IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 5287

REDACTED FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of David Yannick HOLLINGSWORTH

without holding an inquest:
find that the identity of the deceased was DAVID YANNICK HOLLINGSWORTH
born on 4 September 1982
and the death occurred on 11 December 2012
at Jolimont Reserve, Wellington Parade South, East Melbourne

from:

1(a) GUNSHOT INJURY TO THE HEAD.

Pursuant to section 67(2) of the *Coroners Act 2008*, I make findings with respect to the following circumstances:

INTRODUCTION AND PERSONAL CIRCUMSTANCES

1. David Yannick Hollingsworth was born in Les Lilas, France on the 4 September 1982. He was the much loved son of Marie Josie Hollingsworth and step-son of Trevor Hollingsworth. Trevor and David's mother married in 1989. Trevor raised David as his own son and David took the family name of Hollingsworth.
2. David attended De La Salle Secondary College until the he was 15 -16 years of age. He then attended the Christian Brothers' College in St Kilda. David left school at the age of 17 and completed an apprenticeship as an electrician. He continued in that trade and operated his own business for a number years.

3. In December 2011 David travelled to France to meet his biological father after having no contact for the previous 28 years. The meeting did not go as well as David had hoped due to language barrier difficulties.
4. In February 2012 David returned to Melbourne and was distressed to find a large amount of unpaid traffic fines that had accumulated over a long period and he did not know how he was going to pay the fines. David spoke with his mother and requested her help because he felt there was something 'exploding' in his head. David was very depressed, not working and spent a lot of time staying in his room. Consequently, in the same month, David was taken to the Alfred Hospital for assessment, but not admitted.
5. In March 2012 David was assisted by the Salvation Army to secure accommodation at a boarding house situated at room 4/56 Hemmings Street, Dandenong. David resided at that address until the time of his death.

PURPOSE OF A CORONIAL INVESTIGATION

6. The purpose of a coronial investigation into a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.
7. The broader purpose of a coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role. Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These are effectively the vehicles by which the prevention role may be advanced.
8. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation.
9. Detective Sergeant Graham Ross of the Homicide Squad was the coroner's investigator, assisting me by undertaking the investigation and preparing the coronial brief of evidence.

10. In discharging my statutory functions under the Coroner's Act 2008, in particular section 67, the coronial brief contains sufficient evidence to allow me to find David's identity (section 67(1)(a)); his cause of death (section 67(1)(b)) and the circumstances within which he died (section 67(1)(c)), without conducting an inquest.

11. On 13 December 2012, David was formally identified by ante mortem and post mortem fingerprint comparison.

12. On 12 December 2012 Dr Matthew Lynch of the Victorian Institute of Forensic Medicine, conducted an external examination of David at the mortuary and concluded that the death was due to a gunshot injury to the head. I adopt his cause of death as a finding of fact.

13. Toxicology analysis of David's blood revealed ~0.01 mg/L Mirtazapine (antidepressant) and ~0.06 mg/L Tramadol (narcotic used in the treatment of severe pain).

THE CIRCUMSTANCES IN WHICH DAVID'S DEATH OCCURRED

Events leading up to David's death

14. On 8 December 2012 David had an x ray taken due to his concern that he may have prostate cancer. On the same day David visited his mother at her home, and spoke to her about being depressed and she advised him to wait until the week had passed and she would then arrange for him to fly back to France for another holiday. During this conversation, David said "*I wish that someone could help me because I feel that I want to kill myself, if I had a gun I would do it*". David's mother offered him support and encouraged him to be positive.

15. In the afternoon, David made contact with his cousin, Sonia Joachim-Miller (Sonia) and later attended at her home. During this visit Sonia formed the view that David was depressed and troubled. At one stage when David was outside having a cigarette, Sonia contacted Directline and spoke to the operator to whom she advised her cousin was having suicidal thoughts and was depressed. Sonia asked the operator if she could hand the telephone to David for them to speak to him, however she was advised they could not speak to him unless he agreed to talk or he called them. David was not aware of this telephone call.

16. When David was leaving he turned to Sonia and said *"you know what I need, I need a gun...I just want it to be over"*. Sonia provided David telephone numbers for Beyond Blue and Directline on a piece of paper, together with instructions on what he should tell the operator when making contact.

17. David told Sonia that he would go for a walk and make the call later to seek help. The telephone number for Directline was found stored in David's Iphone and investigations

suggest that a call was made on 8 December, 2012 but the duration of the call suggests no connection was made.

18. At 11.30pm Sonia received a call from David during which he told her that he was on the train tracks at Noble Park railway station. Sonia pleaded with David to get off the tracks and to attend at the Clayton railway station where she would meet him. Approximately 20 minutes later, David rang Sonia and told her he was at Clayton railway station, however when she arrived she could not locate him.
19. During another telephone call, David told Sonia he was near the Bunnings store in Notting Hill and said he was going to walk home. Sonia did not have any further contact with David until the next morning, after she made a number of telephone calls to try and speak to him. During the telephone call David told her he was alright. This was the last time Sonia spoke to David.

9 December 2012

20. On Sunday, 9 December 2012, investigations of David's Myki card and CCTV footage reveal that at 9.53am he attended Flinders Street railway station. Shortly thereafter, at 10.23am, he attended Parliament railway station and left at 10.31am.
21. At approximately 3.00pm David went to his mother's house in East Malvern and asked if she could take him to Bunnings. David's mother states that she drove David to the Bunnings store in Notting Hill to get some plaster because he wanted to fix the hole in the roof of his room. In the evening, David's mother spoke with him on the telephone.

10 December 2012

22. On Monday, 10 December 2012, investigations of David's Iphone reveal that he travelled through various suburbs, most likely on the train. David also made a number of telephone calls on this day, but not all calls were answered.
23. During the day David's mother drove him to the doctor where he was advised that he did not have cancer. David's mother, as a result of serious concerns for her son, made a 24 minute telephone call to Lifeline and requested the operator call David to speak to him. The Lifeline operator advised that they could not speak to David unless he rang them.

11 December 2012

24. On Tuesday, 11 December 2012 at 10:30am, telephone records of cell locations indicate that David's mobile phone was in the Dandenong vicinity when he called his mother.

25. At 12:45pm David's mother made a telephone call to him and he advised her that he had been to Centrelink or was going to Centrelink.
26. CCTV depicts that at approximately 2.30pm David got off a Pakenham train at Parliament railway station. David exited the station, walked in the vicinity of Spring Street and crossed the road outside the Windsor Hotel.
27. Around this time PSO Aquilina, whilst performing general security duties at Parliament House, was approached by a female that reported a male she believed was acting strangely and had been hanging around in the nearby park. The female believed the male was either watching her or following her and she requested PSO Aquilina walk her back to her workplace.
28. On the description provided and having viewed the CCTV, I find that David was the male the female raised concerns about to PSO Aquilina.
29. At 2.40pm PSO Aquilina contacted the PSO control room and reported David's actions and requested he be monitored on CCTV and another PSO be deployed. Whilst under observation David did not approach anyone else; except for PSO Aquilina to ask for directions. A short time later, David re-approached PSO Aquilina again asking him for directions and if he had a cigarette. PSO Aquilina gave David directions and he walked away. Also at this time PSO Dixon arrived to provide additional security at Parliament House.
30. CCTV reveals that at 2.50pm David went back to Parliament railway station.
31. At 2.52pm PSO Aquilina contacted police communications and enquired if there had been any reports to keep a look out for any suspicious males matching the description of David.
32. At 3.00pm PSO Aquilina returned to the PSO control room where he briefed his supervisor about David and that he believed he may have been following females. The afternoon shift PSO members where briefed about the male and were advised to contact police communications if he returned to the vicinity. PSO Vongvixay was not present during this briefing.
33. PSO Vongvixay commenced his shift performing parliamentary sitting duties before being redeployed to undertake general patrol duties due to a shortage of personnel. He was not briefed on the events that had occurred earlier in the day, including the interaction between David and PSO Aquilina.
34. Despite a thorough investigation by Detective Sergeant Graham Ross, including checking bank records, Myki records and CCTV, it is not known what David did when he was last seen at Parliament House at 2.50pm until when he returned at 8.27pm.

Immediate circumstances in which the death occurred

35. At 8.27pm PSO Vongvixay was performing security duties at Parliament House when David approached him, standing in the vicinity of the Parliament steps and the vehicle carriageway. David asked PSO Vongvixay for directions and CCTV depicts PSO Vongvixay to point in the direction of Collins Street.
36. At 8.28pm David struck PSO Vongvixay with a hammer, removed his firearm from its holster and then ran south along Spring Street.
37. At 8:30pm Victoria Police attended Parliament House in response to a telephone call that a male had assaulted a PSO with a hammer, taken his firearm and then fled the scene. At 8.31pm Ambulance Victoria received a telephone call to attend Parliament House.
38. At approximately 8.40pm numerous reports were made to 000 of a noise consistent with a gunshot.
39. At 8:45pm, while searching the surrounding area to locate David, Senior Constable Singh observed him lying prone and motionless at the Jolimont Reserve situated at the intersection of Wellington Parade South and Charles Street, Melbourne East. The firearm was located approximately one metre away from David's body.
40. I find that David shot himself at approximately 8:40 pm with PSO Vonvixay's firearm and there is no evidence of any third party involvement.
41. Despite extensive media attention, Victoria Police have been unable to identify any witnesses or CCTV that identify the approximately 1.1km route taken by David from Parliament House to Jolimont Reserve.
42. On Wednesday 12 December 2012 at 3.48am David was certified deceased by Dr Ramantham at the Western General Hospital.

FAMILY CONCERNS

43. At the directions hearings on 8 January and 4 December 2013, David's mother appeared in person and raised a number of concerns. After the first directions hearing, David's mother confirmed her concerns, in a letter dated 20 February 2013, to be:
    - The media's reporting of her son's death and publishing photographs of him deceased;
    - The failure to secure support from '000' and '13 11 14';
    - the Victoria Police's response to the report by the female that David was behaving in a suspicious manner;

- the Alfred Hospital discharging her son without any follow up.

44. I will address each of these concerns below.

Media reporting after the death

45. David's mother's main concern was the role that the media played after her son's death. At the directions hearing on 8 January 2013 she stated, *"David was stressed. David did not mean maybe to kill this man but the media is killing me. First, when you battle cancer and you see on the big plasma TV the whole body of your son is bad. His clothes that he wear. Your Honour, I can't sleep. I can't do nothing. I can just see the face of my son".*

46. The media's reporting of this case, whilst showing a lack of respect for both David and David's family by publishing the deceased body, is not something I am able to make any recommendations in relation to, because I am limited by the *Coroners Act 2008* in what I can investigate and find.

Police response to David being reported as behaving in a suspicious manner:

47. At the directions hearing on 8 January 2013, David's mother stated, *"David first was at two o'clock - 2.30 in the city. Apparently he have - some woman have concern about his up and down and they went and tell it to a policeman or someone who was working but what I would like to know if someone have report to the police what - that they have concern about David. What did the police have done from two to eight.....What I'm concerned too was who have been after the police (indistinct) my son home, OK, because the police have say to me a few things when I went. I did not see so it means someone have been in it. And what I'm concerned the most is, Your Honour, what was the police was doing from two to eight. That is my concern."*

48. Whilst it was reported that David was behaving in a suspicious manner, he was monitored on CCTV and there was no evidence to suggest that Victoria Police could arrest him for any offences.

49. However, I do find that David was not following females in the vicinity of Parliament House on 11 December 2012. Whilst, there is no direct evidence, I find that David attended at Parliament House to obtain a firearm.

PSO's working alone

50. At the directions hearing on 8 January 2013, David's mother stated, *"Certainly why it was one person only working at the Parliament House. If it is two-person maybe David will not go ask*

him because another one will see him. My son is gone. I just have his remains but I just do it for the next people.....My big concern, why it was one person only working. Why when this woman went to the police and said, "This man looks suspicious" - he could carry a bomb. Your Honour, we are lucky that the man is alive but if David was a murderer and he have a bomb - it could be your son, your wife, me, everyone of the media; we don't know. So the police or the people - like I said, the police they are very nice. I have nothing; I'm just speaking my mind. What they have done it could be a catastrophe if David had a bomb in his bag. Lucky that he want to take his own life but that's the type of things I want to protect in the future for this type of things to don't happen."

51. David's death highlights the health and safety risks of PSO's and police officers working alone (commonly referred to as working 'one-up'). Prior to, and including 11 December 2012, on a non-parliamentary sitting day it was normal for three PSOs to be rostered on a shift at Parliament House.
52. Since this incident, the Protective Services Division of Transit and Public Safety Command (PSD) has assigned five (5) PSO's to Parliament House per shift. All patrol duties including duties on the front steps are now conducted two-up.
53. Additionally, PSD has addressed the issue of members not being aware of relevant information and incidents occurring during the shift. Since this incident, in conjunction with a verbal handover, a written daily briefing information sheet has been introduced to ensure an effective communication process is available to all members rostered for duty at Parliament House.'
54. PSD worked closely with WorkSafe Victoria and Victoria Police to implement the above changes to patrol practices. The improvements to communication, staffing numbers and the requirement to work 'two-up' received a positive response from WorkSafe Victoria.
55. PSD has also amended the divisional Standards of Practice relating to patrol practices to reflect the above changes.
56. I find that the changes introduced by PSD since this incident does not warrant me making any recommendations.
57.

Lifeline

58. At the directions hearing on 8 January 2013, David's mother stated "*I have phoned the Hotline the day before David die and they said to me, look - they did not respond of my phone call that I was a bit concerned that he was depressed. And I said to them I'm scared that my son take his life. Please give him a call because the son they don't listen to their mum or their*

dad when they are depressed, but if someone phone that's going to make a difference. We are not here to phone them, there is the number, so that was my response."

59. The coronial brief contains a statement from Thilibni Perera, the company secretary for Lifeline that states it is not within the Service's charter to provide a call-back service. The primary reason for this is Lifeline does not have the resources to facilitate such a service.

60. Ms Perera states *'If there is a third party who is suicidal, the Crisis Supporter will strongly encourage the caller to get the person at risk to contact Lifeline or another service (such as their GP, emergency department, 000), so that they can receive the assistance required. Our Crisis Supporters are prohibited from making calls to any third parties. If the caller or a third party is at imminent risk (i.e. about to harm themselves or have already harmed themselves), the Crisis Supporter must consult with their in-shift Support Supervisor who will make the decision about whether to contact Police.'*

61. Lifeline is a valuable service for vulnerable people in need. I find that Lifeline's response to David's mother's telephone contact was appropriate in the circumstances.

Why the Alfred Hospital discharged her son without any follow up?

62. David was taken to the Alfred Hospital in February 2012, assessed for mental health issues, but not admitted. I find that the involvement of the Alfred Hospital is too far removed in time from David's death to warrant any further investigation as to whether his assessment was within the parameters of reasonable health care management.

COMMENTS

63. David's death highlights the insidious nature of mental illness and the difficulty in predicting when an individual is at risk of crossing the suicide threshold. Prior expressions of intent can rapidly go out of date and thus be less helpful as an indicator of future behaviour. There is a significant mortality rate for people suffering mental illness, with the individual's actions frequently being impulsive. Distressingly, despite the continuous support of his loving family, the tragic outcome could not be prevented.

I direct that a redacted copy of the finding be published on the internet.

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

- Josie and Trevor Hollingsworth.
- Chief Commissioner of Police.
- Detective Sergeant Graham Ross, Homicide Squad, Coroners Investigator.

Signature:

IAIN WEST
DEPUTY STATE CORONER
Date: 19 December 2013