IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2012/0990

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

(Amended pursuant to section 76 of the *Coroners Act 2008* on 9 April 2015)

I, AUDREY JAMIESON, Coroner having investigated the death of TOMISLAV BREKALO

without holding an inquest:
find that the identity of the deceased was TOMISLAV BREKALO
born 7 September 1982
and the death occurred on 17 March 2012
at Brimbank Park under the Western Ring Road (under the EJ Whitten Bridge), Keilor East, 3033
from:

1 (a) INJURIES SUSTAIN IN FALL FROM A HEIGHT

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Mr Tomislav Brekalo was 29 years of age at the time of his death. He lived with family in Ardeer and his medical history included psychological issues, recurrent bronchitis, dermatitis, severe acne, and recurrent back pain secondary to a thoracic spine scoliosis. In 2005, he graduated with a degree in Mechanical Engineering from Monash University and was able to secure various jobs, however only on a short-term basis.

2. At approximately 5:00pm on 17 March 2012, Mr Brekalo drove his vehicle from his home to the EJ Whitten Bridge, situated on the Greensborough bound lanes of the Western Ring Road. Mr Brekalo stopped his vehicle in the emergency lane, and was observed to climb onto the

railing and then step over the railing, falling to the ground where he was discovered. It was apparent that Mr Brekalo had sustained fatal injuries from the fall.

INVESTIGATIONS

3. Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination on the body of Mr Brekalo, reviewed a post mortem CT scan and reviewed the Victorian Police Report of Death, Form 83. Anatomical findings were consistent with the mechanism of injury.

4. Toxicological analysis of blood retrieved post mortem identified the presence of Olanzapine.[1] Dr Lynch ascribed the cause of Mr Brekalo's death to injuries sustain in a fall from a height.

5. The circumstances of Mr Brekalo's death have been the subject of investigation by Victoria Police on behalf of the Coroner. Police located what appeared to be a 'suicide note' inside Mr Brekalo's vehicle. An examination of Mr Brekalo's recent computer history revealed that he had been researching possible local suicide locations.

6. Police obtained statements from Mr Brekalo's mother, his sister, various witnesses, General Practitioner Dr Adrian Nigel Foenander, Psychiatrist Dr Sunil Datta and Psychologist Ms Veronica Valenzuela.

7. Mr Brekalo's first psychological diagnosis and treatment occurred in 2007 after he presented to the Sunshine Hospital with his first recorded onset of psychosis, characterised by paranoid delusions, confusion and impairment in his cognitive abilities. After an inpatient stay, he was commenced on psychotropic medication and managed by Orygen Youth Health. Mr Brekalo perceived that he would one day be without the need for the medication, and began reducing his dosage without being advised to do so. He was diagnosed with Chronic Paranoid Schizophrenia, a diagnosis that Ms Valenzuela reports he struggled to accept.

8. Mr Brekalo's family observed his mental health to deteriorate in mid 2011, and despite their encouragement, he refused to consult with a medical practitioner for a medication review. His mother eventually contacted the Mid West Mental Health Service Crisis Assessment and

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[1] Olanzapine is indicated for the treatment of Schizophrenia and related psychosis. The blood concentration detected was found to be within the expected therapeutic range. Following concerns raised in the statement of Mrs Lucy Brekalo dated 3 September 2012 (Coronial Brief), a second toxicological analysis was obtained to determine whether asenapine (used to treat Schizophrenia) was identifiable. The results determined that it was not.

Treatment (CAT) Team. His medication was subsequently increased with little effect, and in September 2011, he was referred to Private Psychiatrist, Dr Datta. He ceased consulting with Ms Valenzuela in November 2011 after he reported an improvement in his condition.

9. Dr Datta reported that Mr Brekalo had requested a change of his medication several times due to the reported side effect of drowsiness from taking olanzapine. Dr Datta trialled other medications such as risperdal, aripiprazole and asenapine, but opined that his best response was to olanzapine. The drowsiness associated with olanzapine continued to trouble Mr Brekalo and during their last consultation on 13 March 2012, Mr Brekalo decided to switch medications once again over to asenapine, as it had a less sedating effect. He was last reviewed by Dr Datta over the telephone on 16 March 2012, when he stated that he was going to change his medication over to olanzapine, with aripiprazole in the morning to assist with alertness. It is however unclear whether he actually made this change following the conversation..

10. Dr Datta opined that despite treatment and follow-up, Mr Brekalo continued to deteriorate and was not able to hold a job that he felt was suitable by virtue of his education and intelligence.

11. Mr Brekalo was medically investigated in January 2012 as part of a metabolic screening in conjunction with his psychiatric issues. All tests were returned as normal.

12. Mr Brekalo had numerous jobs throughout the years but was unable to sustain prolonged employment. He was last dismissed from employment in February 2012.

13. Mr Brekalo sent a text message that expressed suicidal intent to his mother at 5:01pm on 17 March 2012.

Coroners Prevention Unit

Jumping suicide deaths

14. The Coroners Prevention Unit (CPU)[2] were requested to review the circumstances of Mr Brekalo's death on behalf of the Coroner, including the provision of a descriptive statistical

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

overview of jumping suicides at the EJ Whitten Bridge compared to jumping suicides at other locations, and a report of the possible involvement of the antipsychotic asenapine (brand name Saphris) in any Victorian deaths reported to the Coroners Court of Victoria (CCOV).

15. The EJ Whitten Bridge was opened to traffic in July 1995 as part of the Western Ring Road. It crosses Brimbank Park and the Maribyrnong River in Sunshine North; its height directly above the Maribyrnong River is approximately 60 metres. There is a pedestrian footpath on the northbound carriageway (or western side) of the bridge.

16. Under Section 36(a) of the *Road Management Act 2004* (Vic), VicRoads is the Coordinating Road Authority for the Western Ring Road. According to the VicRoads Register of Public Roads (Part A), there are no agreements in place that transfer responsibility for Western Ring Road management functions to any other entity. VicRoads accordingly appears to be the sole entity responsible for the Western Ring Road including the EJ Whitten Bridge. The VicRoads Chief Executive is accountable to the Minister for Roads and Ports, reporting through the Secretary of the Department of Transport.

17. Between 1995 and 18 August 2014, there have been 12 jumping suicides at the EJ Whitten Bridge. For all 12 jumping suicides at this location, the deceased drove to the bridge and jumped from the northbound side where the pedestrian footpath is located.

18. There is no single universally accepted definition of a suicide hotspot in the literature. However, a jumping suicide hotspot location is generally agreed to have the following properties:

    a. it is a specific, easily accessible public site;

    b. it is a location where there is elevated jumping suicide activity;

    c. people travel from some distance specifically to suicide there; and

    d. it has a reputation as a suicide location.

19. With reference to this definition, the EJ Whitten Bridge is clearly a specific and easily accessible public site. The bridge is used by the public and incorporates a pedestrian footpath along its western side. Additionally, it has emergency lanes along each side so cars can pull over without disturbing the flow of traffic.

20. To determine whether the EJ Whitten has an elevated level of suicide activity compared to other jumping suicide locations, the CPU utilised its database of all Victorian jumping suicides investigated by Coroners from 2000 to present, which includes detailed information on the location of each suicide. In descending order of frequency, each individual Victorian location where two or more jumping suicides occurred during this period included:

    a. the West Gate Bridge was the location with the highest frequency of jumping suicides (104). However, the most recent West Gate Bridge jumping suicide occurred in 2011, and no suicides have occurred following completion of the permanent safety barrier on the bridge;

    b. the EJ Whitten Bridge was the second most frequent location for jumping suicides, with 10 since 2000 (and 12 since the bridge was completed in 1995); and

    c. there were four other bridges or overpasses belonging to the Victorian road network, where multiple jumping suicides occurred: the Moira Street overpass over the Monash Freeway in Malvern (two suicides), the Belford Road overpass over the Eastern Freeway in Kew (two suicides), the Phillip Island Bridge in San Remo (two suicides), and the Collins Street overpass over Wurundjeri Way in Melbourne (two suicides).

21. Based on this data, it is reasonable to conclude that the EJ Whitten Bridge has an elevated level of jumping suicide activity. With the exception of the West Gate Bridge (which has now been effectively 'neutralised' as a jumping suicide location through installation of permanent safety barriers), it is the location with the highest frequency of jumping suicides in Victoria.

22. The data would also tend to support the contention that people travel to suicide specifically at the EJ Whitten Bridge. In all 12 deaths, the deceased drove to the bridge, travelling between three and 23 kilometres from their usual places of residence.

23. Further, there has been some coverage of EJ Whitten Bridge jumping suicides, particularly in local newspapers.[3]

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[3] See for example A Loncaric, "Tragedy prompts bridge plea", Brimbank and North West Weekly, 20 May 2012, <http://www.brimbankweekly.com.au/story/275124/tragedy-prompts-bridge-plea/>, accessed 11 March 2014.

24. On 24 May 2012, Member of Parliament for Keilor Natalie Hutchins spoke in Parliament to "highlight the urgent need for public safety barriers to be erected on the EJ Whitten Bridge" to prevent suicides.[4]

25. On 28 May 2012, Coroner's Investigator Sergeant Glen Weaver received correspondence from VicRoads advising that they were upgrading the M80 Ring Road to improve safety and reduce congestions. Due to the size of the job, the works were being completed in sections, with the areas with the worst congestion and safety records targeted first. VicRoads advised that at that time, they had three sections funded and under construction. VicRoads further advised that they were in the planning and preliminary design phase for the section between Sunshine Avenue and the Calder Freeway, which includes the EJ Whitten Bridge. While they had not finalised their design, they advised they were looking at ways of improving public safety on the bridge, including the possibility of containment barriers.

26. In August 2012, a petition on GoPetition called for VicRoads to install safety barriers on the EJ Whitten Bridge to prevent jumping suicides.[5]

27. On the basis of the above considerations, I am satisfied that the EJ Whitten Bridge is probably a jumping suicide hotspot location, or at the very least a location with the potential to become a jumping suicide hotspot.

28. Following extensive reviews of the literature regarding jumping suicides, and particularly jumping suicides at hotspot locations, the only intervention for which there is clear evidence of effectiveness is a safety barrier that physically prevents people from accessing the edges of the bridge.

29. I appreciate that death prevention is not the sole consideration when determining the appropriateness of erecting a safety barrier at a given location. I recognise that retrofitting a safety barrier to an existing bridge is extremely expensive, and is a protracted and complex process that requires sophisticated planning and engineering. The West Gate Bridge safety

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4 N Hutchins, "EJ Whitten Bridge: safety barriers", 24 May 2012, <http://www.natalie hutchins.com.au/fullspeeches/speeches_240512_1.html>, accessed 11 March 2014.

5 GoPetition, "Suicide/Safety Barriers For EJ Whitten Bridge", 22 August 2012, <http://www.gopetition.com/petitions/suicide-barriers-for-ej-whitten-bridge-melbourne-austra.html>, accessed 11 March 2014.

barrier was planned and designed for more than a decade, and was installed as part of a project that also included strengthening and widening the bridge.

30. Safety barriers can be supported by some members of the community but opposed by others; and I am aware of previous objections having been raised to an EJ Whitten Bridge safety barrier proposal on aesthetic grounds. I do not however consider these objections to have sufficient weight to detract from the importance of death prevention.

31. I also appreciate that drawing public attention to the bridge as a jumping suicide location could pose its own risks, as it might draw further people to jump there. There is currently approximately one jumping suicide per year, but the West Gate Bridge experience demonstrates that an established jumping hotspot in Melbourne can attract many times this number.

32. I am also aware of a perception in some quarters that erecting a barrier at one location merely displaces suicides to another location. For example, following the West Gate Bridge safety barrier completion, there have been repeated anecdotal claims that the problem had now been "shifted" to the rail system and there are more rail suicides. The CPU data however provides otherwise.

Victorian deaths potentially involving asenapine

33. The VIFM's Chief Toxicologist, Dr Dimitri Gerostamoulos, was asked about the testing protocols currently in place for the drug asenapine. Dr Gerostamoulos advised that asenapine is not in the VIFM's routine list of drugs. It is therefore not possible to estimate the prevalence of this drug detected or contributing to deaths, and in particular suicides, investigated by Coroners in Victoria.

34. A search of the National Coronial Information System (NCIS) and the Victorian Suicide Register (VSR) for the terms "asenapine" and "Saphris" revealed that the drug was mentioned in the post-mortem report as a drug prescribed to two deceased: Lyal HERMANN (20114226) and another matter still under investigation The death of HERMANN appears to be intentional self-harm in the context of major depression and suicidal ideation.

35. A search of the scientific research literature to identify whether an association has been established between asenapine and suicide identified one relevant publication - a letter to the

editor published in 2011 in the *Journal of Clinical Psychopharmacology* reporting two cases of an observed association between commencement of asenapine and suicide ideation.

36. I note that some groups have raised concerns regarding the United States Federal Drug Administration's approval of asenapine, challenging the quality of evidence submitted to support the approval and the number of suicides that occurred during clinical trials.[6] However, in the absence of any peer-reviewed literature exploring these issues, I do not consider it appropriate to comment further on the link between asenapine and suicidality, as there appears to have been no definitive association established.

COMMENTS

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

37. There is a strong rationale, purely from a suicide prevention perspective, for erecting a safety barrier at the EJ Whitten Bridge. As discussed, the EJ Whitten Bridge is the location of the highest frequency of jumping suicides in Victoria after the West Gate Bridge, and it can arguably be characterised as either an emerging or an actual jumping suicide hotspot location. The West Gate Bridge is an excellent example – and warning – of what can happen when a jumping suicide hotspot becomes established in Melbourne; it was the scene of hundreds of jumping suicides over 30 years before safety barriers were erected.

38. As at 18 August 2014, the only Victorian recommendation regarding the EJ Whitten Bridge is Coroner Spanos' recommendation in the death of David Holland.[7] Rather than call explicitly for safety barriers at the EJ Whitten Bridge, Coroner Spanos approached the issue indirectly, recommending:

    That in the interests of prevention, VicRoads takes into account the risk of suicide when designing modifying or upgrading any infrastructure, particularly bridges, that could be a possible site for jump from height suicide.

[6] The most credible critique identified was from the US-based Alliance for Human Research Protection, a respected non-government organisation with strong scientific credentials. See Alliance for Human Research Protection, "FDA Approves Another Dangerous Antipsychotic, Asenapine", 16 August 2009, <http://www.ahrp.org/cms/content/view/628/67/>, accessed 25 August 2014.

[7] COR 2008 4584.

39. The VicRoads response (dated 6 October 2010) was relatively positive; Chief Executive Mr Gary Liddle indicated that:

> In implementing the Coroner's recommendation, VicRoads is currently working to develop specific guidance indicating the type of projects that should include a consideration of suicide risk and will seek assistance in identifying suitable criteria from experts in mental health.

40. Mr Liddle also indicated that he was "keen to receive regular statistics and other information collected by Victoria Police and the Court about suicides and attempted suicides by jumping from its bridges and other infrastructure".

41. In reviewing Member of Parliament for Keilor Natalie Hutchins' 24 May 2012 speech, I note the following passage:

> The EJ Whitten Bridge will be upgraded as part of the M80 ring-road upgrade. I urge VicRoads and the Minister for Roads to take the request for public safety barriers seriously and include them in the final design. I also call for those barriers to be installed before the upgrade in 2014.[8]

42. I have not been provided with any further information directly from VicRoads regarding this upgrade, and a recent (28 April 2014) report in The Age newspaper indicates that allocated funding for the Western Ring Road upgrade has been diverted to support the East-West Link.[9]

43. In November 2014, VicRoads were requested to advise of its progress towards developing specific guidance to manage suicide risk when designing, modifying or upgrading any infrastructure, particularly bridges, that could be a possible site for jump from height suicides. VicRoads were also asked to provide information specifically about the status of the EJ Whitten Bridge upgrade as part of the M80 ring-road upgrade.

44. VicRoad's response darted 27 November 2014 advised that the M80 Ring Road Upgrade was planned to be delivered in sections. The works have been prioritised based on improving the

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[8] Parliament of Victoria, *Parliamentary Debates*, Legislative Assembly, 24 May 2012, page 2309 (Ms N Hutchins).

[9] J Massola and J Gordon, "Federal government diverts ring road funding to East West Link", The Age, 28 April 2014, <http://www.theage.com.au/victoria/federal-government-diverts-ring-road-funding-to-east-west-link-20140428-zr0v7.html>, accessed 26 August 2014.

most congested section and those with the worst safety record first. So far, three sections have been completed.[10]

45. VicRoads advised that in August 2012, it had developed a policy (*VicRoads' Bridge Public Safety Barrier Policy*) (the Policy) to guide the installation of barriers or other measures to prevent suicide.[11] The Policy states that VicRoads will monitor any site with one or more suicides and will investigate these sites to determine whether the structure itself may have been a contributing factor. Under the Policy, once a bridge has been identified as eligible for treatment considerations, the approach taken will be:

    a. interagency collaboration and management;

    b. data collection and analysis;

    c. review options;

    d. develop and implement a plan; and

    e. evaluate effectiveness.

46. The Policy expands on point e. above to explain a process of cost evaluation, community consultation, and media engagement under the guidance of specialist agencies such as *Beyondblue*, SANE Australia or Lifeline.

47. VicRoads advised that it plans to install public safety barriers on the EJ Whitten Bridge when the section from Sunshine Avenue to the Calder Freeway is upgraded. VicRoads further advised that there is no timeframe to when the works from Sunshine Avenue to the Calder Freeway will be undertaken as this section is currently not funded.

48. In the interim, VicRoads advised it is investigating options and timeframes for opportunities to install temporary barriers, which would also require additional funding. VicRoads intends to raise this matter with the incoming State Government and the Federal Government at the earliest opportunity with the intention of securing funds to enable at least temporary public safety barriers to be installed on the EJ Whitten Bridge.

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[10] Calder Freeway to Sydney Road, Western Highway to Sunshine Avenue and Edgars Road to Plenty Road.

[11] A copy of the policy was provided.

49. VicRoads explained that it will continue to closely monitor the bridge via closed circuit television and will be vigilant in addressing any unusual behaviour.

RECOMMENDATIONS

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

50. I **recommend** that VicRoads urgently liaise with the incoming Victorian State Government and the Federal Government in relation to the implementation of their Policy in an effort to secure necessary funding to enable temporary public safety barriers to be installed on the EJ Whitten Bridge immediately to prevent jumping suicides at that location.

51. I **recommend** that VicRoads urgently liaise with the incoming Victorian State Government and the Federal Government in relation to the implementation of their Policy in an effort to secure necessary funding to enable permanent public safety barriers to be installed on the EJ Whitten Bridge to prevent jumping suicides at that location.

FINDINGS

I make no further comment in relation to the VicRoads 2012 *VicRoads' Bridge Public Safety Barrier Policy* regarding matters not germane to the death of Mr Brekalo.

I accept and adopt the medical cause of death as identified by Dr Matthew Lynch and find that Mr Tomislav Brekalo died from injuries sustain in a fall from a height in circumstances where I am satisfied that he intended to take his own life.

I acknowledge the extensive research and synthesis of data performed by the Coroners Prevention Unit.

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

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

Mr Z and Mrs X

Dr Adrian Nigel Foenander, Braybrook Medical Centre

Dr Sunil Datta

Ms Veronica Valenzuela

VicRoads

Mr Dean Yates, Secretary, Victorian Department of Transport, Planning and Local Infrastructure

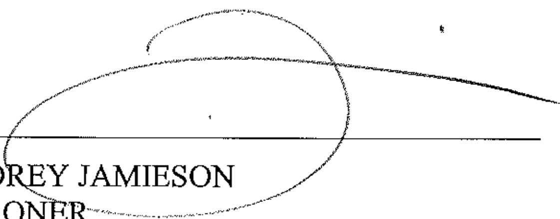
The Hon Mr Luke Donnellan MP, Minister for Roads and Road Safety

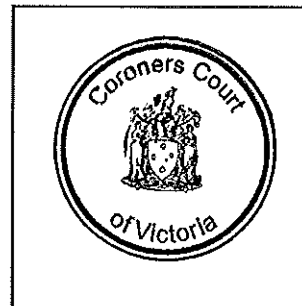
Commonwealth Department of Infrastructure and Regional Development

Commonwealth Department of Health and Ageing

Sergeant Glen Weaver

Signature:





AUDREY JAMIESON
CORONER
Date: **9 April 2015**