FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

*Section 67 of the **Coroners Act 2008***

Court Reference: 635/2008

In the Coroners Court of Victoria at Bendigo.

I, Richard Wright, Coroner

having investigated the death of:

Details of deceased:

Surname:	ATWOOD
First name:	MATTHEW RAY
Address:	Unit 20, The Terrace, Bendigo La Trobe Uni, Bendigo Victoria 3550

AND having held an inquest in relation to this death on 14th July 2010.

at Bendigo.

find that the identity of the deceased was Matthew Ray Atwood

and the death occurred on 11th February 2008, between 0250 and 0730 hours

at Outside Unit 13, The Terraces, Bendigo La Trobe University, Bendigo, Victoria 3550

from

1a. LACERATED RIGHT BRACHIAL ARTERY FOLLOWING A FALL ASSOCIATED WITH ALCOHOL INTOXICATION

In the following circumstances:

Background

Matthew Atwood journeyed from New Hampshire in the United States to commence a course at the Bendigo Campus of La Trobe University. He landed in Sydney on 7 February 2008 and arrived by train in Melbourne on Sunday, 10 February 2008. Whilst in Sydney, Matthew and other arriving students were taken on a number of orientation excursions around the city, to the Blue Mountains and a ferry trip to Taronga Park Zoo. The excursions were preceded by an orientation session on 7 February 2008.

On arrival in Melbourne, Matthew was conveyed to Bendigo and settled in his accommodation in an area called The Terraces. At the time, the University was still on vacation, with the academic term due to start in the following week. As a consequence, student numbers were limited and mainly consisted of students detailed by the University to assist new arrivals settle into their accommodation and campus life.

Circumstances

Matthew Atwood was one of a number of students from the United States enrolled to spend the forthcoming, first semester of 2008 at Bendigo. These students, including Matthew, were having dinner together in Terrace 5. A group of local students, who had been assigned the task of mentoring and supporting international students, arrived and introduced themselves. The larger group socialised and drank alcohol together in Terrace 5 for approximately one hour. After this, the larger group split in two and Matthew (and others) accompanied a local student, Luke Herron, to his accommodation at Terrace 20.

The event at Terrace 20 attracted other students through the night. Alcohol was consumed and Matthew was observed drinking both beer and an inexpensive "cask" white wine, which was called "goon" by the students. Around 10.30 pm a decision was taken to journey into the central business district of Bendigo, a distance of about 3 kilometres.

About eight students in two cars, including Matthew and Luke Herron, arrived at the Black Swan Hotel in Pall Mall, the major thoroughfare in the city. The Black Swan was one of the few establishments open for business. The group consumed beer up until 1.00 am. Soon after they were collected by another student, Kaitlyn Yeoman's, and conveyed back to the campus.

On arrival at the campus, Ms Yeoman's, Luke Herron and Matthew Atwood returned to Terrace 20, had some food, and continued talking. Ms Yeoman's left the unit at around 2.00 am. Matthew left approximately 30 minutes later, heading for his room.

Another member of the group that had travelled with Matthew to Australia was a Ms Daniella Chaloux. Ms Chaloux was to spend her semester at La Trobe University as well, but at its Bundoora campus. This campus is in a northern suburb of Melbourne. Matthew Atwood had a number of telephone conversations with Ms Chaloux on the night of 10 February 2010.

As Matthew was walking towards his accommodation, he placed a call to Ms Chaloux. This call was timed at 2.36 am. The call lasted 15-20 mins. The call "dropped out" at one stage and Ms Chaloux called back. As Matthew approached his Terrace, he advised Ms Chaloux that reception might be lost and they terminated the call. Ms Chaloux was the last person to speak with Matthew.

Matthew Atwood was found deceased outside the glass entrance door to Terrace 13 at 7.30 am on Monday, 11 February 2010.

Investigations

When Matthew's body was discovered, police were called. Detective Senior Constable Morris was tasked with investigating the events surrounding Matthew's death. On the basis of his investigations, Mr Morris reached the following conclusions.

The campus grounds were patrolled by a security guard. On the night, the guard was Mr Craig Dunstan. Mr Dunstan would have been patrolling in the Terraces area from 2.35 am to 2.50 am. He did not hear or see anything unusual.

It is believed that Matthew approached Terrace 13, which was vacant, not long after his telephone call with Ms Chaloux. He may have been disoriented, or have confused Terrace 13 for his own accommodation. He was close to the locked door of Terrace 13. It is believed that Matthew had lowered his jeans to defecate in the vicinity of the door to Terrace 13, lost his balance and fell into the glass panel of the door.

A shard of glass from the door has severed an artery in Matthew's arm, leading to his death.

In the circumstances of Matthew Atwood's death, an autopsy was required. The autopsy was carried out at Bendigo Hospital. The Victorian Institute of Forensic Pathology conducted the toxicology. On the basis of the toxicology results and his own observations, the pathologist concluded:

> The main finding at the post mortem examination was that of a lacerated right brachial artery which in the context of the summary of circumstances is considered the cause of death. The high blood alcohol in association with the tetrahydrocannabinol level detected by the toxicology studies would be considered contributing factors in that they would have impaired the deceased (sic) judgement and predisposed the deceased to the fall and so the injury.

There were a number of concerning issues relating to this death. Not the least of these was how a young healthy student could die in such peculiar circumstances. It was decided that an Inquest be held into the death of Matthew Atwood.

Role of a Coroner

The coroner's function is investigative and inquisitorial rather than adjudicative and adversarial. Coroners are required to investigate matters in their jurisdiction and, in the case of a death, determine the identity of the deceased, how the death occurred, the cause of death and the particulars needed to register the death.

It is clear that the identity of the deceased and the cause of death, in this case, are known. The primary inquiry for the Coroner relates to the circumstances of the death, where in this case there were no eye witnesses and no CCTV footage.

The Inquest

An Inquest into the death of Matthew Atwood was conducted in Bendigo on 14 July 2010. Senior Constable Lavery of Bendigo Prosecutions Branch, a member of Victoria Police, assisted the Coroner.

The following witnesses were called to give evidence at the Inquest:

Ms Debra Langton	Director of International & Development Operations, Swinburne University of Technology (Formerly Director, La Trobe International, La Trobe University
Dr Robert Dyson	Deputy Director, Strategic Initiatives, Building & Grounds, La Trobe University.
Ms Shiri Synan	Admissions Officer, La Trobe University
Mr Mark Forder	Facilities Manager, Regional Campuses, La Trobe University (Formerly Deputy Manager, Buildings and Grounds, La Trobe University at Bendigo)
Mr Craig Dunstan	Security Guard, Northstate Security, Bendigo
Detective Senior Constable David Morris	Bendigo Crime Investigation Unit, Victoria Police

Each of the witnesses provided written statements to the Coroner and was subject to questioning. The witnesses from the University addressed a number of issues identified by the Coroner, where they had personal knowledge of the relevant facts:

- What the (study) program involved in terms of orientation for the students.
- What support practices were in place for those students?
- Why there was no "safety glass" around the building.
- What support practices were in place for the students about alcohol awareness in our country?
- What follow up measures were taken after the accident?

Ms Langton

Ms Langton described the orientation program provided to international students at Bendigo. It was called the Welcome Festival and supplemented the general University-wide Orientation Week. The Welcome Festival covers country specific information on issues such as local laws and customs, socialisation with other students, transport matters, safety and security.

The mentoring group of peers, established local students, identified above also assist international students, in familiarisation and socialisation into the University and the locality.

A pre-departure kit is provided to students. It advises on matters such as currency, Customs requirements, quarantine, voltage levels for electrical items, etc. The University provided airport pickup and transport to the Bendigo campus.

Ongoing support is provided to students through the office of the International Students Support Coordinator.

As noted above, Matthew Atwood arrived in Bendigo before term started. The Welcome Festival had not commenced, although there had been an orientation program conducted when the students arrived in Sydney.

Ms Synan

Ms Synan, in her position as Admissions Officer, has primary responsibility for students coming to La Trobe University prior to their arrival in Australia. She assesses individual applications and sends out letters of offer to qualified prospective students. In the process, she provides documentation used for a student's visa application. Ms Synan also provided general information to the Inquest on the in-country management and support for international students. She had no personal knowledge of Matthew Atwood or his short time at the Bendigo campus.

Dr Dyson

Dr Dyson was in a position to inform the Inquest on issues relating to the physical infrastructure of the campus and, critically, the use of non-safety glass in pedestrian areas of the facility. The built environment in Australian institutions, such as university campuses, is determined by the Australian Design Rules.

Dr Dyson's evidence was that, as far as he knew, glass in doors such as the one that contributed to Matthew's death, was at the required standard for those doors when they were installed. The design rules change over time. Any breakages result in re-glazing at the current standard in force when the re-glazing occurs.

After the accident, the University commissioned an audit of its glass installed. The audit was initially conducted by a firm named Meinhardt. Dr Dyson was not happy with the company's work and it was replaced by O'Brien Glass. O'Brien was contracted to complete an audit and replace glass.

Mr Forder

As noted above, Mr Forder was Deputy Manager, Buildings and Grounds, at the Bendigo Campus when Matthew arrived at the University. He had basic responsibility for implementing the University's response to the glazing audit conducted by O'Brien's. The O'Brien's' brief was to identify all glass which was not safety glass and to replace it with glass meeting the current

Australian Standard. The exercise was commenced on 4 August 2008, more than 1,700 glass panels were replaced, the re-glazing was finished on 20 April 2009 and the job signed off on 14 July 2010.

Mr Dunstan

Mr Dunstan was the security guard on duty on the evening of Sunday, 10 February 2008, into the early hours of Monday, 11 February. He patrolled the whole grounds of the facility over a 2 hour period, with particular emphasis on the student accommodation areas. In his evidence to the Inquest, he observed that the usual complement of residents on campus was said to be 168 people, compared with the 35 in residence on the Sunday.

Part of Mr Dunstan's rounds each night takes in the Terraces. It is clear from his logs that he must have been close to Matthew at the time he left Terrace 20. He was neither seen nor heard by Mr Dunstan. He was in the vicinity of the Terrace at approximately 2.30 am, which is about the time Matthew placed his call to Ms Chaloux in Melbourne.

When the security patrol was completed, Mr Dunstan was relieved by another guard around 3.30 am. He was alerted to Matthew's death at 7.30 am that day.

Detective Morris

As noted above, Detective Senior Constable David Morris was the officer in charge of the scene and was responsible for preparing the brief to the Coroner. As part of his initial inquires, Mr Morris took statements from the following students who, except for Ms Chaloux, had been present with Matthew on the night:

- Michael Pierce
- Lisa Busch
- Brian Denham
- Daniella Chaloux

  (The above being US students)
- Kaitlyn Yeoman's
- Luke Heron

(Local students)

Based on these statements and other inquiries, Mr Morris developed the scenario set out above, detailing the events leading up to Matthew's death. There was no mention in the statements of cannabis consumption. As toxicology results were not available at the time, Mr Morris was not aware of this fact when he interviewed the students. Mr Morris also obtained statements from:

Craig Dunstan	Security Guard on Duty
John Milic	Painter, who discovered Matthew's body
Neville Britton	Mortuary Assistant, Bendigo Health, responsible for the autopsy
Dr Vince Murdolo	Pathologist, Bendigo Health

Based on his investigations, Mr Morris concluded that there were no suspicious circumstances surrounding the death. In his evidence at the Inquest, his opinion in this regard was confirmed.

*COMMENTS:

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

Findings

On the basis of the evidence before the Inquest, I find that Matthew Ray Atwood died from misadventure in the circumstances set out above.

The primary factor that contributed to his death was the absence of appropriate safety glass in the door to Terrace 13. I am satisfied that the absence of safety glass was not a breach of any code or building requirement.

Other factors of relevance to this unfortunate death included the alcohol ingested by the deceased. It should be noted that local alcoholic beverages were probably more powerful, in terms of alcoholic content, than those usually available in the United States. A blood alcohol reading of 0.13 g/100 mL, as identified in the toxicology, is nearly 3 times the limit for safe operation of a motor vehicle in Victoria.

The fact that the University teaching term had not commenced when this accident occurred, should also be noted. It is reasonable to conclude that Matthew was either "lost" or disoriented in returning to his apartment on the night. During term, there would have been, more than likely, many students out and about, even at that early hour, who could have assisted.

*Conclusion:

The Shorter Oxford Dictionary definition of "misadventure" is "bad luck; a piece of bad luck; a mishap, a misfortune". The death of this young man is sadly four square with this definition. Given the steps the University has taken to eliminate non-safety glass in all the public areas on campus, there is little chance that this unfortunate event could be repeated.

Signature:

Richard Wright

Coroners Court of Victoria

Richard Wright

Coroner

4th March 2011