her in 2008 "I told Leanne to kill herself and I would be right behind her".

Evidence of Alexander O’Sachy

163. Alex provided a record of interview with police on 8 September 2006. He has not provided evidence in a sworn fashion either by way of a statement or in court. There were many unanswered questions.

164. When he was brought to court to provide evidence to the inquest on 23 April 2013 he was directed to do so pursuant to section 39 of the Coroners Act 2003. Notwithstanding the substantial protection given to him in relation to any answers which may incriminate him he refused to answer any questions. He was subsequently charged with contempt of court and sentenced to a period of six months imprisonment cumulative to his current sentence. His parole eligibility date was extended by a period of three months.

165. In his record of interview he denied any sexual relationship with Leanne or that he ever hit her or kicked her. He denied giving Leanne any drugs. The evidence is clear that those statements are simply untrue.

166. He agreed that they had a verbal argument that day. He denied other information, which Daniel had provided to police, that he and Leanne were fighting and arguing a lot. He was aware that she was using drugs including intravenously but he did not supply the drugs to her. He denied having ever said to Leanne that she should go and kill herself.

167. He denied having ever set up the noose or that he was present whilst Leanne harmed herself. He said that she had walked out earlier that day and then walked back in and went out again and disappeared, which is when he went looking for her and found her hanging. He denied having ever seen the electrical cord that was used before. He stated he did not recall the first police visit that day. He agreed that he was raving on about a missing $250 but he did not think Leanne had taken it and knew who had.

168. He also told police that when he found Leanne her feet were just touching on the concrete floor.

Autopsy Examination

169. On 8 September 2006 an autopsy was conducted by Dr Alex Olumbe. Blood samples were taken for testing.

170. Toxicology showed only revealed low levels of the antidepressant medication alprazolam (Xanax), therapeutic levels of drugs administered whilst at PAH and the presence of an inactive metabolite of cannabis. No morphine, alcohol, or other dangerous/illegal drugs were detected. This is in the context that there was evidence that Leanne had appeared drug affected on the day of her death, and had been seen on her bed apparently mixing morphine in a spoon and had taken 8 Xanax tablets.

171. Ill-defined bruising and abrasions were identified on the skin of the front and right side of the neck. It was considered that these marks would be consistent with ligature marks in a hanging episode and could have been inflicted by an electrical cord such as the one seized as evidence in this case (photos of the cord were examined by Dr Olumbe). No other injuries to the neck were identified.

172. Examination of the brain confirmed the presence of hypoxic brain injury, and acute bronchopneumonia (in the lungs) secondary to aspiration of stomach contents, which are consequent to hanging and the unconscious state.

173. The cause of death was confirmed as hypoxic brain injury, as a consequence of hanging.

Further Forensic Review

174. As a result of Linda Hart's evidence, and in particular that she had seen Leanne fully suspended, Dr Olumbe reviewed the pathology findings. He confirmed that Leanne had 2 linear marks on her neck. One was horizontal above the Adam's apple. The second mark was diagonal on a separate plane. There was no mark higher up underneath the chin bone.

175. Dr Olumbe was provided with Linda Hart's version of events and the physical characteristics of the scene. Dr Olumbe concluded that if Leanne had been suspended from the neck with her feet off the ground, then he would have expected a prominent ligature mark.

176. Daniel O'Sachy maintained in his initial interviews and subsequently in other hearings that Leanne's feet were a foot and a half off the ground when he found her. In this respect scale drawings were obtained depicting a mannequin in position suspended from the beam in question. The drawings depict two scenarios. Both these scenarios depict that a person of Leanne's height would have her feet definitely touching the ground and not suspended above.

177. The Australian Forensic Review Group in Melbourne was also consulted by the QPS with respect to the death. Dr Michael Burke (Senior Pathologist, VIFM), answered a number of questions in the form of a written statement. He says that:
    - Upon examining the photographs of the neck injury, there are concerning features. The majority of abrasions seen to the neck in cases of hanging are above the prominence of the Adam's apple at the front of the neck. Leanne's injury is directed across the Adam's apple.
    - The injury to the right side of the neck appears to be at a separate plane to the abrasion which straddles the midline. In a common case of a single loop around the neck hanging, the two abrasions would be expected to be in the same plane.
    - In this case where the evidence from Daniel O'Sachy that Leanne's feet were a foot and a half off the ground when he found her, Dr Burke finds it extremely difficult to reconcile the injury to the right hand side of the neck occurring when an individual's weight is carried by the ligature, and yet the ligature mark is well below the level of the thyroid cartilage.

- The injury to the right side of the neck extends acutely upwards – in cases of hanging the injury to the neck is usually more prominent at, or around, the point on the skin opposite the point of suspension. The point of suspension in hanging is usually the left posterior aspect of the neck. One would expect the abrasion on the right side of the neck to extend at some point around to the front of the neck if Leanne had been suspended off the ground.
- There is no objective evidence of an assault, although, one does not always see bruises to the abdominal soft tissues even in cases of documented blunt force injury.

178. The following question was also put to Dr Burke – 'if Leanne was killed by ligature strangulation to mimic hanging, and then placed in a position to mimic hanging, would further injuries/bleeding/bruising of the neck structures be expected?' Dr Burke states that cases of hanging, by their nature, do not tend to be associated with large soft tissue bruises, whereas deaths from ligature strangulation tend to be associated, in the majority of cases, with bruises to the muscles of the neck. This is due to the differential movement between the assailant and the victim. In the normal event of 2 adults, bruises are normally seen. The absence of bruises may be seen when there is a marked difference in the physical size and strength of the assailant and victim (e.g. adult and child).

179. In evidence Dr Burke stated that the injury to the right of the neck was more typical in a hanging case. However it was lower than usual on the right side and lower than the one across the neck. He opines that she could not have been suspended off the ground.

180. He also considered there was no evidence of a strangulation as usually there would be bruises from a struggle and nothing was seen.

181. He stated that the ligature was complex and it was possible one of the loops caused the injury across the Adam's apple but he also thought that the injury on the right side was still quite odd as you should also see a injury to the left and it is odd that it does not loop around the neck. He agreed this could be due to injuries in two separate incidents, one being a non-fatal injury. In his view he would have determined the cause of death as being due to hypoxic brain injury of an unascertained cause. He said the injuries are as consistent with hanging and strangulation. On the likely period of survival he agrees with the opinion expressed by Prof Duflou.

182. Professor Johan Duflou, is the Clinical Director of the Department of Forensic Medicine in Sydney and a consulting forensic pathologist. He was briefed with relevant material by Legal Aid Queensland and provided a report. He stated that in his opinion the autopsy findings are entirely consistent with hypoxic brain damage due to hanging.

183. There is at least one partial ligature mark on the neck, and possibly two. He agrees with Dr Burke that there appear to be two planes of linear abrasion. In his opinion there are two more likely causes for this anomaly, including the ligature could have slipped upwards, either during the process of hanging or while being removed from the noose, or more likely still the ligature encircled the neck at least twice. He stated it was entirely possible given the rather complex ligature that it may have encircled the neck a number of times.

184. He stated that in his view there is no objective evidence of a prior episode of ligature strangulation in this case. In such cases the ligature is much more commonly horizontally placed; there are very frequently associated external injuries in the form of bruises and abrasions; bruising to the neck structures is almost invariable; and petechial haemorrhages on the face and eyes are almost always present. None of these findings were observed in this case.

185. Prof Dufluo said that according to an analysis of the scene of the hanging by scientific police, it appears entirely implausible for the deceased to have been fully suspended with her feet off the ground. He also is in agreement with both Dr Olumbe and Dr Burke and is of the firm view that the extent of neck compression injury in this case was significantly less than would be expected in cases of full suspension. He concluded the physical evidence points very strongly to the deceased not being fully suspended.

186. On the likely length of survival he quoted research which indicated that unconsciousness is very rapidly effected by compression of the neck with a ligature, usually in the region of 10 seconds or so. The person appears to sustain damage to the brain very rapidly, and final movements are generally observed within about 4 min or so. He notes that even if the deceased had been removed from the ligature within a number of minutes, it still took a possibly 18 min between an ambulance being called and first contact of ambulance officers with the deceased.

187. Dr Robert Hoskins of CFMU reviewed the toxicology findings and indicated that Leanne had consumed 0.06mg/kg of alprazolam. Dr Hoskins opined that Leanne would have consumed 2 or 3 tablets of alprazolam on the day of her death. The effects of alprazolam depend on regular use. If Leanne was a regular user, it would appear to have no effect. However, if Leanne was not a regular user, the effects of this amount would likely cause observable intoxication with signs very close to drunkenness (i.e. staggering and slurring).

188. There was evidence produced during the criminal proceedings as well that the electrical cord was tied in a way around Leanne's neck that was rather complicated. It was asserted by the Crown that Leanne could not have tied the cord in that manner all on her own.

Conclusions on How the Death Occurred

189. There is very clear evidence that Leanne was a very troubled young woman. Her high risk behaviours predated her contact with Alex O'Sachy.

190. However Alex O'Sachy was very clearly not the right person with whom she should have been in contact. He was a very significant drug abuser and supplier of drugs and the evidence in this case is littered with references from his associates who were of the same ilk. There is evidence that he preyed on vulnerable young women. There is evidence from a number of sources that he was supplying Leanne with drugs including heroin.

191. It was a very tumultuous relationship and Leanne was treated in an appalling fashion. There is evidence from many witnesses who give examples of Alex's violent behaviour towards other women and particularly those with whom he was in a relationship. There is very compelling evidence this behaviour continued when he was with Leanne and she was the victim.

192. There is clearly evidence to support that on the evening of 6 September 2006 and early morning and morning of 7 September 2006 there were many loud and distressing arguments occurring between Leanne and Alex O'Sachy. Some of this was over heard by Linda Hart. Other neighbours also heard loud voices coming from the garage area on the morning of 7 September.

193. This behaviour was also reported by Daniel O'Sachy in the course of his contact with the Department on the morning of 7 September 2006.

194. At 12:16 PM Linda Hart was talking to her friend Lisa O'Neill who said she could hear the noise of what sounded like an argument. At that time Linda Hart did not reveal to Lisa O'Neill that she saw both Daniel and Alexander assaulting Leanne and stringing her up from a beam using a length of electrical cord.

195. It is highly probable Linda Hart heard and/or saw some abusive and perhaps violent interaction between Alex and Leanne at this time but it was not the events that caused her death as described by Linda Hart. Daniel was also likely at the premises at the time. I accept, having seen the walk-thru, that although she could see the fringes of the area under the house it is most unlikely Ms Hart was able to view the place in the dark and crowded storage area where Leanne was found hanging.

196. It is difficult to understand why Ms Hart has given this version of events, which she appears to genuinely believe. There is of course the difficulty in the fact the evidence was not provided to Police until almost 4 years later. Given she may have had genuine concerns about threats to her well being, that does not fully explain why she did not offer more information on the night in question given she told the court she initially thought one or either of the O'Sachy brothers had killed each other and they would not be home for a very long time.

197. The fact it took a number of statements in 2010 to obtain the whole version with further facts added as time went on, also adds to an uneasiness in accepting the complete accuracy of the evidence.

198. There is little evidence linking Daniel with any of those events described other than I expect he was abusive towards Alex and Leanne because of the fights they were having, so no doubt his voice would have been heard. He was certainly abusive and no doubt threatening to Ms Hart both before and after the events. There is evidence of similar abuse by Daniel to other neighbours, the nature of which could objectively be considered intimidating. Father of the year he is not, but it would be most unlikely for him to bring to the attention of the Police and the Department his concerns about her welfare in the manner that he clearly did, in the days and hours before her death, and then participate directly in her death.

199. Of most significance is the forensic evidence does not support Linda Hart's version. All three forensic pathologists agreed that Leanne was not fully suspended by the ligature as Ms Hart suggested. Of even more significance is that the terminal event occurred around the 3:45 PM mark. Linda Hart was not home at that time. All of the forensic pathologists agree that for the QAS paramedics to obtain a heart beat she was likely to be hanging for between 5 and 10 minutes or perhaps a little longer, but not for hours. If Ms Hart saw anything it was not the event when Leanne Thompson suffered the hypoxic brain damage from which she died.

200. Having considered the events of the day one possibility is that Ms Hart may very well have seen or heard something shocking, and upon learning later what happened thought that what she heard or saw was Leanne being hung. Given some of her psychological vulnerabilities this may have then morphed into the version she provided.

201. That being said there are still a number of concerning aspects to the evidence. It is evident from many sources that Alex O'Sachy had told Leanne to kill herself on many occasions, including that day. There are the statements he made to his girlfriends in 2008, which are remarkably similar and to the effect he told Leanne to kill herself and he would be right behind her. There is the evidence of a number of disturbing notes seen by Leanne's mother and other notes found, which have been linked to Alex O'Sachy.

202. The origin of the electrical cord has been linked to white goods under the house. It is a complex series of entangled knots. The plugs had already been cut off. It does appear to be one which had taken some time to put together.

203. Leanne was clearly distressed that day, and it would seem more than usual given the attempts Daniel made to escalate his concerns to the authorities. She was drug affected with Xanax. Accepting she was already a very disturbed young woman, her distress that day is without doubt linked to Alex O'Sachy's abusive treatment of her in the days and hours leading up to her death. She was likely under the influence of Xanax when N and Daniel saw her on the road and nearly hit by some vehicles. She may not have taken 8 but certainly took multiple tablets and either got this directly from Alex or took it from his supplies. She made her way back to the house after the incidents on the road. She was possibly hanging under the house when the Police first arrived, although this is not by any means certain. If not she was very shortly after.

204. The person who has likely seen her last is Alex O'Sachy. He has not given any sworn evidence tested through a forensic examination of his evidence. There is no objective forensic evidence Leanne struggled, was seriously assaulted or was defending herself. I accept there was something in the nature of the pushing and punching as described by Daniel and she could have been kicked as described by N. The absence of bruising may be explainable by the fact there is no evidence of the force used and the evidence of footwear is equivocal. Not a lot of force may have been used.

205. The forensic evidence supports a finding that if she has died of hanging she was not fully suspended. The injuries to the neck were not those of a typical hanging case. Dr Burke thought the injuries were consistent with hanging or strangulation and he would consider the cause unascertained. Dr Olumbe and Prof Duflou were more accepting of the case being one of hanging, notwithstanding the odd features.

206. There is clearly evidence of a series of abusive attacks over a period of time and on the day, which may have culminated in a decision by Leanne in her particularly vulnerable state to take her own life.

207. How and when Leanne got to the storage area, who put together the noose, who put it over the beam and in what circumstances Leanne's neck came to be in the noose, is, in the absence of an explanation from Alex O'Sachy, and in

combination with the concerning matters raised in this case leaves her final moments and that of Alex O'Sachy's involvement in what she did still uncertain.

Findings required by s45

Identity of the deceased – Leanne Melissa Thompson

How she died – Leanne was a very troubled 15 year girl. She was at the time of her death not living with either of her parents, and had not for some time. She had been made the subject of a Child Protection Order. She had been engaging in a number of high risk behaviours including drug abuse and sexual behaviour including alleged prostitution. She was difficult to engage with despite efforts by the Department to facilitate other living circumstances. There had been episodes of self harming and a potential suicide attempt. She was involved in a destructive, violent and abusive relationship with 28 year old Alexander O'Sachy. He was supplying her with drugs. On 7 September 2006 she was found hanging underneath the house where she was residing with Alexander O'Sachy. It is likely she has taken her own life. Alexander O'Sachy had been heard to tell her to kill herself on multiple occasions including on the day she died. The extent to which her state of mind was affected by drugs he made available to her and/or was brought upon by his abusive actions or the extent to which she was otherwise encouraged or in some way, assisted by him is and remains uncertain.

Place of death – IPSWICH ROAD PRINCESS ALEXANDRA HOSPITAL WOOLLOONGABBA QLD 4102 AUSTRALIA

Date of death– 07 September 2006

Cause of death – 1(a) Hypoxic Brain injury, due to, or as a consequence of
1(b) Hanging

I close the inquest.

John Lock
Brisbane Coroner
BRISBANE
3 May 2013