



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 002715

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of: Coroner Therese McCarthy

Deceased: **EKU**

Date of birth: **1970**

Date of death: 16 May 2024

Cause of death: 1(a) Multiple injuries sustained in a fall from height

Place of death: Emporium Melbourne
287 Lonsdale Street, Melbourne, Victoria

Keywords: Fall from height; Community Temporary Treatment Order; Mental Health; CPU

INTRODUCTION

1. On 16 May 2024, **EKU** was 53 years old when she was found deceased on the lower ground floor of the Emporium Melbourne Shopping Centre. At the time of her death, **EKU** lived in Middle Park, Victoria, with her mother, **██████████** and her sister, **██████████**
2. **EKU** was a graphic designer and ran her own graphic design business for several years working for various organisations in Melbourne. She later moved into the fashion and retail industries, having last worked at Feathers in David Jones.
3. **EKU** was a valued family member who was dearly loved and supported by her mother, her sisters and brothers, and her nephews.

MENTAL HEALTH CHALLENGES

4. **EKU** suffered many mental health challenges. Life was very painful at times, and she was plagued by delusional disorder and late-onset schizophrenia. She experienced paranoia which caused her to suffer distressing delusional thoughts. **EKU** ultimately stopped working in January 2024 due to a decline in her mental ill health.
5. **EKU** was assisted by several different mental health services. She spent time as an inpatient, was prescribed various medications, and it is observable, that no one could have been more motivated to stay well than **EKU**
6. In February 2022, **EKU** was admitted to the Inpatient Psychiatric Unit (IPU) at the Alfred after an intentional overdose reportedly in response to distress from psychotic symptoms. She had a follow-up at the Alfred Health St Kilda Road Clinic (SKRC) and was formally discharged from SKRC in August 2022. **EKU** then engaged with a private psychiatrist.¹
7. On 17 January 2024, **EKU** was admitted to the Alfred IPU due to an increase in her psychotic symptoms over the previous two months. She was highly distressed and reported chronic suicidal ideation, however, did not voice a plan or intent at that time.²
8. On 1 February 2024, **EKU's** care was transferred to the Brief Intervention Team at SKRC for ongoing management in the community. Her medications at that time were 1mg of

¹ Statement of Dr Morteza Jafarinaia, Consultant Psychiatrist, Alfred Health.

² Medical records, Alfred Health, Psychiatry progress notes recorded on 17 January 2024.

brexipiprazole³ daily and 5mg diazepam⁴ as needed. At a consultant psychiatrist review on 13 February 2024, EKU presented with ongoing psychotic symptoms with poor insight and psychosocial decline and agreed to increase her dosage of brexpiprazole to 2mg daily, but after a few days informed her case manager that she decided to revert to a lower 1mg dose.

9. EKU attended and engaged in psychology sessions at SKRC until her case manager and psychologist raised concerns in late April 2024 and early May 2024 of a deterioration in her mental state. EKU appeared to be suffering greater preoccupation and distress regarding her delusions, suicidal ideation without plan or intent, and lack of insight. EKU had also started to act on her delusions, meeting with lawyers and attending the police station.⁵
10. On 7 May 2024, EKU was seen by Consultant Psychiatrist Dr Morteza Jafarinia (**Dr Jafarinia**) who attempted to increase her subtherapeutic brexpiprazole dosage, however EKU declined any adjustment.⁶ SKRC held a clinical review meeting on 8 May 2024, with a plan to consider an assertive approach to treatment including consideration of placing EKU on an order for assessment and treatment in the community under the *Mental Health and Wellbeing Act 2022 (Vic) (MHW Act)* due to risk of further deterioration.⁷

THE CORONIAL INVESTIGATION

11. EKU's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008 (Vic) (the Act)*. Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person who immediately before their death was a patient within the meaning of the MHW Act is a mandatory report to the coroner.
12. 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.

³ Brexpiprazole is an atypical antipsychotic used to treat schizophrenia.

⁴ Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.

⁵ Statement of Dr Morteza Jafarinia, Consultant Psychiatrist, Alfred Health.

⁶ Medical records, Alfred Health, Psychiatry progress notes recorded on 7 May 2024.

⁷ Medical records, Alfred Health, Psychiatry progress notes recorded on 8 May 2024.

13. 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.
14. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of EKU's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.
15. In July 2025, I assumed carriage of the investigation into EKU's death after the retirement of then Coroner John Olle for the purpose of finalising the investigation and making findings.
16. This finding draws on the totality of the coronial investigation into the death of EKU 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.⁸

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

Circumstances in which the death occurred

17. Leading up to her death, EKU was very unwell. The day before her death on 15 May 2024, EKU was seen by her case manager and psychologist and placed on a Community Assessment Order under the MHW Act. She was reviewed by Dr Jafarinia, who formed the view that EKU was experiencing ongoing psychotic symptoms with subjective distress and fleeting thoughts of suicide, though she denied any current plan or intention. Dr Jafarinia considered that EKU had trouble appreciating the seriousness of her condition and was resistant to pharmacological treatment. She presented as teary and reported that she was disappointed to be placed on the order.⁹
18. A voluntary inpatient admission was discussed, however EKU declined due to her commitment to her current housesitting obligations. She was however accepting of

⁸ 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.

⁹ Medical records, Alfred Health, Psychiatry progress notes recorded on 15 May 2024.

community treatment and was placed on a Community Temporary Treatment Order (CTTO) under the MHW Act. EKV was provided with information regarding her medication options and contact information for the Crisis Assessment and Treatment Team and SKRC clinicians in case of emergency. EKV was also referred to The Alfred triage alert, with an appointment arranged for two days' time to review her medications. It was proposed that EKV be commenced on an oral antipsychotic before transitioning to a depot injectable antipsychotic. The team also obtained EKV's address while she was housesitting.¹⁰

19. At 8.39pm on 16 May 2024, EKV sent a text message to her sister [REDACTED] stating, "*what a shame, I was so looking forward to housesit. The community order ruined everything*".¹¹
20. Immediately after, at around 8.40pm, members of the public located EKV unresponsive on the lower ground floor of the Emporium Shopping Centre with serious injuries after she had fallen from the third floor above. Emergency services were contacted and attended, but sadly EKV could not be revived and was pronounced deceased at the scene.¹²
21. Closed-circuit television (CCTV) footage showed EKV walking to the balustrade on the third floor of the Emporium and looking over the balustrade before walking off while texting on her mobile phone. EKV then puts her mobile phone away, walks back to the balustrade, and proceeds over the balustrade, falling to the lower ground level below. The height of the fall was estimated by investigating Victoria Police members to be between 50 and 60 metres.¹³

Identity of the deceased

22. On 20 May 2024, EKV [REDACTED] born [REDACTED] 1970, was visually identified by her brother, [REDACTED] [REDACTED]
23. Identity is not in dispute and requires no further investigation.

Medical cause of death

24. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination on 17 May 2024 and provided a written report of her findings dated 20 May 2024.

¹⁰ Statement of Dr Morteza Jafarinia, Consultant Psychiatrist, Alfred Health.

¹¹ Coronial Brief, Photograph of text message sent by EKV to [REDACTED] on 16 May 2024.

¹² Victoria Police, Police report of death for the coroner dated 17 May 2024.

¹³ Coronial Brief, Statement of First Constable Daniel Abraham.

25. The post-mortem examination showed multiple lacerations and bruises, and a post-mortem computed tomography (CT) scan revealed fractures of the ribs, spine, pelvis, and limbs. The injuries sustained were consistent with the reported circumstances.
26. Toxicological analysis of post-mortem samples identified the presence of diazepam¹⁴ and its metabolite nordiazepam.
27. Dr Zhou provided an opinion that the medical cause of death was '*1(a) Multiple injuries sustained in a fall from height*'.
28. I accept Dr Zhou's opinion.

CORONERS PREVENTION UNIT REVIEW

29. The Coroners Prevention Unit (CPU) reviewed the care and treatment provided to **EKU** by Alfred Health.¹⁵
30. The CPU considered that the SKRC clinicians reacted appropriately to **EKU's** apparent deterioration in mental state and recognised the need for medication change to manage her increasing psychotic symptoms. Clinicians attempted to admit **EKU** voluntarily for close supervision during this medication change, however she was unwilling to be admitted and felt strongly committed to her house sitting.
31. **EKU** consistently denied suicidal plan or intent in the lead up to her death, and while her risk of suicide was exacerbated by her distressing delusions and dismay at being made the subject of a treatment order, she appeared willing to engage with the service and there was no indication that she was at imminent risk of harm. The CPU advised that placing **EKU** under a CTTO therefore afforded appropriate clinical oversight in the setting of her refusal of medication change, current risk, and recent deterioration while complying with least-restrictive principles.
32. The CPU was of the view that it was reasonable and patient-centred to provide **EKU** with medication options to consider. A wait time of two days before initiating medication was also reasonable given **EKU** did not appear to be at immediate risk of harm. The CPU did not

¹⁴ Adverse effects of diazepam include confusion, incoordination, physical dependence, sedation, and seizures in withdrawal. Overdose can cause ataxia, drowsiness, and muscular weakness.

¹⁵ The 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

identify any issues with the care provided to EKV or any prevention opportunities regarding her treatment in the community.

FINDINGS AND CONCLUSION

33. Pursuant to section 67(1) of the Act I make the following findings:
- a) the identity of the deceased was EKV born 1970;
 - b) the death occurred on 16 May 2024 at the Emporium Melbourne, 287 Lonsdale Street, Melbourne, Victoria, from *multiple injuries sustained in a fall from height*; and
 - c) the death occurred in the circumstances described above.
34. Having considered all of the circumstances, including EKV's level of distress, her history of dealing with chronic mental ill health including frightening delusions and psychosis, and the manner of her death, I am satisfied that EKV intentionally took her own life.

I extend my sincere condolences to EKV's family 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:

Senior Next of Kin

St Kilda Road Clinic

Consultant Psychiatrist Dr Morteza Jafarinia

Senior Constable Daniel Abraham, Coronial Investigator

Signature:



Coroner Therese McCarthy

Date: 29 May 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.
