IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 0412

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*

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

I, AUDREY JAMIESON, Coroner having investigated the death of DANIEL CHRISTIAN MCKINDLEY

without holding an inquest:

find that the identity of the deceased was DANIEL CHRISTIAN MCKINDLEY

born 10 August 1975

and the death occurred on 29 January 2016

at Rosalind Park, View Street, Bendigo Victoria 3550

**from:**

1 (a) INJURIES SUSTAINED IN FALL FROM HEIGHT

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

1. Daniel Christian McKindley was 40 years of age at the time of his death. He had a 16 year old son and lived at a boarding house, Mitchell Lodge in Bendigo. Mr McKindley suffered from chronic back pain, anxiety and depression.

2. At approximately 6.00am on Friday 29 January 2016, Mr McKindley was located by three passers-by at the bottom of Poppet Head Lookout tower in Rosalind Park, Bendigo. Mr McKindley was lying on some rocks at the base of the tower. Emergency services were

contacted and police attended shortly afterwards. It was apparent that Mr McKindley was deceased.

## INVESTIGATIONS

3. By way of Form 8, issued pursuant to section 24 of the *Coroners Act 2008* (Vic) and dated 3 February 2016, fingerprint identification conducted by Victoria Police was used to determine the identity of the deceased as Daniel Christian McKindley.

*Forensic pathology investigation*

4. Dr Matthew Lynch, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination upon the body of Mr McKindley, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Anatomical findings were consistent with the known mechanism of injury. Toxicological analysis of Mr McKindley's post mortem blood identified alcohol at a concentration of 0.21g/100mL[1] and delta-9-tetrahydrocannabinol (THC).[2] Dr Lynch ascribed the cause of Mr McKindley's death to injuries sustained in a fall from height.

*Police investigation*

5. Upon attending the Rosalind Park in Bendigo, Victoria Police did not identify any signs of third party involvement. Police noted that the Poppet Head Lookout tower is approximately 25 metres tall, with two other levels at approximately eight metres and 16 metres above ground. There was a locked gate on the stairs of the tower which prevented access from climbing the tower, unless it was climbed around. Due to Mr McKindley's location upon landing, police believed he had fallen from the 16 metre high platform. Police located a learner's permit, mobile phone, a picture and a note with Mr McKindley.

6. Senior Constable (SC) Rodney Webster, the nominated coroner's investigator,[3] conducted an investigation of the circumstances surrounding Mr McKindley's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*,

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[1] This compares with the 0.05g per 100ml being the legal limit for blood alcohol concentration for fully licensed car drivers.

[2] Delta-9-tetrahydrocannabinol (THC) is the active form of cannabis (Marijuana). Persons under the influence of cannabis will experience impaired cognition (reasoning and thought), poor vigilance and impaired reaction times and coordination.

[3] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

statements made by his son Christian McKindley, co-residents at Mitchell Lodge Jamie Nugent and Terry Campbell, and General Practitioner at Bendigo Primary Care Dr Gaurav Singh.

7. General Practitioner Dr Gaurav Singh reported that he saw Mr McKindley five times between 30 June 2015 and 22 October 2015. Over the course of the consultations, Mr McKindley confided that he was suffering from symptoms of major depression and anxiety due to chronic back pain and social issues. Dr Singh completed a mental health plan on 15 September 2015, and commenced Mr McKindley on anti-depressant medication, mirtazapine and referred him to a psychologist. Mr McKindley denied any suicidal ideation, plans or thoughts. On 22 October 2015, Mr McKindley's anti-depressant medication was changed to sertraline, as the mirtazapine had not been helpful. Dr Singh noted that Mr McKindley seemed compliant with his medical management. He was advised to return in two weeks for a follow-up appointment, but never returned.

8. In the course of the investigation, police identified that Mr McKindley had lived in a 12-room, boarding-house style accommodation at Mitchell Lodge in Bendigo for three years. He had been trying to find alternative accommodation in which his son could stay over, but was unable to relocate and was frustrated by what he perceived to be a lack of assistance in achieving this objective.

9. Christian McKindley stated that he last saw his father on 23 January 2016. He exchanged a number of messages with his father on 28 January 2016, in which they discussed spending time together. Through the messages, Mr McKindley emphasised that he wanted to spend more time with Christian.

10. Co-resident at Mitchell Lodge, Jamie Nugent reported that during the evening of 28 January 2016, Mr McKindley came into his room crying. Mr McKindley told him he had been talking to his son. Mr Nugent stated that Mr McKindley was concerned that his son preferred to spend time with his mother's new partner, rather than him. Mr Nugent stated that were subsequently drinking throughout the evening; Mr McKindley was not a big drinker and seemed more affected than usual. They also used some marijuana. At approximately 10.00pm they went into co-resident Terry Campbell's room. Mr Nugent said that by this point Mr McKindley seemed fine about his son and did not mention the issue again. Mr Campbell stated that while Mr McKindley initially seemed a bit depressed, he started to lighten up as the night went on. When Mr Campbell went to bed at approximately 2.00am on 29 January 2016, they returned to Mr Nugent's room.

11. Mr Nugent said that he and Mr McKindley had another drink and talked about going to the Murray River the next day. He reported that Mr McKindley seemed excited about doing some camping and fishing. At 3.00am, Mr Nugent went to bed and Mr McKindley left his room.

12. At approximately 6.30am on 29 January 2016, Mr Campbell went to the bathroom down the hallway and found a piece of paper laying on the floor under his door. It contained a goodbye note and his key card, with a pin number.

13. At approximately 10.00am on 29 January 2016, Mr Nugent located a box outside his door, containing Mr McKindley's computer.

*Further correspondence*

14. By way of email dated 28 January 2017, SC Webster provided further information to the Court. SC Webster advised that the City of Greater Bendigo Council is responsible for the safety and upkeep of the Poppet Head Tower. The gates are locked every night at dusk, and are opened each morning at approximately 7.30am.

15. SC Webster opined that while there is no easy way to access the tower when the gates are locked, it is possible to climb around the gates. He added that while the fencing on the tower makes it safe for adults and children to be able to use the tower for its intended purpose, the fencing does not appear designed to keep someone out who is intent on climbing the tower.

16. SC Webster added that even if the gates were to change, a person would be able to self-harm while the gates were unlocked during the day. He noted that the only way to make the tower completely safe would be to shut off all public access. SC Webster noted that the Poppet Head Tower is a tourist attraction in the area, and it would be unfortunate if this were to occur.

*Coroners Prevention Unit review*

17. Following the receipt of the coronial brief, I asked the Coroners Prevention Unit (CPU)[4] to review the circumstances surrounding Mr McKindley's death, in particular whether there had been previous deaths associated with the Poppet Head Tower.

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[4] 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.

18. The review identified that the top of the three platforms on the Poppet Head Tower has a large fence around its perimeter, and its fence is angled, making it difficult for people to climb over. However, the bottom two platforms, at eight and 16 metres above ground each have a small fence.

19. A data search indicated that between 1 January 2000 and 30 January 2017, two additional deaths occurred after individuals jumped from the Poppet Head Tower. It was identified that each of the three people who died at this location, including Mr McKindley, lived in close proximity to, or frequented the Bendigo area. The review noted that Poppet Head Tower is one of only 21 locations Victoria-wide that have had three or more jumping related deaths since January 2000.

**FINDINGS**

The investigation has identified that Mr McKindley suffered from depression and anxiety in the months leading up to his death. The precise precipitating factors that led Mr McKindley to adopt the course of action he ultimately chose on the morning of 29 January 2016, cannot be identified with any degree of certainty. However, on the evidence available to me, it appears that Mr McKindley's depression and anxiety, as well as concerns relating to the state of his accommodation and the perception that it was impinging on his ability to see his son, were contributing factors. The significant level of alcohol identified in Mr McKindley's blood is also worthy of note.[5]

I accept and adopt the medical cause of death as identified by Dr Matthew Lynch and find that Daniel Christian McKindley died from injuries sustained in a fall from height, in circumstances where I find he intended to take his own life.

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[5] The association between alcohol consumption and suicide is not entirely clear. Theoretically, consumption of alcohol may influence suicide due to the depressant influence of the substance itself, or acute alcohol intoxication contributing to disinhibited or impulsive behaviours, or alternatively, self-medicating with alcohol may prevent an individual from developing more functional coping strategies. See: Schilling, E., Aseltine, R., Glanovsky, J., James, A. and Jacobs, D. (2009) *Adolescent alcohol use, suicidal ideation, and suicide attempts.* Journal of Adolescent Health, vol 44(4), pp 335-341.

## RECOMMENDATIONS

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

1. With the aim of improving public safety and preventing like deaths, **I recommend** that the City of Greater Bendigo Council conduct a feasibility study to assess whether safety enhancements can be made to the Poppet Head Tower, for example, but not limited to, erecting suicide prevention barriers on each platform.

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

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

Ms Kerry Henstridge
Mr Gary McKindley
Dr Gaurav Singh, Bendigo Primary Care
City of Greater Bendigo Council
Suicide Prevention Australia
Senior Constable Rodney Webster

Signature:

AUDREY JAMIESON

CORONER

Date: **28 February 2017**