IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 4374/10

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of JOANNE FEENEY

Delivered On:	29 February 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street MELBOURNE 3000
Hearing Dates:	13 February 2012
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Sergeant David DIMSEY, Police Coronial Support Unit, assisting the coroner

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of JOANNE FEENEY

AND having held an inquest in relation to this death on 13 February 2012 at Melbourne

find that the identity of the deceased was JOANNE FEENEY

born on 18 October 1970

and that the death occurred on 14 November 2010

underneath the Widford Street overpass, on the Western Ring Road, Broadmeadows, Victoria 3047

from: 1(a) MULTIPLE INJURIES

in the following circumstances:

INTRODUCTION

1. Ms Feeney was a forty year old woman who resided at 10 Bradley Street, Broadmeadows. Ms Feeney had a history of substance abuse, generally amphetamines, and at least one known prior attempt to take her own life. This was in August 2010 when she attempted to do so with carbon monoxide and benzodiazepines. Following this attempt, Ms Feeney was taken to the Northern Hospital, treated in the Intensive Care Unit and discharged with a recommendation for psychiatric follow-up. It appears that Ms Feeney did not engage in psychiatric treatment.

PRESENTATION TO NORTHERN HOSPITAL

2. At about 2.00am on 14 November 2010, Ms Feeney was taken by ambulance to the Northern Hospital complaining of chest pain. At triage, she described the pain as worse on inspiration. When seen by the doctor at about 3.00am, Ms Feeney was alert, orientated, did not appear intoxicated and continued to complain of chest pain. The clinical suspicion was that the chest pain was the result of a lower respiratory tract infection with pleurisy. When the doctor ordered an injection of "Ketorolac" (an anti-inflammatory analgesic), Ms Feeney asked for morphine. Shortly after being refused morphine, Ms Feeney left the hospital with her friend Mr Shane Atkins. She yelled abuse at staff as she left, and resisted their attempts to get her to stay so they could at least remove the cannula. At 3.55am, hospital staff telephoned the local police to ask for a welfare check to be conducted on Ms Feeney.

3. Mr Atkins tried to persuade Ms Feeney to return to the hospital, but she refused. While he was driving home, Ms Feeney received a call from an unknown person on her mobile phone. According to Mr Atkins, after this call Ms Feeney asked him to take her back to the hospital where she allowed one of the nurses to remove the cannula, but refused any further treatment. The nurse then called the police to cancel the welfare check requested earlier.

MOVEMENTS AFTER LEAVING NORTHERN HOSPITAL

4. After leaving the hospital for the second time, Mr Atkins suggested he take Ms Feeney to her friend Kate Dyrimple's house in View Street, Glenroy. Once there, Ms Feeney seemed to be back to her usual self, laughing and talking. Mr Atkins left her there in the company of Ms Dyrimple and his sister April Atkins. A short time later, Ms Feeney started talking about having a fight with one of the nurses at the hospital and became upset. She also mentioned wanting to 'go and fly' several times which made Ms Atkins concerned enough to follow her as she left the house.

WIDFORD STREET OVERPASS

5. Ms Feeney walked the short distance from View Street to Widford Street. Ms Atkins saw her near the bridge/overpass over the Western Ring Road. As she approached, Ms Feeney was sitting on the handrail with her feet dangling over the edge and was talking on her mobile phone. Later investigations revealed that Ms Feeney placed a call to "000" at 5.18.10am and told the operator that she was going to jump from the overpass. At 5.21.50am, she told the operator that she was going and the call was disconnected.

6. During the call, Ms Atkins tried to talk Ms Feeney away from her position. Ms Feeney asked her if there were any cars coming and then slid off the handrail turning around and sliding down into a position whereby she was hanging by her hands. Ms Feeney kept asking if there were any cars coming, while Ms Atkins tried to hold on to her wrists until Ms Feeney let go and fell to the road surface below, landing on the right hand traffic lane of the eastbound carriageway of the Western Ring Road. Ms Feeney died at the scene.

EMERGENCY RESPONSE

7. Police and other emergency services attended the scene from as early as 5.24am. They secured the scene and commenced their investigation of the circumstances surrounding Ms Feeney's death. This finding is largely based on the investigation and brief of evidence compiled by one of the attending police officers Sergeant Chris Carnie from the Major Collision Investigation Unit of Victoria Police.[1] Although initially treated as a "death in police presence", I am satisfied that Ms Feeney had already fallen from the overpass when the first police arrived at the scene. I am also satisfied that Ms Feeney was still breathing after she landed on the roadway and therefore still alive before being struck by the first motor vehicle.

8. The weight of the evidence supports a finding that the first vehicle to strike Ms Feeney was a Ford Taxi M4246 driven by Mr Rupesh Monga, the second was the silver Holden Astra sedan RXB637 driven by Mr David Noble, and the third a burgundy Holden Commodore WPZ860 driven by Mr Ali Halabi. Whilst it was initially thought that a fourth vehicle, a yellow Nissan coupe SBX887 driven by

1 The investigation of Ms Feeney's death commenced as a joint investigation by the Homicide Squad and the Major Collision Investigation Unit with lead investigator being Detective Sergeant Chris Carnie from the MCIU, and the Ethical Standards Department performing an active oversight role.

Mr Geoffrey Dore, may have struck Ms Feeney, subsequent police inspection of the vehicle revealed no physical evidence that this was so, and I find insufficient weight to support such a finding.

9. All four drivers stopped at the scene and were co-operative with the investigation. Mr Noble and Mr Halabi complied with a request to submit to a preliminary breath test (PBT) and tested negative for alcohol. The other two drivers, Mr Monga and Mr Dore were given permission to leave the scene by a police officer who has not been identified. Mr Monga did however report the accident to his employer the following afternoon. Taxi 4246 was also identified by GPS records as being the only taxi in the vicinity at the time of Ms Feeney's death. Subsequent inspection of the taxi revealed blood and fibres consistent with some level of impact. Mr Dore volunteered his details to police at Broadmeadows the following day and submitted his vehicle for inspection.

10. The police investigation identified no problems with road infrastructure as having caused or contributed to Ms Feeney's death. Det. Sgt. Carnie concluded that Ms Feeney jumped from the overpass with the intention of taking her own life. He produced a "suicide" note found at Ms Feeney's home. By virtue of its contents and the circumstances, I agree with his assessment that this note more probably relates to an earlier attempt by Ms Feeney to take her life, perhaps that of August 2010.

MEDICAL EVIDENCE AS TO CAUSE OF DEATH

11. A full postmortem examination or autopsy was conducted by Forensic Pathologist Dr Melissa Baker from the Victorian Institute of Forensic Medicine (VIFM) who also reviewed the circumstances as reported by the police and postmortem CT scanning of the whole body. Dr Baker provided a detailed written report of her findings and attended the inquest to testify. According to Dr Baker, the significant anatomical findings at autopsy were - a base of skull fracture with associated patchy subarachnoid haemorrhage; frontal skull vault and facial bone fracture; multiple bilateral rib fractures and bilateral pneumothoraces; lacerations of right lower lobe of lung, right hemidiaphragm and liver; transection of pancreas; lacerations of distal aorta and avulsion of right renal artery; right lower limb fractures; vertebral body (T8) and spinous process fractures (T4 to T7); extensive pelvic and sacral fractures with marked disruption of the pelvis, protrusion of bowel, rupture of bladder and exposure of fractured bone; and, scalp and facial laceration bruises and abrasions with associated deposition of black grease like substance over the left side of the face.

12. Dr Baker attributed death to multiple injuries sustained in a fall from a height followed by being struck or run over by motor vehicles. She was unable to determine if Ms Feeney died as a result of injuries sustained in a fall from a height alone, and commented that it was quite feasible that she may have been dead or in the process of dying when struck by the motor vehicles. Although Dr Baker could not say definitively which injuries were sustained in the fall and which resulted from motor vehicle impact, she expressed the opinion that commented that the extent and nature of injuries overall was such that it was unlikely they occurred from a fall alone. She further commented that if it is accepted that Ms Feeney was breathing before she was struck by any motor vehicle, it is not possible to determine which, if any, injuries resulting from which vehicle impact cause or contributed to her death.

13. Toxicological analysis of postmortem blood samples also undertaken at VIFM revealed methylamphetamine ~0.8mg/L, amphetamine ~0.2mg/L, morphine 0.03mg/L, oxazepam (a benzodiazepine sedative/hypnotic drug available as "Serepax", "Murelax" and "Alepam") ~1.9mg/L, diazepam (a benzodiazepine sedative/hypnotic available as "Antennex", "Ducene", "Valium" and "Valpam") ~0.7mg/L and its metabolite nordiazepam ~0.05mg/L, temazepam, oxazepam and a trace of oxycodone.

14. I find that Ms Feeney intentionally took her own life by falling from the Widford Street overpass some eight metres to the Western Ring Road below. I find that in falling she sustained multiple serious injuries which were probably sufficient to have caused her death without more. I find that she sustained further injuries from impact with three motor vehicles which probably contributed to her death; I am unable to determine to the requisite standard of proof, the order in which her individual injuries were sustained. The evidence does not support any adverse finding against any of the police officers who attended the scene, against Ms Atkins who attempted to save Ms Feeney, or against any of the drivers who struck her as she lay on the roadway as they had insufficient opportunity to take effective evasive action.

15. From a broader "prevention" perspective, Det. Sgt. Carnie identified two issues - the first was the first responder's difficulty in accessing the roadway due to fencing, the steepness of the embankment and the jersey barriers installed to facilitate roadworks; the second was the failure of the unidentified police officer to obtain the names and contact details of Mr Monga and Mr Dore before allowing them to leave.[2] In relation to the first, it is appropriate that VicRoads are alerted to the difficulties experienced by police first responders in accessing the roadway to attend to Ms Feeney. In relation to the second I note that the joint recommendations of Det. Sgt. Carnie (MCIU) and Det Sen Const Brown (ESD) that "the patrol folder prompt card regarding traffic incident management be distributed to all members from the area alerting them regarding their responsibilities at fatality scenes" was accepted and actioned internally by Victoria Police. On that basis I make no formal comments or recommendations under the ***Coroners Act 2008***, as I might otherwise have been appropriate.

Pursuant to section 73(1) of the Coroners Act 2008, I order that the following be published on the internet:

This finding in its entirety.

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

The family of Ms Feeney

Det Sgt Chris Carnie (20339), Major Collision Investigation Unit, Victoria Police

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2 Although both drivers were located and provided statements for the brief, they should probably have been subjected to a PBT and their vehicles quarantined prior to inspection.

Det Sen Const Jordan Brown (33236), Ethical Standards Department, Victoria Police

VicRoads

Ms April Atkins

Mr Rupesh Monga

Mr David Noble

Mr Ali Halabi

Mr Geoffrey Dore

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 29 February 2012