IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 007139

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*
*Section 67 of the **Coroners Act 2008***

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| Findings of: | Deputy State Coroner Paresa Antoniadis Spanos |
| Deceased: | LN |
| Date of birth: | 9 December 1995 |
| Date of death: | 24 December 2023 |
| Cause of death: | 1(a) Traumatic intracranial haemorrhage sustained in an unwitnessed fall |
| Place of death: | Alfred Hospital, 55 Commercial Road, Melbourne, Victoria |

## INTRODUCTION

1. On 24 December 2023, LN was 28 years old when he died in hospital following an unwitnessed fall outside him home. At the time, Mr LN lived with his girlfriend and a housemate in Caulfield North.

2. Mr LN was from the United Kingdom. He and TS had been in a relationship for about three years and had resided in Caulfield North for several months with their friend, SV, in a first floor flat.

3. Mr LN worked as a shuttering carpenter, loved sport, and was fit and active. According to Ms TS, Mr LN drank alcohol regularly and occasionally used recreational drugs.

## THE CORONIAL INVESTIGATION

4. Mr LN's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Mr LN's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into Mr LN's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I

will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

## MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

### Identity of the deceased

9. On 24 December 2023, LN, born 9 December 1995, was visually identified by his father, DN, who signed a formal Statement of Identification to this effect.

10. Identity is not in dispute and requires no further investigation.

### Medical cause of death

11. Forensic Pathologist, Dr Hans de Boer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 27 December 2023 and provided a written report of his findings dated 2 January 2024.

12. The post-mortem CT (computed tomography) scan revealed linear right occipital skull fracture, right subdural haemorrhage with mass effect, pontine haemorrhage, posterior lung consolidations, and fatty liver. Dr de Boer noted the findings at external examination of the body were consistent with the reported circumstances and there were no other remarkable findings.

13. Routine toxicological analysis was not performed as no suitable ante mortem specimens were able to be obtained from the admitting hospital. However, Dr de Boer noted that medical records from Alfred Hospital indicated analysis of ante-mortem samples detected a blood alcohol concentration of 59 mmol/L[2] (0.27 g/100 mL[3]) and cocaine.[4] He explained that a blood alcohol level of 0.27 g/100 mL is a very high level, which would generally have substantial

[1] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. 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 as to those matters taking into account the consequences of such findings or comments.
[2] At 12.46am on 22 December 2023.
[3] In Australia, it is illegal for full license holders to drive with a blood alcohol concentration of more than 0.05 g/100 mL. A blood alcohol concentration in excess of ~ 0.30% can cause death in the absence of other contributing factors. Aspiration of gastric contents is a significant risk factor in such cases. Other drugs capable of depressing the central nervous system will increase the effects of alcohol when co-consumed.
[4] At 6.23am on 22 December 2023.

effects on coordination, behaviour, and reflexes. If present, the other substances may have contributed to drug toxicity.

14. Dr de Boer provided an opinion that the medical cause of death was *"1(a) Traumatic intracranial haemorrhage sustained in an unwitnessed fall"*.

15. I accept Dr de Boer's opinion.

**Circumstances in which the death occurred**

16. Throughout the day on 21 December 2023, Mr LN and Ms TS kept in touch with each other via telephone calls and text messages. On the same day, Mr LN attended an end of year work function.

17. EP stated that she joined Mr LN and his friends for drinks at the West Beach Pavilion in St Kilda at about 1.00pm, noting that Mr LN had already been there for about an hour by the time she arrived. According to Ms EP, it was a warm day, and everyone drank alcohol steadily throughout the day. She stated that, *"LN seemed very happy and in a good mood throughout the afternoon and evening. He was noticeably intoxicated later in the evening, and although I am unsure of the exact number of drinks he had, I estimate it was around 10 beers."* HY arrived at the at the West Beach Pavilion at about 4.00pm, joining the group of about 15 people. They then moved to Fifth Province, another drinking venue also located in St Kilda.

18. Ms TS arrived home from work at about 5.00pm. In the evening, Mr LN's mobile phone ran out of battery and Ms TS was unable to contact him. Ms TS stated she was not overly worried about Mr LN that evening as she knew he was with friends. However, she was annoyed with him as he had stayed out late the previous evening. Both Ms TS and Ms SV[5] were home during the evening and retired to bed at about 10.00pm.

19. At some point during the evening, staff declined to serve Mr LN any more alcohol due to their perception that he was intoxicated and they asked him to leave. According to Ms EP, *"At the time he was asked to leave, LN was noticeably intoxicated and*

[5] Following Mr LN's death, Ms SV returned to the United Kingdom and was not available to provide a statement to police.

*slightly unbalanced when walking, but this was his typical behaviour when under the influence — not out of the ordinary for him."*

20. Mr HY stated, *"One of the last memories I have of LN was him almost falling asleep at the bar with a beer. A few of us started to make arrangements, since LN was getting kicked out by a bouncer at the Fifth Province."*

21. Mr LN and his colleague, WK,[6] walked across the road to a kebab shop to get some food. Thereafter, Mr LN made his own way home, arriving at about 11.15pm.

22. At about this time, Ms SV was awoken by a noise. She subsequently roused Ms TS, and they both opened the front door of their flat to investigate. They found Mr LN on the ground at the bottom of the stairway in the communal area.

23. Eduard Edelman, a resident of a ground floor flat in the apartment building, stated he heard a *"very loud sound of fall and impact of my front wall, near my front door"*. He did not investigate the sound until he heard crying and screams. When he opened the door, he saw the two women upstairs and Mr LN lying on the stairs, his head against the front wall of Mr Edelman's flat. He tried to calm Ms TS and Ms SV, asking them to call emergency services. Mr Edelman and his wife then moved Mr LN from the stairs and covered him with a blanket. Mr Edelman recalled, *"He was breathing, mumbling, he was absolutely conscious, not required to be given CPR [cardiopulmonary resuscitation]."* Mr Edelman also noted that Mr LN was intoxicated at the time as there was a *"very heavy"* smell of alcohol present.

24. Ms SV contacted emergency services at 11.20pm. Ambulance Victoria paramedics arrived at 11.28pm, assessing Mr LN to have a Glasgow Coma Score[7] of 3. Mr LN was hypertensive with fixed dilated pupils and had a right parietal lobe deformity. Paramedics requested the assistance of a Mobile Intensive Care Ambulance. Mr LN was subsequently transported to The Alfred Hospital, arriving at 12.04am where he was immediately intubated.

25. A CT brain scan demonstrated extensive bilateral intra and extra-axial haemorrhages with severe associated mass effect and evidence of evolving hypoxic ischaemic encephalopathy

[6] Unfortunately, Mr WK was not available to provide a statement to police following Mr LN's death due to being overseas.

[7] The Glasgow Coma Scale (GCS) is a neurological assessment tool used to determine a person's level of consciousness, particularly after a head injury. It assesses three aspects of responsiveness: eye-opening, verbal response, and motor response. Each category is scored, and the total score, ranging from 3 to 15, provides a general indication of the severity of the injury. A score of 3 indicates a deep coma or death, while 15 signifies a fully alert and responsive individual

with reduced enhancement of intracranial vessels, most notably within the left hemisphere. There was also evidence of foramen magnum herniation and an occipital fracture with extension to the base of skull and left occipital condyle. A CT scan of the chest, abdomen, pelvis, and spine revealed anterior sternal fracture and suspected left head of 10th rib fracture. A blood alcohol concentration of 59 mmol/L (0.27 g/100 mL) and a positive cocaine drug screen were also later noted in the medical records.

26. Following multidisciplinary consultation, it was determined that Mr LN's brain injury was not survivable. Mr LN was transferred to the intensive care unit for palliative management while his father travelled from the United Kingdom to visit with him.

27. At 4.50pm on 23 December 2023, Mr LN was neurologically assessed and found to be brain dead. Mr LN's father, DN, arrived on the evening of 23 December 2023. Life support was subsequently withdrawn, and Mr LN was verified deceased at 7.30pm on 24 December 2023.

28. In her statement to police following Mr LN's death, Ms TS noted that the banister in the communal stairwell was *"quite low"* and Mr LN was a tall man.

## FURTHER INVESTIGATION

29. According to Senior Constable (**SC**) Andrew Lawrence, Coronial Investigator, he attended the scene of Mr LN's fall on 14 March 2025 and measured the height of the handrail upstairs as 840 millimetres (**mm**).

30. SC Lawrence also obtained records from the City of Caulfield[8] which indicated approval to undertake renovations at 56 Kooyong Road, Caulfield North, was granted in 1992.

31. As part of my investigation, I obtained a statement from Steven Baxas, State Building Surveyor at the Office of the State Building Surveyor, as to whether the stairwell met the building code requirements for balustrades/ stair railings at the time the building was constructed and at the time of Mr LN's death.

### At the time of construction

32. Mr Baxas stated that it appeared the apartment building had been constructed in about 1960. At this time, the Uniform Building Regulations (**UBR**) were in force.

[8] Now known as Glen Eira City Council.

33. As at 26 April 1961, clause 2712 *Guards and Handrails* of the UBR required handrail height above the nosing of the treads (along the stair portion) to be 34 inches, equating to 863.6 mm. The handrail height required above the landing was 36 inches, equating to 914.4 mm. There were other provisions that required the handrail to be fixed on at least one side of the stair, and the regulations did not permit any obstructions on or above the handrails that would cause a break to a hand hold.

34. According to Mr Baxas, at the time of construction, it was the council's building surveyor who would have been responsible for ensuring that the building complied with the UBR code requirement, in accordance with the building permit process.

**Alterations to the building in 1992**

35. Records obtained by SC Lawrence indicate that alterations to the original building were approved in 1992.

36. The relevant regulations applicable at that time were the Victorian Building Regulations (**VBR**) and the Building Code of Australia (**BCA**) 1990 (amendment 1 as at April 1991 or amendment 2 adopted September 1991), which changed to a performance-based standard. Mr Baxas stated that this code included prescriptive requirements that were 'deemed to satisfy' the performance requirements.

37. Mr Baxas explained that for a stair that is enclosed or bounded by walls, a handrail is required to provide stability for the stair user, whereas a balustrade relates to an open stair which serves as a barrier which often incorporates a handrail, which provides stability for stair users. Mr Baxas noted that the plans obtained by SC Lawrence indicated that the alterations carried out affected the stairwell: *"The stair is bound by a wall on one side and open on the other side, therefore the barrier required to the open side to adopt balustrade requirements."*

38. The 'deemed to satisfy' requirements applicable at the time stated:

    (a) the balustrade is not less than 1 metre, where the difference in level is more than 1 metre but less than 3 metres;[9] and

    (b) the balustrade height within a stairway is 865 mm measured above the nosing of the stair treads[10].

[9] BCA 1990 (amdt 2), section D2, clause D2.16 (a) & (b) Balustrades.
[10] BCA 1990 (amdt 2), section D2, clause D2.16 (c)(i)(ii) Balustrades (where change in height is less than 3.0 metres).

39. For handrails, clause D2.17 stated that handrails must be provided where necessary to assist and provide stability to persons using a stairway and located to at least one side for stair widths less than 2 metres, and continuous between flights. The height of the handrail must not be less than 865 mm above the nosings of the stair treads and the floor surface of the landing and must not have any obstructions to break the handhold.[11]

40. Mr Baxas noted the following about the 1992 alterations to the building:

> *It is important to note that it appears that the stairs in this building were affected by the alterations undertaken in 1992. The regulations applicable at the time were the Building Regulations 1972 (amendment SL 1991 No 23 gazetted 1991 No S107) which required the alterations to comply with those regulations unless full compliance was not reasonably achievable or applicable. In these situations, the building surveyor was able to consent to partial compliance under certain conditions. The conditions for partial compliance at the time related to similar provisions as apply today, such as the volume and extension thresholds, as well as consideration for the ongoing fire safety of the building. From the documents provided, I cannot determine if the building Surveyor consented to partial compliance.*

**Current building requirements**

41. Mr Baxas explained that the current building requirements are within the National Construction Code (**NCC/BCA**) Volume 1 - 2022 (amendment 2), which is a performance-based code with 'deemed to satisfy' provisions. The performance requirement must be satisfied in order to achieve compliance.

42. The applicable performance requirements are as follows:

    (a) Stairways must have suitable handrails where necessary to assist and provide stability to people using the stairway;[12]

    (b) A barrier must be provided where people could fall 1 metre or more from a floor;

[11] BCA 1990 (amdt 2), section D2, clause D2.17 (b) Handrails.
[12] National Construction Code 2022, Volume One (amdt 2), Performance Requirement D1P2 Safe movement to and within a building. Specific requirements for stairs included in (c).

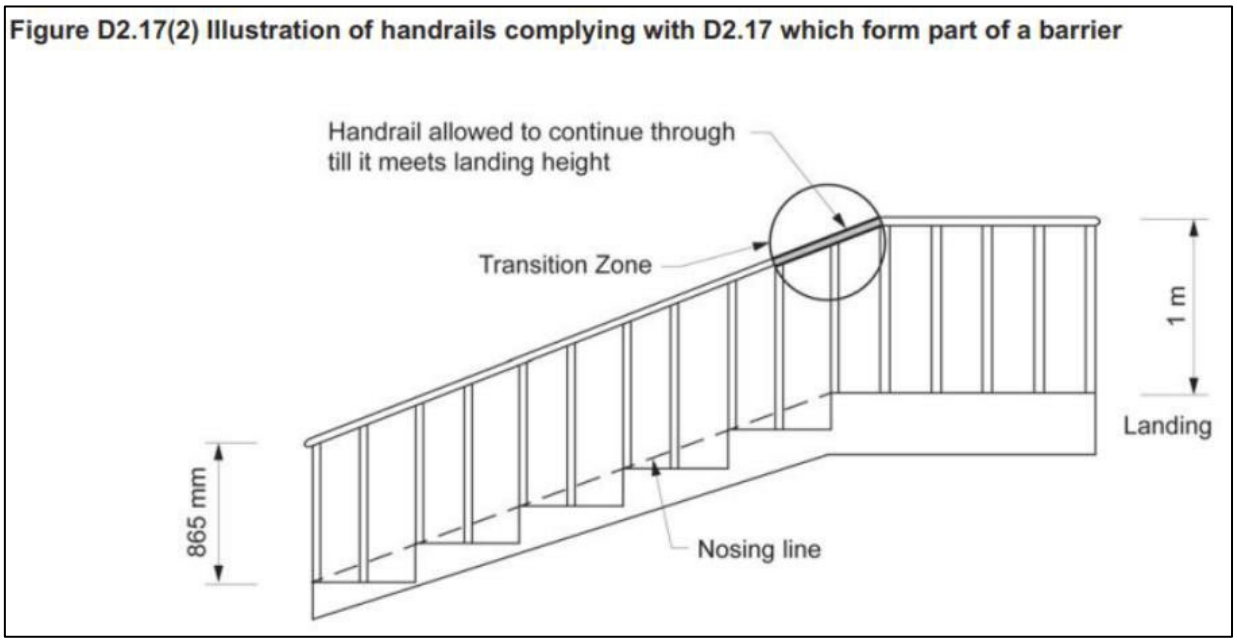
(c) A barrier must be continuous and extend for the full extent of the hazard and of a height to protect people from accidentally falling from the floor and constructed to prevent people from falling through the barrier;[13]

(d) For stairways and landings (to a stair where the barrier does not exceed 500 mm in length), the height of the barrier must be not less than 865 mm (for all other locations, 1 metre). For stairways, the height is measured above the nosing line of the stair treads;[14]

(e) For handrails located along at least one side of the flight, the height must not be less than 865 mm and be continuous between stair flight landings and have no obstruction on or above them that will tend to break a hand-fold. The height is measured above the nosings of the stair treats and the floor surface of the landing.[15]

43. Mr Baxas helpfully extracted the following illustration to explain the above requirements:[16]

**Figure D2.17(2) Illustration of handrails complying with D2.17 which form part of a barrier**




[13] National Construction Code 2022, Volume One (amdt 2), Performance Requirement D1P Fall prevention barriers.
[14] National Construction Code 2022, Volume One (amdt 2), Part D3 Construction of Exits, clause D3D18 Heights of Barriers.
[15] National Construction Code 2022, Volume 1 (amdt 2), Part D3 Construction of Exits, clause D3D22 Handrails.
[16] National Construction Code 2019, Guide to the BCA Volume 1, Fig D2.17(2) Illustration to show the required height of the handrail/balustrade within a stair.

**Whether there is a requirement for the stairway and balustrade at 56 Kooyong Road to be brought up to current standards**

44. Mr Baxas stated that generally, there is no requirement to bring existing buildings up to current building standards.

45. Buildings are only required to be brought up to current standards in the following events:[17]

    (a) when the building undergoes a change of use;

    (b) where the building is sub-divided;

    (c) in circumstances where an alteration to an existing building is proposed and the proposed alterations together with any other alterations completed or permitted within the previous 3 years, relate to more than half the original volume of the building; or

    (d) where alterations affect an exit or a path of travel to an exit.

46. In terms of who was responsible for enforcement of the building requirements, Mr Baxas indicated that since 1 July 1994 (post privatisation of building permits), it is the relevant building surveyor appointed to issue the building permit (this can be a private building surveyor or the Council Municipal Building Surveyor), who is responsible for the issue of the building permit.[18] However, the legislation also gives authority to the council to administer certain parts of the *Building Act 1993* even when a private building surveyor has been appointed for the building work.[19]

47. Mr Baxas explained that section 212(1) of the *Building Act 1993* provides that a council is responsible for the administration and enforcements of some parts of the Act and the regulations. Councils have broad powers that allow them to ensure building standards are maintained. Mr Baxas noted that typically, these council functions are delegated to the Municipal Building Surveyor. This provision applies to all buildings within a council's municipal district. Typically, a council will use these powers when they have been notified or, have observed or identified a noncompliance or a risk to building occupants.

[17] Building Regulations 2018, regulations 229 to 234.
[18] Building Act 1993 (No 126 of 1993), Part 3 – Building Permits, section 24 Refusal of building permit.
[19] Building Act 1993 (No 126 of 1993), Part 12 Building Administration, Division 5 Roles of Councils, section 212 Councils to administer building provisions in its municipal district.

## FINDINGS AND CONCLUSION

48. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was LN, born 9 December 1995;

    (b) the death occurred on 24 December 2023 at Alfred Hospital, 55 Commercial Road, Melbourne, Victoria;

    (c) the cause of Mr LN's death was traumatic intracranial haemorrhage sustained in an unwitnessed fall; and

    (d) the death occurred in the circumstances described above.

49. Mr LN suffered an unwitnessed fall on the evening of 21 December 2023 in which he sustained the fatal brain injury to which he later succumbed. Although unwitnessed, there is nothing in the available evidence to suggest that anyone else was involved in the fall or that he otherwise died in suspicious circumstances.

50. The available evidence supports a finding that Mr LN was intoxicated at the time of the fall and that his coordination, behaviour and reflexes were substantially affected and that his death was accidental.

51. The available evidence does not support a finding to the applicable standard of proof that the low balustrade or handrail in the stairwell contributed to Mr LN's fall, but this possibility is not excluded.

## COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

52. Evidence gathered by SC Lawrence's evidence supports a finding that the height of the handrail in the stairwell at 56 Kooyong Road currently measures 840 mm, which does not meet current building standards. It appears that renovations to the building in 1992 should have triggered an update to the handrail and balustrade to meet building requirements at the time, however there was provision for the building surveyor to consent to partial compliance. It is unclear whether this occurred in 1992.

53. Nevertheless, the height of the handrail and balustrade represents an unacceptable risk to residents and visitors to 56 Kooyong Road, Caulfield North. For this reason, this finding will

be distributed to both Glen Eira City Council and the building's owners' corporation (managed by Alliance Owners Corporation Management) for their information and consideration of remediation in the interests of public safety.

I convey my sincere condolences to the family and friends of Mr LN for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

TS
DN
Alfred Health
Alliance Owners Corporation Management
Glen Eira City Council
North London Coroner's Court
Senior Constable Andrew Lawrence, Victoria Police, Coronial Investigator

Signature:


Deputy State Coroner Paresa Antoniadis Spanos

Date: 28 January 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.