IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2015 001808**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**HELEN**
Date of birth:	**7 MAY 1946**
Date of death:	**14 APRIL 2015**
Cause of death:	**MULTIPLE INJURIES SUSTAINED IN A FALL**
Place of death:	**PLACE A, MELBOURNE, VICTORIA 3000**

HIS HONOUR:

BACKGROUND

1 Helen was aged 68 years at the time of her death. She resided in Abbeyfield Aged Care Facility in Frankston from 2 March 2015 until the time of her death. Helen is survived by her siblings, maintaining regular contact with her sister Gail. She was particularly close to her mother, who passed away on 16 February 2015.

2 Helen had a medical history of bipolar affective disorder and cluster B personality traits. At age 18 years she first attempted suicide[1], and was admitted to psychiatry units at Dandenong Hospital and Kingston Centre. Her admissions were often in the context of suicidal thoughts and behaviour. Helen had a protracted admission to the psychiatry unit in Dandenong Hospital from 23 December 2014 to 2 March 2015, during which she struggled with her mother's concurrent terminal illness.[2]

3 On 2 March 2015, Helen was discharged to Abbeyfield Aged Care Facility in the Peninsula Health catchment area. Helen was accepted for case management by Peninsula Health, but an agreement was reached with Monash Health that any psychiatric inpatient readmission required within three months of her discharge would be provided by the Monash Health inpatient units.[3]

4 On 2 April 2015, a solicitor working in her 9th floor office in Melbourne observed a woman acting erratically on the rooftop of Car Park A. On several occasions the woman ran towards the ledge. On one occasion she collided with the ledge and looked to the ground below. The solicitor called the police.[4] Constable Braden Hickey and Constable Jessica Norman attended the car park and spoke with the woman, who identified herself as Helen. Helen told the officers she parked her car in the car park, but could not remember the exact location or whether she was in the correct car park.

5 S/C Hickey noted that Helen smelled of alcohol, and she told him that she had consumed a couple of wines at lunch with a friend. S/C Hickey asked Helen if she was on the rooftop intending to jump. Helen told him she was fine, and that she would just get the train home, and get someone to come back and help her find her car later. Constable Norman noted that Helen

[1] Coronial brief, statement of Raymond, dated 14 July 2015, 60.
[2] Coronial brief, statement of Dr Christos Plakiotis, dated 14 September 2015, 74.
[3] Above n 2.
[4] Coronial brief, statement of solicitor, dated 15 April 2015, 48-49.

appeared confused and tipsy, but did not appear to be suffering from a mental health condition.[5] After a brief unsuccessful search for Helen's car in the car park, S/C Hickey drove Helen to the bottom of the car park. Helen reiterated she would get the train home, and thanked S/C Hickey for helping. S/C Hickey reported having no further concerns for her welfare at that time.[6]

6 At 4:30p.m., Victoria Police officers were called to attend Flagstaff Gardens between William and King Streets, Melbourne regarding a female who called her social worker and advised she was going to take her own life. Senior Constable Paul Hills and First Constable Kylee Alderton attended Flagstaff Gardens and located the female, now known to be Helen.

7 Helen was on the telephone to her social worker Ben Snell, and asked S/C Hills to talk to him. Mr Snell relayed to the officer Helen's suicidal ideation. S/C Hills conversed with Helen, who expressed her wish to jump from a building. Helen admitted an earlier suicide attempt two weeks prior. She told S/C Hills she had taken 8 Endone tablets and consumed one and a half bottles of wine, and became distressed when talking about her family. S/C Hills called the Police Ambulance and Crisis Assessment Team Early Response (PACER), requesting attendance for assessment. The PACER team attended, assessed Helen, and transported her to Frankston Hospital for further assessment.[7]

8 Helen was admitted for inpatient psychiatric care at Frankston Hospital on 2 April 2015 following suicidal ideation in the context of ongoing psychosocial stressors including grief following her mother's death, dissatisfaction with and loneliness at her accommodation, and recurrent unresolved abdominal pain for which no medical cause was found. Helen was placed on a Temporary Treatment Order (TTO), and was transferred to the Monash Health Biala Unit on 7 April 2015 with the order in place. Upon review on 9 April 2015, Helen's mental state appeared to have improved considerably, and she was no longer feeling severely depressed or suicidal. Options were discussed with Helen for a change of residential accommodation.

9 On 9 April 2015, due to an assessment of improved mental state and lack of suicidality, Helen's TTO was revoked and she became a voluntary patient. On 10 April 2015 Helen was granted day leave to collect clothing from her accommodation, however failed to return to the Biala Unit by 6:30p.m. Consultant Psychiatrist Dr Plakiotis advised nursing staff to contact police if Helen did not return to the Unit by 8:00p.m.[8]

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[5] Coronial brief, statement of Constable Jessica Norman, dated 7 October 2015, 81.
[6] Coronial brief, statement of Senior Constable Braden Hickey, dated 9 October 2015, 78-79.
[7] Coronial brief, statement of Senior Constable Paul Hills, dated 21 April 2015, 82-83.
[8] Above n 2, 74-75.

10 It transpired whilst on day leave, Helen returned to a café near Car Park A. Helen rose from her table, walked to the entrance of Place A, then returned to the café and collapsed. Café staff rushed to assist Helen, and an ambulance was called.[9]

11 Helen was transported via ambulance to St Vincent's Hospital Emergency Department. A notebook found in Helen's possession mentioned her low mood and intention to harm herself, and her psychiatric background was sought. It was established that Helen had recently been a patient of the Biala Unit. Helen's medical condition remained stable, and she was observed as an inpatient overnight with a psychiatric review arranged for the next day.

THE PURPOSE OF A CORONIAL INVESTIGATION

12 Helen's death constituted a *'reportable death'* under the *Coroners Act 2008* (Vic), as her death occurred in Victoria, and appears to have been unexpected or unnatural.[10]

13 The jurisdiction of the Coroners Court of Victoria is inquisitorial[11]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

14 It is not the role of the coroner to lay or apportion blame, but to establish the facts.[12] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

15 The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

16 For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

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[9] Coronial brief, statement of Meghan O'Neill, dated 14 April 2015, 25-26.
[10] Section 4, definition of 'Reportable death', *Coroners Act 2008*.
[11] Section 89(4) *Coroners Act 2008*.
[12] *Keown v Kahn* (1999) 1 VR 69.

17 The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

18 Coroners are also empowered:

(a) to report to the Attorney-General on a death;

(b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

(c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These powers are the vehicles by which the prevention role may be advanced.

19 All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[13] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

20 An impression was taken from Helen's right thumb. A Victoria Police Deceased (Fingerprint) Identification Report dated 15 April 2015 identifies the right thumb impression as belonging to Helen. Identity is not disputed and requires no further investigation.

[13] (1938) 60 CLR 336.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

21 On 16 April 2015, Dr Michael Burke, Senior Forensic Pathologist, Victorian Institute of Forensic Medicine (VIFM), conducted an inspection of Helen's body and provided a written report, dated 20 April 2015, concluding a reasonable cause of death to be 'Multiple injuries sustained in a fall'. I accept his opinion in relation to the cause of death.

22 Dr Burke reported that the post-mortem external examination revealed injuries in keeping with the clinical history, with the Computed Tomography (CT) scan revealing multiple fractures.

23 Toxicological analysis of blood detected mirtazapine[14] (~0.2mg/L), quetiapine[15] (~0.03mg/L), zopiclone[16] (~0.01mg/L), oxazepam[17] (0.1mg/L), promethazine[18] (~0.2mg/L), and paracetamol[19] (~12mg/L).

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

24 Helen was treated St Vincent's Hospital from 10 April 2015 until 14 April 2015 as a voluntary patient.[20] On 14 April 2015 shortly after morning observations, Helen left the ward at St Vincent's Hospital. Hospital security were notified and staff made unsuccessful attempts to contact Helen on her mobile telephone. As Helen was a voluntary patient and there were no acute medical issues requiring urgent treatment, it was felt that having her brought into police custody was not appropriate. The Biala Unit was called to confirm correct contact details, and Helen's sister Gail was contacted and asked to assist with follow-up of Helen's elevated serum calcium levels.[21]

25 At approximately 8:45a.m., Helen returned to Car Park A. CCTV footage of the building shows Helen entering the building and taking the stairs to the rooftop of Car Park A. She then removed her shoes and placed them on the ground near the stair well along with a number of other personal items. Helen climbed up onto the rail and sat motionless for a short while. She then lent backwards over the ledge, falling to Place A. Emergency services were called to the

[14] Mirtazapine is indicated for the treatment of depression.
[15] Quetiapine is an antipsychotic drug used in the treatment of schizophrenia.
[16] Zopiclone is a cyclopyrrolone derivative used in the short-term treatment of insomnia.
[17] Oxazepam is a sedative/hypnotic of the benzodiazepine class.
[18] Promethazine is an antihistamine.
[19] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene.
[20] Coronial brief, statement of Dr Marc Lanteri, dated 31 July 2015, 71-73.
[21] Above n 10, 72-73.

scene. Ambulance Victoria paramedics arrived at 9:06a.m., and declared Helen deceased.[22] Victoria Police officers Leading Senior Constable Julie Mills and Constable Erman Sepetci attended the scene, and conducted an investigation. Following contact with Gail, the officers became aware of Helen's diary and notebook expressing her suicidal ideation over a period of time. L/S/C Mills opined that Helen's death was the result of suicide.[23]

Jumping suicides from publicly accessible buildings in Victoria

26 Helen's death was not an isolated incident at this location. The Coroners Prevention Unit[24] reviewed its database of jumping suicides investigated by Victorian coroners between 1 January 2000 and 14 September 2015, and identified five jumping suicides from Car Park A. CPU reviewed data for jumping suicides from publicly accessible buildings in the City of Melbourne where the death was reported to the Court between 1 January 2010 and 31 December 2015, and advised that 20 jumping suicides occurred during this period. A further 24 jumping suicides occurred between 1 January 2010 and 31 December 2015, where persons accessed a public building to commit suicide, but did not gain access to the public building as a general member of the public.

27 While there is no single universally accepted definition of a suicide hotspot in literature or elsewhere, a jumping suicide hotspot location is generally agreed to have the following properties:

a. A specific, easily accessible public site;
b. A location from which there is elevated jumping suicide activity;
c. People travel from some distance specifically to suicide there; and
d. The location has a reputation as a suicide location.

It appears Car Park A fits the suicide hotspot criteria.

28 According to the available evidence, the Car Park Operator and the Operator Company Chairman are aware of the car park's reputation as a suicide location. An employee of the Car Park Operator, Ms A, advised that most levels of the car park have a barrier which prevents persons from throwing items from the car park or from jumping from the car park. However, Ms A explained that the side of the car park from which Helen jumped does not have barriers

[22] Coronial brief, statement of Robert Mits, dated 14 April 2015, 76.
[23] Coronial brief, statement of Leading Senior Constable Julie Mills, dated 3 September 2015, 87-90.
[24] A specialist service for coroners created to strengthen their prevention role and provide them with expert assistance. Hereafter referred to as 'CPU'.

installed. Ms A noted discussions occurring between managers regarding possible installation of barriers throughout the levels and to install better CCTV cameras in the hopes of preventing other further jumping suicides from the car park, but she was not aware of these measures being implemented in the car park.[25]

29 On 22 October 2015, a statement was requested from the Operator Company Chairman, to assist my investigation. Specifically, in consideration of the suicide deaths from his premises, whether barriers had been constructed and/or measures implemented to address these tragic incidents. The Operator Company Chairman advised the car park is fully compliant with all government and council regulations. He did not detail any meaningful attempts to implement jumping suicide prevention measures at the car park to prevent further deaths.

30 In addition to the tragic loss of life, significant distress has been caused to the Car Park Operator's neighbouring occupants, who witness these events and/or the distressing aftermath. The Operator Company Chairman received an email complaint dated 14 April 2015 from Mr Geoff Bartlett of Barristers' Chambers Limited on behalf of his tenants who occupy office space near Car Park A. The Operator Company Chairman provided the following response:

> *"This is extremely tragic indeed; we are presently reviewing possible remedies to help avoid this occurring in future. Fyi we spoke with police and were advised since Westgate was fenced, there has been a big increase in suicides from all city carparks as well as standing in front of moving trains. Never the less we will explore if there is anything meaningful that can be done."*[26]

A further complaint was received from Mr Bartlett on 2 September 2015, following a further jumping suicide from the same car park. On behalf of his tenants who have had to bear witness to the multiple suicides from the nearby car park, Mr Bartlett demanded something be done to prevent further suicides. The Operator Company Chairman callously responded:

> *"We have on several occasions asked the police attending for advice and they have said it's happening more frequently all around the CBD office towers & carparks not to mention jumping in front of trains, all since the Westgate was fenced along each side. It is entirely prohibitive to spend the capex required to fence the car park on all sides and would make it very dark and would only push these poor souls to other sites."*[27]

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[25] Coronial brief, statement of Ms A, dated 16 July 2015, 66.
[26] Email correspondence of Operator Company Chairman to Geoff Bartlett, dated 14 April 2015.
[27] Email correspondence of Operator Company Chairman to Geoff Bartlett, dated 2 September 2015.

31 The Operator Company Chairman received a further complaint dated 30 September 2015.

> *"As you would no doubt be aware, on 2nd September 2015, a man committed suicide by jumping from the car park into [Place A]. This tragic incident was observed by approximately 50 employees and members of the public attending the CLC. The psychological impact of witnessing such a tragic event cannot be underestimated...*
>
> *In addition to this recent death, it is our understanding that approximately four or five other suicides have occurred at [Car Park A] over the last several years. These suicides are tragic and impact not only the victims and their loved ones, but also those who witness them or provide post-incident assistance.*
>
> *The lack of adequate barriers on most of the multi-storey car park enables ready access to high jump off points for those wishing to suicide. It is our view that you have an obligation to take action to prevent repeat suicides at this location. In particular, we suggest that you arrange urgent installation of additional barriers in order to mitigate the risk of further suicides and the psychological damage caused to those who might unfortunately witness such events."*[28]

It is unknown whether the Operator Company Chairman provided a response

32 On 5 November 2015, Mr Joseph Genco, Municipal Building Surveyor of the Melbourne City Council, provided a statement to the Court as to whether there are any requirements or policies in place for jumping suicide prevention measures on publicly accessible buildings, and whether there are any future proposals to consider the development of policies to prevent jumping suicide from publicly accessible buildings.

33 Mr Genco noted that the *Building Act 1993* and the *Building Regulations 2006* references the National Construction Code (NCC) for its technical provisions. Volume 1 of the NCC, the Building Code of Australia (BCA) is the relevant code for commercial, industrial and public buildings. There are no requirements in the NCC provisions to prevent jumping suicides in relation to commercial, industrial or public buildings, with the only related requirement in place regarding installation of barriers to prevent accidental falls. Mr Genco noted that there are no local law requirements or policies held by Melbourne City Council requiring measures for

[28] Correspondence from Ms Akasha Atkinson to Operator Company Chairman, dated 30 September 2015.

prevention of jumping suicides from publicly accessible buildings, and he was not aware of future proposals for local law requirements or policies regarding the matter.

34 At the time Mr Genco provided his statement to the Court, The NCC was revised on a yearly basis. Commencing in 2016, revisions will occur on a three-yearly basis. The *Building Regulations 2006* are due to sunset in 2016, and at the time of Mr Genco's statement the Regulations were under review.[29]

35 Enquiries were made with the Victorian Department of Environment Land, Water & Planning regarding the feasibility of changes to the *Building Act 1993* and associated *Building Regulations 2006* to enable a Municipal Building Surveyor to require modification to a publicly accessible building which has been used as a suicide location.

36 On 20 June 2016 Mr Nick Wimbush, Acting Executive Director of Planning, Building and Heritage advised that giving Municipal Building Surveyors powers to mandate modification of existing buildings compliant with the relevant legislation and regulations used as suicide locations would be difficult to implement, and may result in suicidal persons seeking out buildings yet to be modified. Mr Wimbush suggested that the Australian Building Codes Board make amendments to the BCA requirements for publicly accessible buildings as a way of preventing suicides with particular consideration to the requirements for car parks.[30]

FINDINGS

37 Having investigated the death of Helen and having considered all of the available evidence, I am satisfied that no further investigation is required.

38 On the basis of the evidence available, I am satisfied that Helen's death was intentional.

39 I find that the care provided to Helen by Monash Health and St Vincent's Hospital was reasonable in consideration of the circumstances.

40 I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was Helen, born 7 May 1946; and

[29] Statement of Mr Joseph Genco, dated 5 November 2015, 1-2.
[30] Correspondence of Mr Nick Wimbush, dated 20 June 2016.

(b) that Helen died on 14 April 2015, at Place A, Melbourne from multiple injuries sustained in a fall; and

(c) that the death occurred in the circumstances described in paragraphs 23 to 24 above.

41 I convey my sincerest sympathy to Helen's family and friends.

COMMENTS

42 Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

43 The Operator Company Chairman is aware that multiple suicides have occurred at Car Park A. He is aware of continued complaints and requests to address the issue and is aware of the devastating impact on the occupiers of premises which neighbour his car park. The Operator Company Chairman and the Car Park Operator appear to have little to no desire to ensure the safety of persons using their car park, or to prevent likely future suicides from their car park.

44 I understand the challenges in implementing legislative change regarding amendments to currently compliant publicly accessible buildings where they are used as a suicide location. I do not believe the callous attitude of the Car Park Operator is reflective of the broader commercial community in this State. Further, I accept that the Australian Building Codes Board may be better placed to assist with the implementation of long-term measures to effect change in the area nationwide. However, despite the complexity and challenge entailed, I consider this issue too important to be shelved because it is perceived too difficult. Commencing in 2016, the NCC is now reviewed every three years, and given the number of suicides outlined in paragraph 26, three years is too lengthy a time to wait for consideration of prevention measures in this area.

RECOMMENDATIONS

45 Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendations connected with this death:

46 That the Victorian Department of Environment Land, Water & Planning implement amendments to the *Building Act 1993* and *Building Regulations 2006* to provide Municipal

Building Surveyor with powers to require modification to publicly accessible buildings which have been used as a suicide location; and

47 That during the next review of the National Construction Code, the Australian Building Codes Board consider the implementation of a requirement for increased jumping suicide prevention measures on commercial, industrial and public buildings under the National Construction Code, with particular attention to car park facilities.

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

(a) Helen's family/senior next of kin;

(b) Investigating Member, Victoria Police;

(c) Car Park Operator and Operator Company Chairman;

(d) Victorian Department of Environment Land, Water & Planning;

(e) The Australian Building Codes Board; and

(f) Interested Parties.

Signature:

MR JOHN OLLE
CORONER
Date: 22 August 2016