IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 0368

FINDING INTO DEATH WITHOUT INQUEST

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

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of MAREE ELIZABETH HOY
without holding an inquest:
find that the identity of the deceased was MAREE ELIZABETH HOY
born on 19 November 1968
and that the death occurred on or about 13 October 2010
at 29 Fleet Street, Narre Warren South, Victoria 3805
from:

1 (a) CARBON MONOXIDE TOXICITY

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Ms Hoy was a 41-year-old married woman who lived with her husband Gary and his children in Narre Warren. Ms Hoy's own son from her first marriage, Lachlan, was aged fourteen and lived with his father, but spent alternate weeks with Ms Hoy in her household. According to her treating general practitioner, Dr Alan Cuneen, Ms Hoy medical history included multiple sclerosis (diagnosed in 2004) and longstanding depression, which was being treated with the antidepressants "Cipramil" (citalopram or escitalopram) and "Zyprexa" (olanzapine) at the date of her death.

2. Ms Hoy had been employed as an Office Manager at Premium Floors, Dandenong South for 12 years when, in early 2010, she resigned looking for more satisfying employment. She worked for a mortgage broker for a few days and then, through an agency, worked as a personal assistant at Monash University for six weeks before obtaining a full-time position as

an Executive Assistant/HR Assistant with City Management (Aust) Pty Ltd (City FM). Ms Hoy commenced in her new position on 9 August 2010 and was required to complete a six-month probationary period. She disclosed her depression (stable with treatment) and multiple sclerosis in documentation completed at the commencement of her employment.

3. At home, Ms Hoy voiced a number of concerns about her new position, at times saying that she did not find it fulfilling, at other times that she often did not have much to do and/or did not know what was expected of her. According to her husband, there were also some tensions within their blended family, and their financial circumstances were somewhat straitened. In the period immediately preceding her death, Ms Hoy and her husband spent an enjoyable weekend away together on 9 to 10 October 2010, and he felt she seemed sad when the weekend was over.

4. Ms Hoy returned to work on the morning of Wednesday 13 October 2010. Shortly after her arrival at about 8.30am, she was required to attend a meeting with the company's HR Manager and Senior HR Officer where she was given a written notification of the termination of her employment. Apparently, Ms Hoy packed up her belongings and left forthwith without causing any disturbance or raising any issues. At about 8.55am, Ms Hoy left a message on her husband's voice mail telling him that she had just been fired.

5. Subsequent police investigations revealed that Ms Hoy went to a hardware store in Narre Warren North, where at 10.56am she purchased 5m of plumbing hose, before going to a pharmacy in Narre Warren South where at 11.05am she purchased a packet of phenergan tablets. A short time later, Ms Hoy returned home and parked her vehicle in the garage. She then used the hose to connect the vehicle's exhaust to the cabin through the driver's side window, using a towel to secure the hose and stop any air entering the cabin.

6. Mr Hoy did not receive the message from his wife until about midday, as he had arranged (and his wife knew) to have his phone switched off until then. On receiving the message he became concerned for her welfare and wanted to ensure she was not alone. He tried to contact Ms Hoy unsuccessfully, rang her sister and, ultimately, his son's girlfriend who was able to go home to check on her. At about 2.45pm, Ms Hoy was found in the driver's seat of the vehicle, lying back, obviously deceased. The vehicle was still running. Emergency services were called and first responders arrived within minutes but Ms Hoy could not be revived.

7. Police attended and commenced their investigation of the circumstances in which Ms Hoy died. In the front passenger seat of the vehicle, they found a handwritten suicide note addressed to her husband,[1] a packet of phenergan with 15 tablets missing, receipts for purchase of the phenergan and the plumbing hose. They ascertained from Mr Hoy that his wife's employment had been terminated that morning and that she had attempted to take her life in the past at times of great distress. Police found no suspicious circumstances and concluded that Ms Hoy had taken her own life.

8. An external examination by Forensic Pathologist Dr Melissa Baker from the Victorian Institute of Forensic Medicine (VIFM) revealed no significant injuries and post-mortem CT scanning of the whole body revealed no injuries or obvious natural disease. In light of the toxicologist's findings, Dr Baker advised that it would be reasonable to attribute Ms Hoy's death to *carbon monoxide toxicity.*

9. No autopsy was performed as urgent toxicological analysis of post-mortem blood revealed a carboxyhaemoglobin saturation of 69% which the toxicologist advised was consistent with lethality. Toxicological analysis also revealed citalopram and olanzapine at levels consistent with normal therapeutic use and a trace of promethazine (phenergan, an anti-histamine with some sedative effect).

10. I find that Mr Hoy died as a result of carbon monoxide toxicity and that she intentionally took her own life. I find that the termination of her employment on the morning of 13 October 2010 was a significant stressor which contributed to her decision to take her own life.

THE "PREVENTION" ROLE[2] - TERMINATION OF EMPLOYMENT

11. Following consideration of the police brief, I requested clarification from Ms Hoy's employer about the termination of her employment, as it appeared that her employment status had been a significant stressor in the months preceding her death, and the termination of her employment on the morning of 13 October 2010 was causally significant to her decision to take her own life.

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[1] The note commenced as follow: "I'm sorry – I'm such a failure & disappointment I'm humiliated & just can't do this anymore. You were the one shining light & I feel you deserve better..."

[2] See Preamble and Purposes of the ***Coroners Act 2008.***

12. Mr Chris Richardson, Human Resources Manager, provided a detailed response to questions posed by Leading Senior Constable Kelly Ramsey from the Police Coronial Support Unit (PCSU). He explained that Ms Hoy's work performance had been unsatisfactory, in terms of its timeliness and accuracy, that her immediate supervisor and other managerial staff had cause to discuss this with her on a number of occasions, and that she had given verbal undertakings to address the issues raised. Regardless, Ms Hoy's work performance did not improve and the decision was taken on 7 October 2010 to terminate her employment, postponed until they could speak to her after a short leave break, on 13 October 2010. According to Mr Richardson, Ms Hoy was offered the opportunity to have someone else present during the discussion on 13 October 2010, but declined.

13. While it is beyond the scope of the coronial investigation of Mrs Hoy's death to assess the merits of any grievance she may have had about the termination of her employment and/or the merits of the employer's decision to terminate her employment, workplace issues and termination of employment are recognised suicide stressors and I accordingly asked the Coroner's Prevention Unit (CPU) to research any standards or best practice benchmarks around the termination of employment.

14. In their reports dated march 2011, CPU identified a number of issues with the advice on termination of employment that was currently available. Of particular note was the almost exclusive focus on the minimum standards required by law, and the absence of meaningful consideration of best practice. Furthermore, CPU noted that framing guidelines in terms of avoidance of legal liability, meant that there was a failure to emphasise concern for the wellbeing of the individual, and a tendency to focus on procedures pre-termination, providing little guidance around the act of termination itself, and how to deal with an employee after termination. CPU concluded that there is no national or state-wide accepted model of best practice around termination of employment, but recognised that it is possible that codes do exist at an institutional level, and are not available in the public domain. These may well be ad hoc and significantly variable in terms of content.

15. In an updated report dated October 2012, CPU advised that the Fair Work Ombudsman (Australian Government) has produced the following material of relevance:

- Best Practice Guide – Managing Underperformance

This document highlights the benefits of working at best practice, and outlines what that means in relation to the management of underperformance, including the termination of employment. It specifies a five step management process, and includes a table of common performance issues, causes and appropriate actions, as well as a checklist to ensure appropriate management.

- Letter of termination of employment (with notice)

  Provides a five step process that an employer operating at best practice should follow before terminating an employee's employment. It includes a letter template, specifying the important procedural aspects of the termination process.

- Letter of an unsuccessful probation period template

  Provides a four step process which outlines best practice when an individual whose employment falls within the probation period is underperforming and whose employment may not be continued. It includes a template letter.

COMMENTS

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

1. The Fair Work Ombudsman is to be commended for developing the guidelines mentioned above which appear to address the dearth of information about best practice and the termination of employment which was available at the time of Ms Hoy's death, and at the time of the initial investigation/research conducted by the CPU.

2. Quite apart from the legality of the termination of Ms Hoy's employment, which I have already indicated is beyond the reasonable scope of a coronial enquiry, her death and the surrounding circumstances highlight that termination of employment and the manner in which it is handled can be critical for individuals who are in difficulty.

RECOMMENDATIONS

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

1. That, in order to ensure that employees who are terminated are supported in accordance with best practice, as the lead organisation in the promotion and enforcement of health and safety in Victorian workplaces, WorkSafe Victoria ensures that the Fair Work Ombudsman's guidelines relating to best practice in managing underperformance and termination of

employment, are brought to the attention of employers and individuals in management positions as soon as practicable, and are readily accessible.

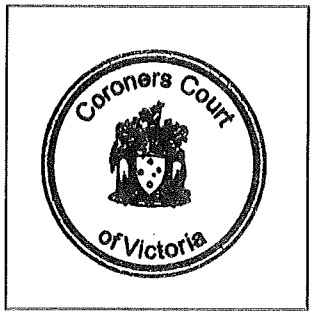
Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that the following be published on the internet:

This finding in its entirety.

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

The family of Ms Hoy
Senior Constable Tanya Lavin (34163) c/o O.I.C. Narre Warren Police
CEO, City Facilities Management (Aust) Pty Ltd,
Dr Alan Cuneen, Waverley Family Healthcare
Fair Work Ombudsman
Department of Education, Employment and Workplace Relations (Commonwealth)
WorkSafe Victoria

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: 31 October 2012