FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 4794/07

Inquest into the Death of GERARD PATRICK O'BRIEN

Delivered On:	25th March, 2011
Delivered At:	Coroners Court of Victoria, Level 11, 222 Exhibition Street, Melbourne, 3000
Hearing Dates:	13th September, 2010
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Ms Sarah HINCHEY of Counsel to assist the Coroner, instructed by Guild Lawyers Ms MELIS on behalf of Victoria Police Ms O'REILLY on behalf of VicRoads

FORM 37

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

Court reference: 4794/07

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname: O'BRIEN
First name: GERARD
Address: 19 The Strand, Moonee Ponds, Victoria 3039

AND having held an inquest in relation to this death on 13th September, 2010

at Melbourne Magistrates Court

find that the identity of the deceased was GERARD PATRICK O'BRIEN born on the 1st May, 1974

and that death occurred on the 25th November, 2007

at the Westgate Bridge, Port Melbourne, Victoria 3207

from: 1a. INJURIES SUSTAINED IN A FALL FROM A HEIGHT

in the following circumstances:

INTRODUCTION & PERSONAL BACKGROUND

1. Mr O'Brien was a thirty-four year old single man who shared a house in Moonee Ponds with two friends and worked in the telecommunications industry for the last five years of his life. He was raised in the Warnambool area, the second youngest of ten children and had indifferent health during his early years. As an adult he suffered from gout with regular flare-ups causing him pain and restricted movement, and from September 2006, was diagnosed with moderately severe renal impairment which required regular prescription medications and specialist review. Nevertheless, Mr O'Brien was generally well, attended a gym and walked regularly.

2. He was not without personal difficulties. As at the date of his death, Mr O'Brien's driver's licence had been cancelled and he was disqualified from obtaining another licence as a consequence of drink driving offences and other driving offences occurring earlier in 2007.[1] These offences appear to have occurred at a difficult time in Mr O'Brien's life when he was thought to be abusing prescription medications in conjunction with excessive alcohol, in the context of relationship difficulties and personal crises. The latter included threats to take his own life, on one occasion explicitly referring to jumping from the Westgate Bridge, and on others making more general and/or implicit threats.[2]

EVENTS ON 25 NOVEMBER 2007

3. On Sunday 25 November 2007, Mr O'Brien was in a red Holden Commodore sedan in the Port Melbourne at around 1:00am when he was observed by an ambulance officer who formed the belief that he was intoxicated and reported the matter to police. A divisional van was despatched and, after observing Mr O'Brien's vehicle for a short time, attempted to intercept him in Todd Road. When he failed to pull over, a pursuit ensued along the outbound lanes of the Westgate Freeway and up onto the Westgate Bridge. Mr O'Brien pulled over to the left and stopped near the top of the bridge with the police some 200-300 metres behind at that stage. They tried to stop close enough to his vehicle to prevent him getting out, but Mr O'Brien managed to get out, reach the bridge railing and climb up onto it.[3] Leading Senior Constable Michael Aston tried to stop Mr O'Brien by calling out and reached him only in time to grab the back of his shirt which tore away as he fell to his death on the ground some 60 metres below.

INVESTIGATION

4. This finding is based on the totality of the material the product of the coronial investigation of Mr O'Brien's death, that is the inquest brief compiled by Detective Sergeant Wayne Woltsche from the Homicide Squad of Victoria Police, additional statements provided by Acting Inspector Raaymakers and Senior Sergeant Gibson from Victoria Police, the testimony of those witnesses who testified and any documents tendered through them during the inquest, and the submissions of counsel. All this material, together with the inquest transcript, will remain on the coronial file.[4] I do not purport to summarise all the material/evidence in this finding, but will refer to it only in such detail as is warranted by its forensic significance and the interests of narrative clarity.

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1 See VicRoads Certificate under section 84 of the *Road Safety Act 1986,* which appears as Exhibit 13 in Exhibit "J" the balance of the inquest brief.

2 Statements of Mr Shaun Solier at page 95 & Mrs Jan Solier at page 100 of inquest Exhibit "J".

3 Statement of LSC Ashton at pages 31-38 of inquest Exhibit "J", statement of Const Suarez at pages 39-44 of inquest Exhibit "J" and transcript of her evidence at 22 and following.
NOTE: Since March 2009, temporary safety barriers have been installed on the Westgate Bridge which prevent or at least impede ready access to the railing, with a significant reduction in the number of *jump from height suicides* at this location.

4 Access to the coronial file may be sought pursuant to section 115 of the *Coroners Act 2008.*

PURPOSES OF A CORONIAL INVESTIGATION

5. The purpose of a coronial investigation of a *reportable death*[5] is to ascertain, if possible, the identity of the deceased person, the cause of death, and the circumstances in which the death occurred.[6] The *cause* of death refers to the *medical* cause of death, incorporating where appropriate 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]

6. The broader purpose of coronial investigations 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,[8] 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 or 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.[9] These are effectively the vehicles by which the prevention role is advanced.[10]

7. It should be noted that a Coroner is explicitly prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence. However, the Director of Public Prosecutions must be notified if the Coroner believes an indictable offence may have been committed in connection with the death, and the Coroner may refer to such notification in a finding or comment.[11]

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5 The *Coroners Act 2008,* like its predecessor the *Coroners Act 1985,* requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death in section 4 includes all deaths that appear *"to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury".* Clearly, Mr O'Brien's death falls within this definition.

6 Section 67(1) of the *Coroners Act 2008,* which applies to the coronial investigation of Mr Peysack's death. All references to legislation which follow are to the provisions of the *Coroners Act 2008* unless otherwise stipulated.

7 See for example Harmsworth v The State Coroner *[1989] VR 989;* Clancy v West *(Unreported 17/08/1994, Supreme Court of Victoria Harper, J.)*

8 This "prevention role" is now explicitly articulated in the Preamble and Purposes of *the Act* - see section 1(c). Whilst the Coroners Act 1985 did not explicitly refer to the coroner's prevention role, the implicit and generally accepted purpose of coronial investigations under that Act was the prevention of similar deaths in the future.

9 See sections 21(1), 19(2) and 21(2) of the *Coroners Act 1985* regarding "reports" "comments" and "recommendations" respectively.

10 See also sections 73(1) & 72(5) of *the Act* which requires publication of coronial findings, comments & recommendations and responses respectively; sections 72(3) & (4) which oblige the recipient of a coronial recommendation to respond within 3 months specifying a statement of action which has or will be taken in relation to the recommendation.

11 This is the combined effect of sections 69 & 49(1).

UNCONTENTIOUS MATTERS

8. In relation to Mr O'Briens' death, a number of the matters required to be ascertained, if possible, are uncontentious, namely his identity, the medical cause of death, and as regards the circumstances in which he died, the date and place of death, and the intentional nature of the act which resulted in this death. I find as a matter of formality, that Mr Gerard Patrick O'Brien born on the 1 May 1974, late of 19 The Strand, Moonee Ponds, died at the Westgate Bridge, Port Melbourne, shortly before 2:00am on Sunday 25 November, 2007.

9. An autopsy and ancillary investigations were undertaken by Senior Forensic Pathologist Dr Noel Woodford from the Victorian Institute of Forensic Medicine (VIFM) who also reviewed the circumstances as reported by police to the Coroner. Dr Woodford found multiple chest injuries, multiple limb and skull fractures and lacerations to several internal organs, including the pericardium, heart, liver and kidneys. Dr Woodford attributed the medical cause of Mr O'Brien's death to *injuries sustained in a fall from a height* and commented that the nature, distribution and severity of the injuries was in keeping with being sustained as the result of a fall from a considerable height onto a firm surface.[12] He noted that the results of postmortem toxicological analysis revealed a blood alcohol concentration of 0.13g/100ml but no other commonly encountered drugs or poisons.[13] Based on Dr Woodford's autopsy report, I find that the cause of death is *injuries sustained in a fall from a height.*

10. Another aspect of the circumstances which was not contentious, certainly by the commencement of the inquest, was that Mr O'Brien had jumped or fallen with the intention of taking his own life. A finding that a person intentionally took their own life, is not lightly made, but the available evidence does support such a finding here. Apart from the evidence already mentioned, that is the evidence from the Soliers of threats made by Mr O'Brien to take his own life and the fact that he was a disqualified driver who had been drinking, Det Sgt Woltsche identified a number of other aspects of a life unraveling which may have contributed to Mr O'Brien's decision to take his own life.[14] Although there was no definitive suicide note, a number of documents found amongst his personal property after his death indicated that Mr O'Brien may have been contemplating taking his own life for some time.[15]

THE CIRCUMSTANCES IN WHICH DEATH OCCURRED - THE "PURSUIT"

11. The focus of the coronial investigation/inquest was on aspects of the circumstances in which the death occurred, namely -

- the role played by the police pursuit, if any, in Mr O'Brien taking his own life,

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12 Dr Woodford also made findings indicative of a mild degree of renal impairment consistent with the diagnosis made in September 2006 and treatment thereafter.

13 I note that the blood alcohol concentration was 0.017g/100ml in vitreous humour which is considered more stable/accurate in postmortem samples.

14 These are conveniently summarised by Det Sgt Woltsche at page 9/10 of the inquest brief summary - inquest Exhibit "J".

15 See Exhibit 8 in inquest Exhibit "J" and statement of James O'Brien, the deceased's brother who found them at page 77.

- the appropriateness of the pursuit by reference to applicable Victoria Police policies, and,
- whether there were any viable alternatives to a pursuit.

12. While family members were aware that Mr O'Brien was unhappy with life and even somewhat depressed, they were unaware that he was at risk of suicide or self-harm.[16] Without the benefit of hindsight, the investigation revealed nothing in Mr O'Brien's movements or behaviour in the hours immediately preceding his death to raise concerns for his welfare in his house mates.[17] When last seen by one of his house mates, Mr Kevin Delaney, in the afternoon of 24 November 2007, Mr O'Brien was leaving home with a slab of beer and was assumed to be going to a party.[18]

13. Other than what can be gleaned from telecommunications records obtained by the police, Mr O'Brien's movements and actions thereafter are largely unknown from the time he left home in the afternoon of 24 November until about 1:00am on 25 November. The telecommunications records indicate that Mr O'Brien sent a text message, by way of a "stir" to Mr Delaney at 6:14pm regarding the federal election results. At 7:29pm he used his mobile to call an escort agency which he had used previously, but did not make a booking. This call was made via the Port Melbourne phone tower, while two later calls made at 9:34pm and 10:49pm to the Herald Sun "Your Say 50/50" phone line were made via the St Kilda phone tower. No record of the content of these two calls was available.[19] Whilst the content of the latter two calls is not known, the text message and the making of the phone calls are, in my assessment, ambivalent or neutral as to any imminent intention to take his own life.

14. Ambulance Paramedic Mr Tim Dorey was with his partner Mr Jason Quick at the KFC outlet at about 1:00am on 25 November 2007. As the ambulance was too large to use the drive through lane, Mr Dorey walked up to the drive through window and apologised to Mr O'Brien who was the driver already at the window for "jumping the queue". Mr Dorey's evidence was that Mr O'Brien did not seem to register that he had been spoken to, and appeared impaired, in the sense of intoxicated. Mr Dorey noticed an open bottle of beer on Mr O'Brien's lap. After a brief discussion with his partner, they both saw Mr O'Brien drive out of the KFC car park and head south towards Todd Road.

15. Mr Dorey notified the police. He stated that Mr O'Brien was travelling at an estimated speed of 100kph and saw him turn left into Todd Road and right into the Perce White Reserve near Sandridge Beach. The ambulance did not continue to follow Mr O'Brien but waited in the vicinity for the police to arrive.[20] Consistent with Mr Dorey's evidence that his primary concern

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16 Statements of James O'Brien and Maureen O'Brien at pages 77 & 86 respectively of inquest Exhibit "J".

17 Statements of Chris Thomas and Kevin Delaney at pages 64 & 70 respectively of inquest Exhibit "J".

18 Statement of Kevin Delaney at page 71 of inquest Exhibit "J".

19 Exhibit 6 of inquest brief Exhibit "J" and statements of relevant call receivers at pages 70 & 74.

20 Exhibit "A" and transcript pages 7 and following. Clearly, they did not know the identity of the driver at the time but had ascertained with a registration search that it was registered to a seventy year old male.

was that the driver was intoxicated, police were despatched on the basis that ambulance personnel had followed a drunk driver (described as "quite drunk"), had pulled over and would keep an eye on him until police arrived.[21]

16. LSC Ashton was the driver and Const Suarez the passenger in the police divisional van which responded, arriving in the vicinity of Todd and Williamstown Roads at about 1:20am. After being briefed by the ambulance paramedics, they drove into Perce White Reserve where they saw a number of vehicles including Mr O'Brien's in a bank of parallel parking spots. They found the vehicle unlocked, unoccupied, the key in the ignition, the engine off and the radio playing. Having ascertained from the occupants of another vehicle that Mr O'Brien had walked into adjoining bushland and that there was only one entrance and exit to the carpark, they decided to wait.[22]

17. At about 1:47am, LSC Ashton and Const Suarez saw Mr O'Brien's vehicle drive past them towards the carpark exit onto Todd Road. LSC Ashton turned on the headlights of the divisional van and followed. When Mr O'Brien failed to heed the stop sign at Todd Road, LSC Ashton turned on the red and blue flashing lights of the divisional van and continued to follow him as he accelerated north along Todd Road towards the freeway entrance. After a short time, LSC Ashton activated the siren and they discussed whether the vehicle was going to stop or they were going to initiate a pursuit. At the intersection with Williamstown Road, LSC Ashton was driving at about 80-90kph in a 60kph zone and not appearing to gain any ground on the other vehicle. Const Suarez called in the pursuit while they were still travelling north in Todd Road towards the entrance to the Westgate Freeway and at an estimated speed of 100kph without gaining ground on Mr O'Briens' vehicle.[23]

18. Without minimising the potential dangers and the impact on the person being pursued, on any view, this was a relatively short police pursuit. The distance covered was something like 2.4kms[24]. Based on an average speed of 100kph[25] the pursuit lasted less than 1.5 minutes. The transcript of communications between the intergraph operator, Acting Senior Sergeant Ciaran Boyle who assumed the role of "pursuit controller"[26] and LSC Ashton and Const Suarez, also captures how quickly events unfolded.[27]

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21 Transcript page 10 & 13, 17 and Exhibit 5 in inquest Exhibit "J".

22 Statement of LSC Ashton at page 31 of inquest Exhibit "J", statement of Const Suarez Exhibit "C" and transcript of her evidence at pages 15 and following. Exhibit "B" was a google map marked at inquest by Const Suarez to clarify where the divisional can was waiting as Mr O'Brien drove past them from left to right towards the carpark exit onto Todd Road.

23 LSC Ashton's statement at page 35 and Exhibit 5 of inquest Exhibit "J", Const Suarez' statement Exhibit "C" page 3 and transcript pages 17,21 and following.

24 Exhibit "D" - the distance from the roundabout at the end of Todd Road to the point where both vehicles stopped near the top of Westgate Bridge, according to the scale on the exhibit.

25 As estimated by both LSC Ashton and Const Suarez and conveyed by them to the intergraph - see footnote 3 references above.

26 His statement Exhibit "E" and transcript page 26.

27 Exhibit 5 of inquest Exhibit "J" from page 2 and following.

19. Acting Inspector Robert Raaymakers from the Strategic Police and Road Safety Awareness Group provided a statement and attended the inquest to speak to Victoria Police policy relevant to police pursuits. He produced the policy entitled "Urgent Duty Driving and Pursuits" in force as at 25 November 2007.[28] The policy articulates and defines three key urgent duty driving situations for police - urgent response, imperative pursuits and elective pursuits. The policy deals with risk assessment, guidelines regarding the types of vehicle, qualification of drivers, the circumstances which warrant urgent duty driving or pursuits to commence, continue or conclude, and the use of pursuit resolution strategies such as use of the police airwing, back up units and tyre deflation devices.

20. The subject pursuit was an "elective pursuit" as defined by the policy, that is it involved the pursuit of a vehicle that has failed to stop after being signalled to stop for a lawful purpose and the reason for the pursuit was to intercept an offending driver. This is to be distinguished from an "imperative pursuit" which is the pursuit of a vehicle that is creating a danger to the public by its presence on the road, or where there are reasonable grounds to believe that immediate apprehension of the driver or occupants is essential to prevent danger to any persons. The reasons for this type or pursuit is to minimise or remove the danger.

21. It follows that risk assessment and/or the decision to commence, continue to conclude a pursuit is very much influenced by the nature of the pursuit and its underlying rationale or aim. On the basis of A/g Sen Sgt Boyle's statement and evidence at inquest, which I accept, having just resumed the role of pursuit controller, he was about to call an end to the pursuit when he was advised that Mr O'Brien's vehicle was travelling at 125kph, well in excess of the speed limit, and had just stopped. His rationale for so doing was sound.[29]

22. The possibility of alternative action available to LSC Ashton and Const Suarez, other than initiating an elective pursuit, was addressed in a statement provided by Senior Sergeant John Gibson from the Road Safety Legislation & Policy Advisory Unit.[30] He identified section 62 of the *Road Safety Act 1986* regarding the seizure of keys from drivers in certain circumstances. Suffice to say, for present purposes, that the opportunity to do so would have required police to wait for Mr O'Brien to return and to be about to drive, in order to form the requisite view that he was incapable of doing so by reason of his physical or mental condition. The other police powers and offences referred to in Sen Sgt Gibson's statement have their own practical constraints and limitations.[31]

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28 Victoria Police Manual 102-3 with cross-references to the Road Rules-Victoria, Rule 305, conveniently summarised in his statement Exhibit "G".

29 Exhibit "E" and transcript page 27 - "*Now, if the pursuit was to continue and if the pursuit was going at 125 kilometres per hour, I would have terminated it - my intention was to terminate it straight away ... The pursuit had exceeded the speed limit. My belief was at this point it was an elective pursuit. No other information I had in my role conducting the risk assessment would have let me let that pursuit continue so I would have terminated it anyway but it had come to a stop once I inquired about the speed.*"

30 Transcript page 38.

31 Sections 49 & 65 of the *Road Safety Act 1986; Road Rules (Victoria)* Rule 297.

23. Of course, LSC Ashton and Const Suarez could have decided not to wait or not to attempt to intercept Mr O'Brien, or not to initiate the elective pursuit at all. On the assumption that there is a broader public interest in road safety and the enforcement of drink driving laws in particular, it is difficult to see how such decisions, if taken, could have been justified without the benefit of hindsight.

CONCLUSIONS

24. Based on all the available evidence, I find that while Mr O'Brien intentionally took his own life, he did so impulsively, in the heat of the moment, while attempting to avoid interception by the police, knowing the serious consequences he would face. I find that the conduct of LSC Ashton and Const Suarez was appropriate in the circumstances as they knew them to be. They had information from a credible source that Mr O'Brien was driving while intoxicated and, without prescience as to the tragic outcome, could not reasonably have done less.

Signature:

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PARESA ANTONIADIS SPANOS
CORONER
25th March, 2011 25th March, 2011

DISTRIBUTION OF FINDING: The O'Brien Family

Chief Commissioner of Victoria Police

VicRoads