FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: COR 2009 0655

Inquest into the Death of ALLEM HALKIC

Place of death:	West Gate Bridge, Port Melbourne, Victoria 3207
Hearing Dates:	17 October 2011 – 21 October 2011 and 25 November 2011
Appearances:	• Mr David Galbally QC with Ms Alix Osbourne - on behalf of the family (Madwicks, Lawyers) • Mr Trevor Wraight of Counsel - on behalf of VicRoads (DLA Piper) • L/S/C Remo Antolini, PCSU - Assisting the Coroner
Findings of:	Audrey Jamieson, Coroner
Delivered On:	27 June 2012
Delivered At:	Level 11, 222 Exhibition Street, Melbourne, 3000

FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST[1]

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

Court reference: COR 2009 0655

In the Coroners Court of Victoria at Melbourne

I, AUDREY JAMIESON, Coroner

having investigated the death of:

Details of deceased:

Surname:	HALKIC
First name:	ALLEM
Address:	6A Sheppards Court, Altona Meadows

AND having held an Inquest in relation to this death on 17 October 2011 – 21 October 2011 and on 25 November 2011

at Melbourne

find that the identity of the deceased was ALLEM HALKIC

and death occurred on 5 February 2009

at the West Gate Bridge, Port Melbourne, Victoria 3207

from:

1a. MULTIPLE INJURIES

in the following summary of circumstances:

1. On 5 February 2009, Allem Halkic[2] jumped from the West Gate Bridge in the vicinity of the Todd Road exit sign on the inbound lanes. Attending Police and Ambulance paramedics experienced difficulty finding Allem on the ground, under the Bridge. Once

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the investigation. The material relied upon included statements and documents tendered in evidence together with the transcript of proceedings and submissions of legal representatives and counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

[2] Mr and Mrs Halkic requested that their son be referred to as "Allem" during the course of the Inquest. For consistency I have endeavoured where possible to also use only his first name in this Finding.

located, resuscitation measures were implemented, however, Allem died from his injuries at the scene.

BACKGROUND CIRCUMSTANCES

2. Allem Halkic was 17 years old at the time of his death. He lived with his parents, Alijah (Ali) and Dina Halkic in Altona Meadows. He was an only child and had just commenced Year 12 at Paisley Bayside College, Newport. Allem had a medical history of Type I diabetes mellitus, diagnosed in May 2004. He had no history of mental ill health. He had a broad circle of friends and was well liked.

3. Since in or around December 2008, Allem had been in an intimate relationship with Ms Leah Sammut. The relationship was only known to a few because Ms Sammut was also in an ongoing three year relationship with Mr Milos Stojiljkovic, whom Allem had never met.

4. From late December 2008, a rift had been occurring between Allem and his close friend, Mr Shane Gerada.

5. Between 2 February 2009 and 3 February 2009, the rift between Allem and Mr Gerada deteriorated further with Mr Gerada sending a number of derogatory and threatening SMS messages to Allem's mobile phone.

6. On the evening of 4 February 2009, Allem had been at a friend's house playing poker. He returned home at approximately 10.30 pm and had a brief conversation with his father before retiring to his bedroom. Ms Sammut contacted Allem to advise him that Mr Stojiljkovic was aware of their relationship. Allem told Ms Sammut he thought he knew who had informed Mr Stojiljkovic.

SURROUNDING CIRCUMSTANCES

7. On 5 February 2009, at 1.01 am, Allem contacted Mr Gerada on his mobile. They spoke for 12 minutes. Subsequently, Allem contacted Ms Sammut and told her that Mr Gerada admitted to sending a 'Myspace' message to Mr Stojiljkovic about their relationship. Allem told Ms Sammut that it was his fault for the mess they were now in.

8. Between 1.20 am and 2.30 am Allem wrote a "suicide note" and left it on his bed. At 2.30 am Allem contacted a friend, Aaron Ellis, requesting to borrow Mr Ellis' car. He told his friend that he was "in trouble". Mr Ellis agreed to pick Allem up and take him to the Kentucky Fried Chicken (KFC) near the West Gate Bridge where Allem had told Mr Ellis that he had arranged to meet someone.

9. At approximately 3.30 am, Allem was picked up by Mr Ellis outside his own residence where Allem was waiting. Allem asked Mr Ellis to take him to a brothel before going to the KFC as discussed. At approximately 3.50 am Allem and Mr Ellis attended a brothel, "741" Geelong Road, Brooklyn and remained for approximately 40 minutes. At 4.34 am Allem and Mr Ellis left the brothel and proceeded to the KFC carpark, Todd Road, Port Melbourne.

10. At approximately 4.38 am, Mr Ellis left Allem at the KFC carpark on the understanding that Allem was being picked up by his uncle. Allem asked Mr Ellis not to tell anyone that he had dropped him there and he gave Mr Ellis $400.

11. At approximately 4.39 am, Allem commenced walking outbound on the West Gate Bridge on the inbound lanes on the left hand side next to the rail. He sent an SMS message to Mr Gerada and at 4.53 am, Allem used the VicRoads Emergency Phone (identification number 769[3]) on the Bridge initially advising the call-taker in the VicRoads Traffic Control Room[4], Mr Ian Collings, that there was someone walking on the Bridge. Mr Collings tried to elicit more information as to what the person was wearing and what direction he was walking. Allem only gave vague responses to the Mr Collings' questions then immediately before hanging up said:

> *You better get someone out here quick before I jump.*[5]

12. Mr Adam Eaton who was in the control room with Mr Collings, located Allem walking on the Bridge on camera 57.[6] At 4.53.30 am, Mr Collings called D24[7] advising them

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[3] The allocated number "769" encompasses three telephones all in the vicinity of Todd Road

[4] The control room is located at 60 Denmark Street, Kew

[5] Exhibit 3 – Statement of Ian Collings dated 9 April 2009, T @ p59.

[6] See Exhibit 4 – VicRoads map indicating cameras and phones on the West Gate Bridge in 2009.

[7] D24 is synonmous with Police Emergency Communications Centre which is also synonomous with ESTA (Emergency Services Communications Authority) who are the emergency call-takers who electronically transfer the information to the specific requested emergency service for despatching.

that there was a young male on the Bridge and the traffic management officers 'patched' the camera 'live vision' through onto the police's monitor at the Police Communications Centre.[8] Mr Eaton continued to watch Allem on the camera and kept moving the camera along as Allem was walking so that the police could simultaneously *keep an eye on him*.[9]

13. The Emergency services number, "000", received nine calls from motorists reporting a pedestrian on the Bridge.

14. At approximately 4.55 am, Senior Constable (S/C) Travaglini and Constable Janiw from Melbourne West Police Station were despatched to attend the vicinity of the West Gate Bridge inbound lanes as a matter of urgency as there had been a report of a male walking on the Bridge.[10]

15. At approximately, 4.57 am, S/C Travaglini and Constable Janiw arrived at the start of the outbound lanes of the Bridge.

16. At approximately 5.00 am, approximately 1.1 kilometres from the Todd Road Shell Service Station, Allem jumped from the West Gate Bridge by placing his hands on the railing and vaulting over feet first. He fell approximately 17.8 metres onto the ground below, landing in a fenced off area under the Bridge. Ambulance Paramedics were dispatched at 5.02 am and arrived at the Bridge at approximately 5.13 am and were searching the area below. At approximately 5.18 am, Allem was located by Police who alerted the paramedics to his whereabouts. On their arrival, the paramedics found Allem to be non-responsive with a weak pulse and with a diminished, irregular and laboured respiratory rate. Resuscitation attempts were initiated. Mobile Intensive Care Ambulance (MICA) paramedics had been dispatched at 5.02 am on a Code 2 - acute non-time critical[11]. They arrived at the Bridge at 5.20 am and were at the scene with Allem and the other paramedics at 5.26 am.

17. Resuscitation attempts continued under the supervision of the MICA paramedics.

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[8] Exhibit 5 – Statement of Adam Eaton dated 31 May 2009.

[9] T @ p76.

[10] Exhibit 23 – Statement of S/C Giovanni Travaglini.

[11] "An acute incident requiring an urgent response without warning devices. This is used for urgent but not time-critical life-threatening situations." (see Exhibit 31)

18. At approximately 5.40 am Allem was declared deceased.

JURISDICTION

19. At the time of Allem's death, the *Coroners Act* 1985 (the Old Act) applied. From 1 November 2009, the *Coroners Act 2008* (the new Act) has applied to the finalisation of investigations into deaths that occurred prior to the new Act commencement.[12]

20. In the preamble to the new Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety are referred to in other sections of the new Act.[13]

21. Section 67 of the new Act describes the ambit of the coroner's findings in relation to a death investigation. A coroner is required to find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.[14] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

22. A coroner may also comment on any matter connected with the death, including matters relating to public health and safety and the administration of justice.[15] A coroner may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with a death, which the coroner has investigated including recommendations relating to public health and safety or the administration of justice.[16]

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12 Section 119 and Schedule 1 - Coroners Act 2008

13 See for example, sections 67(3) & 72 (1) & (2)

14 Section 67(1)

15 Section 67(3)

16 Section 72(1) & (2)

Identification

23. The identity of Allem Halkic was without dispute and required no additional investigation.

INVESTIGATION

Medical Investigation:

24. Mr Alija Halkic lodged an Objection to Autopsy pursuant to section 29 *Coroners Act 1985* (as it then was).

25. On 6 February 2009, Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an external examination and reviewed a post mortem CT scan of Allem's body. The CT scan showed multiple injuries including bilateral pneumothoraces and severe facial fractures. Blood was also seen within the external auditory canal suggesting a fractured base of skull.

26. Dr Burke reported to the coroner that in the absence of a full post mortem examination, a reasonable cause of death could be attributed to multiple injuries.

27. The objection to autopsy was upheld.

28. Toxicological analysis did not detect any alcohol, common drugs or poisons.

Police Investigation:

29. The coronial investigation was placed in abeyance pending the finalisation of criminal proceedings against Mr Shane Gerada.

30. Mr Shane Gerada was charged with numerous criminal offences including Stalking, Use telecommunications device to harrass/menace, Intentionally threaten serious injury and Recklessly threaten serious injury. On 8 April 2010, in the Magistrates' Court of Victoria at Melbourne, Mr Gerada pleaded guilty to the stalking charge related to his communications with Allem between 2 February and 5 February 2009. He was convicted and placed on an 18 month Community Based Order. The remaining charges were withdrawn.

31. The conviction of Mr Gerada effectively dealt with, to the extent that was possible at the time, the "bullying" of Allem via telecommunications or cyber-bullying.

Request for Inquest

32. Mr Alijah Halkic lodged a Request for Inquest under section 52(5) *Coroners Act 2008.* Without repeating all the particulars contained in the Request and other correspondence, Mr Halkic raised a number of concerns about the safety of the West Gate Bridge including matters related to the "delay" in the construction of safety barriers.

Coroners Prevention Unit:

33. In an attempt to address some of the matters raised by Mr Halkic, I requested the Coroners Prevention Unit[17] (CPU) to undertake research on the following issues of concern connected with the death of Allem:

- The nature and frequency of jump from height suicide in Victoria, in particular:
  - jump from height suicide at the West Gate Bridge compared to other locations; and
  - preliminary findings on the frequency and location of jump from height suicide and after the Inquest, to include the frequency of rail suicide in Victoria since the construction of safety barriers on the West Gate Bridge.
- The time line for planning and construction of safety barriers on the West Gate Bridge.

34. The CPU research report produced from my request is attached to this Finding in **Attachment A**. In summary, this research identified that the West Gate Bridge has been the site of approximately a third of jump from height suicides in Victoria between 2000 and 2012. Recommendations made by coroners into suicides at the West Gate Bridge between 2004 and 2006 resulted in the establishment of the West Gate Bridge Strengthening Alliance (WGBSA), with VicRoads as the lead agency. VicRoads

[17] The Coroners Prevention Unit was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research on issues connected with death under investigation and in relation to the formulation of prevention recommendations, as well as assisting in monitoring of coroners' recommendations.

executed due diligence in addressing concerns expressed by members of the WGBSA with respect to:

- movement of the suicide problem to another location; and
- how erecting barriers would impact the structural stability of the West Gate Bridge.

35. An assessment was undertaken of the likelihood of the movement of the suicide problem to another location if safety barriers were installed at the West Gate Bridge. The advice from this assessment was that a suicide shift was unlikely. In response to the second concern, the WGBSA determined that the sides of the West Gate Bridge needed to be strengthened before barriers could be installed. VicRoads commissioned a detailed analysis to establish how this strengthening would be achieved.

36. In January 2008, the Victorian Government announced a $120 million "West Gate Bridge strengthening project", which was expected to be completed by mid 2011. I was advised that the works were intended to sufficiently strengthen the sides of the Bridge to allow the subsequent installation of safety barriers.

37. The installation of temporary public safety barriers began in April 2009 and were operational by June 2009. A design for permanent public safety barriers was finalised by March 2010. The Coroners Court of Victoria was advised by VicRoads on 9 May 2012 that the permanent safety barriers were complete and operating as intended. Additional measures introduced by VicRoads included night-time security patrol of the West Gate Bridge, which involved a continuous circuit patrol across and below the Bridge. There was also increased monitoring of the West Gate Bridge with CCTV.

38. Jump from height suicides at the West Gate Bridge declined sharply following the installation of the temporary safety barriers. The average annual frequency declined from 10.5 deaths before the temporary safety barriers were installed, to 1.6 deaths after the temporary safety barriers were installed. In addition, a decline in the average annual frequency was observed for all jump from height suicides. At locations other than the West Gate Bridge, a temporary increase in the average annual frequency was observed. This appears to have been restricted to 2010. An examination of rail suicides before and after the installation of the temporary safety barriers showed no change in average annual frequency of deaths.

39. At the time the Inquest was ready to proceed, the research undertaken by the CPU revealed that the construction being undertaken on the West Gate Bridge effectively negated the need for a public hearing into the lack of safety barriers at the time of Allem's death. It was, and is, acknowledged that the West Gate Bridge had become a common site for suicide by jumping and accounted for a significant proportion of all suicides by jumping in Victoria. The Coroners Court of Victoria has held a longstanding interest in preventative measures to reduce their incidence.

INQUEST

40. A Mention Hearing was held on 28 February 2011 and a Directions Hearing was held on 28 March 2011.

41. An Inquest was held pursuant to section 52(1) *Coroners Act 2008*. The issues identified as requiring further examination through a public hearing included:

- Communication between VicRoads and the emergency services;
- The response times of emergency services;
- Access to the area under the West Gate Bridge by emergency services, and
- The mechanisms in place in February 2009 for detecting pedestrians on the Bridge.

Viva voce evidence was obtained from the following witnesses:

- Doctor Michael BURKE, Forensic Pathologist, Victorian Institute of Forensic Medicine
- Mr Ian COLLINGS, Traffic Management Officer, VicRoads
- Mr Adam EATON, Traffic Management Officer ,VicRoads
- Ms Emily JEFFRESS, Ambulance paramedic, Ambulance Victoria
- Mr Nicholas CHAPMAN, Ambulance paramedic, Ambulance Victoria
- Mr Colin JENNER, MICA paramedic, Ambulance Victoria
- Sergeant Steven DUFFEE, Victoria Police
- Acting Sergeant Joanne O'HARA, Victoria Police (Senior Constable at the time)
- Constable Shaun TOLLIDAY, Victoria Police

- Senior Constable David MALLOCH, Victoria Police (Constable at the time)
- Senior Constable Louise CONNELL (nee ANGELOVICH), Victoria Police (Constable at the time)
- Acting Sergeant Giovanni TRAVAGLINI, Victoria Police (Senior Constable at the time)
- Leading Senior Constable Peter SHRIMPTON, Victoria Police (Constable at the time)
- Detective Senior Sergeant Stephen COOPER
- Mr Anthony BALM, Manager Quality Review Team, Ambulance Victoria
- Mr Kevin DEVLIN, VicRoads
- Mr Nial FINNEGAN, VicRoads
- Detective Senior Constable Sally WEBBER, Victoria Police Investigating Officer (Senior Constable at the time)
- Mr Alijah HALKIC

FINDINGS and COMMENTS

Medical evidence

42. Dr Burke informed the Court that he had requested Dr Chris O'Donnell, Consultant Forensic Radiologist to review the CT scan that Dr Burke had himself reviewed at the time of his external examination in February 2009. Dr O'Donnell provided an email report back to Dr Burke on 13 October 2011. A copy was tendered into evidence[18]. Dr O'Donnell identified an extensive list of injuries including diffuse brain oedema and swelling suggestive of hypoxic/ischaemic injury to the brain and probable air embolism within the heart. Dr Burke stated:

> *The importance of the air embolism is that if Allem died of air embolism, it doesn't matter what time the ambulance officers arrived, he would have died.*[19]

[18] Exhibit 2 – Email report from Dr Chris O'Donnell dated 13 October 2011

[19] Transcript of Proceedings (T) @ p18 (Dr Burke)

43. In relation to features of hypoxic ischaemic injury to the brain identifed on CT scan by Dr O'Donnell, Dr Burke stated:

> *So he has a significant brain injury. If your question is if the ambulance officers had (sic) have been there 10 minutes earlier I don't think it would have made any difference at all.*[20]

44. Despite the additional information about Allem's injuries provided by Dr O'Donnell's CT scan report, Dr Burke saw no basis on which to alter the cause of death in the absence of a full post mortem examination. He confirmed that multiple injuries accurately reflected the cause of Allem's death. Dr Burke emphasised his opinion that Allem's injuries were not survivable regardless of the time paramedics got to him. He said that if air embolus played a role then it could have occurred at anytime including at a hospital. Allem's death was inevitable given the extent of his injuries.

Detecting pedestrians on the West Gate Bridge

45. Allem set off from the Shell Service Station on Todd Road at approximately 4.39 am, heading outbound on the inbound lanes. He was not detected in the VicRoads control room until he used "Help Phone 769". The two Traffic Management Officers on duty overnight in the Control Room have a number of monitors displaying traffic flow at different locations to "keep an eye on". They are not designed to pick up pedestrian movement and it was dark[21] at the time Allem walked up onto the Bridge. The primary purpose of the cameras on the Bridge is for traffic management.[22] They are designed for live vision only and are not designed to record.

Response to Allem's telephone call from the Bridge

46. The particular phone used by Allem – "Help Phone 769" was immediately identified on the computer monitor screen in the control room[23]. Mr Collings stated that he would not have seen Allem on the Bridge in the absence of receiving his telephone call, however, the call was of significant importance to the Traffic Management Officers to allocate immediate resources in trying to locate Allem with the use of the Bridge cameras and

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[20] T @ p19 (Dr Burke)

[21] T @ p65

[22] Exhibit 3 – Statement of Adam Eaton dated 31 May 2009

[23] T @ p 31

notifying D24. Mr Collings was also using a camera to try to locate Allem while he was on the phone to D24.[24] Once Mr Eaton informed Mr Collings that Allem had gone over the side of the Bridge, their on-call Incident Management Officer was contacted so that he could make his way to the Bridge to provide access to Emergency Services underneath the Bridge. The Incident Management Officer held keys to the gate which enable access to this restricted area.[25]

47. Mr Collings made the call to D24 within 30 seconds of receiving the call from Allem.

48. I am satisfied and find that the response by the VicRoads employees, Mr Collings and Mr Eaton was timely, efficient and appropriate having regard to the limited resources available to them to monitor pedestrian traffic on the Bridge.

49. The response by D24 was immediate. They had the information of the "Help Phone 769" used by Allem and they received the "live" imaging from the VicRoads Control Room. Police were despatched with priority. S/C Travaglini and his partner activated lights and sirens and were at the Bridge within approximately 2 minutes. They had just started travelling up the Bridge in the outbound lanes when they received an update over their communications system that Allem had jumped.[26] A location of "below the Todd Road exit sign" was given[27] by way of a further update.[28]

Locating Allem and access under the Bridge

50. The area under the Bridge was difficult to traverse due to the uneven terrain, shrubbery and the lack of lighting. Cameras located under the Bridge at the time were not night vision cameras and there was insufficient illumination at night which would have enabled them to be utilised in the search for Allem.[29] It was a dark environment and Allem had landed in a fenced off area.[30]

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[24] T @ p 45

[25] Exhibit 3 & T @ pp 30-31 (Ian Collings)

[26] T @ p 279 (Giovanni Travaglini)

[27] T @ p 268 (Giovanni Travaglini)

[28] T @ p 280 (Giovanni Travaglini)

[29] T @ p80 (Adam Eaton)

[30] T @ p 122 (Nicholas Chapman)

51. S/C Travaglini and his partner, Constable Janiw stopped and alighted from their police vehicle close to the first "Todd Road Exit" sign on the inbound lanes. Another police vehicle was already there. S/C Travaglini then headed down the Bridge towards the next and last "Todd Road Exit" sign and when he looked over the rail of the Bridge he could see two other Police officers on foot headed towards the location directly below him. At approximately 5.15 am, S/C Travaglini located Allem by shining his flash light onto the ground below. S/C Travaglini believed that he could see Allem's head moving from left to right. S/C Travaglini remained in this position, shining his torch down to provide additional illumination for the members on the ground and subsequently, ambulance paramedics.

52. S/C Joanne O'Hara and Sergeant Duffee were the police members on the ground seen by S/C Travaglini and the first to be in the location of Allem. Sergeant Duffee helped S/C O'Hara through a cyclone fence to get to Allem. S/C O'Hara attended to Allem believing he was still alive. She spoke to him, *to comfort him in case he could, on the off chance, hear.*[31] She could see blood in his mouth and tried to put him in the recovery position as he started to make gurgling sounds. As she was attempting this, another officer, Constable Peter Shrimpton appeared by her side and assisted S/C O'Hara to roll Allem over into the recovery position.

53. At approximately 5.13 am, Ambulance paramedics Emily Jeffress and Jim Coates were the first paramedics to arrive at the West Gate Park carpark. They had travelled from the Ambulance service's Altona branch on a Code 1,[32] over the Bridge and exiting at the Todd Road exit as instructed by their dispatch centre. They located an empty Police vehicle in the carpark and liaised with the South Melbourne ambulance crew[33] who had also been dispatched on a Code 1[34] and arrived soon after. Between them the paramedics decided that Ms Jeffress and Mr Coates would take off on foot towards the

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[31] T @ p 199 (Joanne O'Hara)

[32] *A Code 1 response is a response without delay, with lighs and sirens* – T @ p 97 (Ms Jeffress) & Exhibit 31

[33] The South Melbourne crew was paramedics Nicholas Chapman and graduate paramedic, Nick Korkliniewski.

[34] T @ p 131 (Mr Chapman)

Bridge carrying their gear,[35] while the South Melbourne crew drove off down Wharf Road[36] to try to find Allem and another way in under the Bridge.[37]

54. Sergeant Duffee headed back to the carpark to alert the ambulance paramedics as well as radioing it through that they had located Allem and that they needed para-medical assistance. Sergeant Duffee was the 251[38] in-charge at the scene. He met up with Ms Jeffress and Mr Coates and led them back to where Allem had been found.

55. The South Melbourne ambulance crew returned to the West Gate Park carpark and initially took off on foot towards the underneath of the Bridge but the driver returned to their vehicle and subsequently obtained access under the Bridge through the opened gates while Mr Chapman continued on foot, carrying equipment and a torch, across the terrain and through the fence which had been cut,[39] and located Allem, his collegues and police.

56. MICA paramedic Colin Jenner and his partner had been dispatched from Footscray on a Code 2[40] because the location of Allem was not known at the time of despatch and the MICA unit was backing up the other units.[41] On their arrival at the West Gate Park carpark, they were led through the rough terrain carrying their equipment, by a police officer.[42] The MICA paramedics assumed control of the resuscitation endeavours of Allem. The other paramedics continued to assist under the direction of the MICA paramedics. The decision to stop resuscitation attempts was made by the MICA

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[35] The paramedics carried three pieces of equipment, an oxygen cylinder with a closed circuit attached to it (weighing approximately 12 kilograms), a cardiac monitor and a trauma bag – T @ p106 (Ms Jeffress).

[36] T @ pp 121-122

[37] T @ p 121 (Mr Chapman)

[38] "251" is the supervsing sergeant for the relevant area on a shift.

[39] T @ pp 126-128

[40] *Code 2* is described as *Acute non time critical* – T @ p 139 (Colin Jenner) & see Exhibit 31: "An acute incident requiring an urgent response without warning devices. This is used for urgent but not time-critical life-threatening situations."

[41] T @ p 136-137 (Colin Jenner) and see Exhibit 31

[42] T @ p 136

paramedics on their assesment that Allem's injuries appeared to be incompatible with life.[43]

57. The emergency medical management of Allem by Ambulance paramedics was not in question. By all accounts they assessed and implemented appropriate measures in a timely and professional way. Their endeavours to render emergency medical assistance to Allem was conducted by the torch light of Police members at the scene and S/C Travaglini from on top of the Bridge.

58. St Kilda Road Police Station covers the West Gate Bridge. Detective Senior Sergeant Cooper informed the Court that at the time of Allem's death there was one set of three keys to the West Gate Bridge lower gate located at the section sergeant's office in the St Kilda Road Police Station.[44] There was no specific protocol at the time but "station instructions" on their use which was primarily for a "planned response". Detective Senior Sergeant Cooper stated that a potential suicide on the Bridge was not a planned response but an emergency. He said:

> *That's an unplanned response (sic) which would turn into a planned incident on the way.*[45]

59. Once it was known that Allem had jumped, the keys at St Kilda Road Police Station could have been sought however, VicRoads were the primary source of access.[46]

60. The West Gate Bridge Protocol[47] was sent to the other stations in the local area of the West Gate Bridge, that is Melbourne West Police Station and Melbourne East Police Station on 25 March 2009, prior to the erection of the temporary safety barriers and reference in the protocol to the "traffic light keys" being capable of unlocking the gate was added to the protocol after the erection of the temporary safety barriers.[48] Neither the protocol or the capacity of the traffic light keys was in existence at the time of Allem's death.

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[43] T @ p 140

[44] T @ p 328 (Stephen Cooper)

[45] T @ p 343 (Stephen Cooper)

[46] T @ p 349

[47] Exhibit 15 and Exhibit 29

[48] T @ p 329 (Steven Cooper)

61. Access under the Bridge for attending police and Ambulance paramedics was not straightforward. But there are many reasons for this and the difficulties encountered in finding Allem cannot be simply attributed to a lack of keys or an awareness about the availability of keys, to the gate on Todd Road. At the outset it was not entirely clear where Allem had gone over the side of the Bridge, the location being difficult to pinpoint due to the event having only been seen via the VicRoads camera. There were no reports of direct eyewitnesses and although none of the attending emergency services personnel had previously attended an incident underneath the Bridge, I am satisfied that they were all focussed and intent on finding Allem as quickly as possible.

62. The cameras on the Bridge provided no ongoing assistance in the pursuit to locate Allem. They are intended for traffic management, not for looking at, or for people. According to Mr Collings they are *designed for broad scale viewing, not finite viewing.*[49] Furthermore, the cameras in the Control Room have no ability to record an incident. Their capacity was restricted to real time monitoring and *in exceptional circumstances you may take a screen print, as you would on your computer*[50] which would provide a *snapshot* of the incident.

63. Increased security at the Bridge has also been influenced by the declaration of the Governor in Council in March 2007 that the West Gate Bridge is an 'essential service' for the purposes of Part 6 of the *Terrorism (Community Protection) Act* 2003. VicRoads as the operator of the Bridge has an obligation under this Act to protect the essential service from the effects of terrorist acts and requires the operator to prepare a risk management plan which must contain *a plan of the measures to be undertaken to prevent or reduce the risk including ensuring the physical security of key infrastructure.*[51] In meeting these obligations VicRoads now consults with, and trains in mock emergency situations with a wide range of agencies.[52]

64. There have been significant changes at the Bridge since Allem's death that are not directly related to his death but should prevent a like incident. The project of change and meeting its obligations under the *Terrorism (Community Protection) Act* 2003

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[49] T @ p 37

[50] T @ p 40

[51] S.31(b) *Terrorism (Community Protection) Act* 2003

[52] 25 November 2011- T @ p16

forecasts that there will be a permanent security person under the Bridge, there will be a boom gate situation where there will be provision for remote access and a person there to facilitate that access 24 hours per day, seven days a week.[53]

Evidence of Planning

65. The weight of the evidence supports a finding that Allem had a planned course of action. Following his telephone conversation with Mr Gerada, Allem has written a "suicide note" indicating an intention to take his own life. Later, Allem attended a brothel in Brooklyn before being dropped at the KFC carpark by Mr Ellis at 4.38 am. At least two hours elapsed from writing the note and Allem using the VicRoads emergency "Help phone 769" wherein he informed Mr Collings that he was going to jump. Seven minutes elapsed between that call and Allem placing himself over the side of the Bridge and jumping. If Allem's call is to be interpreted as a "call for help", seven minutes is a relatively short period of time to enable anyone to effectively intervene or break the chain of events that Allem had set in train particularly when regard is had to the location of the events.

66. At the outset to the Inquest, the evidence of Dr Burke was revealing and in part, reduced the need for interrogation of the response times of Ambulance Victoria. The nature of injuries sustained in the fall were such that Allem's death underneath the West Gate Bridge, was not preventable – earlier arrival of ambulance paramedics would have made no difference to the outcome.

67. In final submissions I was urged by Counsel for the family to make findings that the delay for the family hearing this evidence caused *unnecessary emotional and mental trauma which could have been avoided* and that *it is necessary to find a more efficient and expedient manner of dealing with these issues, so that families can move on very quickly in the full knowledge of what occurred, and not be left with lingering doubt, suspicion and rumours for any lengthy period of time.*

68. I accept that any delay to the completion of an investigation can add to the already burdening distress of a family who find themselves involved in the coronial jurisdiction. The reasons for delay can be manifold and include the practice adopted by the Court to await the outcome of criminal proceedings before a decision is made about whether an Inquest is warranted in the circumstances. Once that decision is made to proceed to

[53] 25 November 2010 – T @ p15

Inquest, it is trite to give the impression that listing a lengthy matter can occur immediately. Once that decision is made, the *viva voce* evidence of witnesses is the appropriate course for addressing issues of concern for a family and/or other interested parties. In this investigation, with respect to the evidence of Dr Burke, I acknowledge that his evidence has had an impact albeit distressing, but I cannot say whether the impact would have been lessened by reading it in a report. I cannot say whether reading it, rather than hearing it would have lessened the distress for Mr and Mrs Halkic when other issues remained in question. Only they know the answer to that.

69. With the benefit of hindsight, if I, or any other party, had considered that the Halkic family's distress would have been alleviated or indeed minimised by knowing the full extent of Dr Burke's *viva voce* evidence, the question of Allem's survivability could have been sought from Dr Burke prior to the Inquest.

CONCLUDING COMMENTS

70. The loss of a life by suicide compounds the grieving and sense of loss by family, friends and loved ones. More questions arise for those affected by a death by suicide than those that are affected by a death in circumstances of a medical condition or long term illness. The unanswered questions do not only revolve around the precipitating events to the deceased's decision but often to questioning how the preciptitating events could have been perceived with such significance as to influence the deceased's actions. Commensurably, questions around why the deceased did not demonstrate a changed mental state or articulate distress, anxiety, an inability to cope – why did family, friends and loved ones not notice that something was wrong. Regrettably, these questions often remain unanswered for the grieving regardless of the thoroughness of an investigation. The loss of a child or young person by suicide manifestly intensifies this unenviable position for family, friends and loved ones of the deceased. It remains a mystery why Allem felt unable to endure or "ride through" the bullying threats about his relationship with Ms Sammut when, as far as I have been able to ascertain, he had a loving family and many friends that could have supported him - if only he had called upon them to do so. Allem's death is indeed a tragedy.

71. As previously indicated, this Inquest did not explore the precipitating factors to Allem's decision making on the night of 5 February 2009. The accepted precipitating factors

were the series of threatening SMS messages Allem received from Shane Gerada along with his use of a social media website. Criminal proceedings against Mr Gerada for these threats rendered the issue of "cyber bullying" in Allem's death no longer appropriate to be examined further at the Inquest. This should not, however, be interpreted that I do not consider "cyber bullying" to currently be an immeasurable societal problem affecting the health and safety of many, in particular, the young. Mr Halkic and others have been outspoken in the call for the creation of specific offences for bullying and "cyber bullying" and the legislature has already responded and made some changes[54] to the law since Allem's death. Whether the criminal law or access to civil damages is the appropriate means for dealing with this societal problem that often involves and affects very young children is a matter of current debate but given the limited scope of this investigation, not something that I can comment on save to say that it is the role of the coronial system to contribute to the reduction of preventable deaths and promote public health and safety.

FINDING AS TO CAUSE OF DEATH

I accept and adopt the medical cause of death as identified by Dr Michael Burke and find that Allem Halkic died from multiple injuries sustained when he jumped from the West Gate Bridge on 5 February 2009.

AND I further find that Allem's actions were with the intention of taking his own life.

AND I am unable to find that Allem would not have taken his own life on this night if safety barriers had been in place. It would be speculative to conclude that he would not have adopted some other means and as such I cannot make a finding that his death was preventable on that night.

[54] See *Crimes Amendment (Bullying) Act 2011*

AND I find that Allem's death was no longer preventable once he jumped from the Bridge near the "Todd Road Exit" because the nature and extent of his injuries were not survivable. The factors that hampered emergency personnel locating Allem, including the knowledge/availablity of keys to the locked gate, are regrettable but I find that they made no difference to the outcome.

AND I make no recommendations in this matter as I am satisfied that the substantive issues related to Allem's death including the "cyber bullying" of him, the construction of safety barriers on the West Gate Bridge and access for Emergency Services to the restricted area under the Bridge, have been addressed and/or steps put in place to minimise the risk of like deaths. Based on an analysis of suspected suicides investigated by the Coroners Court of Victoria I am satisfied that since the installation of safety barriers on the West Gate Bridge, jump from height suicides have not increased at other locations nor increased the frequency of rail suicides as recently reported in the media. These deaths continue to be monitored by the Coroners Court of Victoria and the CPU engages in ongoing consultation with responsible government departments and public health and safety agencies to keep coroners appraised of the nature and frequency of these deaths and the presence and efficacy of potential suicide prevention strategies.

AND I acknowledge the research assistance of the Coroners Prevention Unit in this matter.

Pursuant to section 73(1) of the **Coroners Act 2008**, this Finding will be published on the internet.

I direct that a copy of this finding be provided to the following parties for their information:

- Mr Alijah and Mrs Dina Halkic

- The Hon. Robert Clark, MP
  Attorney-General of Victoria
  Level 26, 121 Exhibition Street
  Melbourne Victoria 3000

- The Hon. Mary Wooldridge, MP
  Minister for Community Services
  Minister for Mental Health
  Minister for Women's Affairs
  Level 22, 50 Lonsdale Street
  Melbourne Victoria 3000

- The Hon. Terry Mulder, MP
  Minister for Transport
  Level 16, 121 Exhibition Street
  Melbourne Victoria 3000

- Dr Ruth Vine
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  Level 17, 50 Lonsdale Street
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- Dr Rosemary Lester
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- Mr Greg Sassella
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- Mr Jim Betts
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- Ms Janet Dore
  Chief Executive Officer
  Transport Accident Commission
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- Mr Gary Liddle
  Chief Executive Officer
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  60 Denmark Street
  Kew Victoria 3101

Signature:

AUDREY JAMIESON
CORONER
Date: **27 June 2012**