IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 000204

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**JUDGE SARA HINCHEY, STATE CORONER**
Deceased:	**NICOLAS RUSSELL MILES**
Date of birth:	13 June 1992
Date of death:	12 January 2015
Cause of death:	Head and neck injuries sustained in a train incident
Place of death:	At the railway track adjacent to Waterloo Road, Glenroy Victoria 3046

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HER HONOUR:

BACKGROUND

1 Nicolas Russell Miles (**Mr Miles**), aged 22-year-old at the time of his death, lived in Preston with his brothers, Christopher Miles and Liam Miles. Mr Miles' parents were Russell and Rosemary Miles. Rosemary died from cancer when Mr Miles was 10 years old. Also around this time, Mr Miles' paternal grandfather took his own life by placing himself in front of a train.

2 Mr Miles experienced difficulty in school academically and had been diagnosed with attention deficit disorder at about 6 years of age. Mr Miles' medical history included anxiety and psychosis.

3 At the time of his death, Mr Miles had been working as a personal care attendant, but he did not enjoy his work and was looking to begin a bakery course.

4 From April to November 2013, Mr Miles consulted general practitioner (GP) Dr Tatiow Ng at the Belair Medical Centre on three occasions for minor ailments. Dr Ng did not note any matters relating to mental health in the medical records.

5 GP Dr Dinali Perera, also of the Belair Medical Centre, stated that she first saw Mr Miles on 18 September 2014 when he presented with concerns about anxiety. Dr Perera stated that Mr Miles reported being prescribed the antidepressant escitalopram 12 months prior, but that he had ceased his medication two months prior. Dr Perera stated that Mr Miles was '*very agitated with fidgeting, teeth grinding, poor eye contact/darting eyes and pressured speech*'. Their consultation lasted more than half an hour and Mr Miles reported panic attacks, anxiety and recurrent hallucinations involving a menacing purple being. Dr Perera also formed the impression that Mr Miles suffered significant social anxiety, paranoia and mild depression. Dr Perera's treatment plan was to recommence escitalopram, refer Mr Miles to a psychologist and arrange regular review with her for monitoring. The following week, Dr Perera completed a Mental Health Care Plan for Mr Miles and referred him to Clinical Psychologist, Dr Hanife Guducu.

6 Dr Guducu stated that Mr Miles attended her for eight sessions from 25 September to 17 December 2014. She stated that Mr Miles reported visual hallucinations from a young age. Dr Guducu noted a strong family history of depression and anxiety. She recommended that, in addition to her therapy, Mr Miles attend a psychiatrist for review of his antidepressant and to be

prescribed antipsychotic medication. Dr Guducu described Mr Miles' anxiety as "*very severe*" and noted his depressive symptoms.

7 Accordingly, Dr Perera referred Mr Miles to Consultant Psychiatrist Dr Raid Al Humrany, who stated that Mr Miles attended him on two occasions on 18 November and 2 December 2014. Dr Al Humrany stated that Mr Miles denied any suicidal thoughts on direct questioning at both consultations, and that he assessed Mr Miles' risk of self-harm as low. Dr Al Humrany formed the opinion that Mr Miles' diagnosis was "*mixed anxiety and low depressive mood with brief psychotic symptoms in the context of chronic generalised anxiety disorder, chronic dysthymia, attention deficit disorder and personality disorder*". His plan was for Mr Miles to continue taking escitalopram long term, to begin the antipsychotic medication Zyprexa (olanzapine) and to continue ongoing care with his psychologist and GP.

8 On 20 November 2014, Mr Miles attended Dr Perera for review, together with his brother Christopher. Dr Perera stated that she observed a dramatic change in his behaviour from his last appointment one week prior; she observed fidgeting, teeth grinding and darting eyes, and Christopher expressed his concerns. Dr Perera attempted to contact Dr Al Humrany during the consultation, but was unsuccessful. She stated that Mr Miles reported being agitated and frightened, but denied feeling suicidal. Dr Perera allowed Mr Miles to return home with Christopher. She later contacted Dr Al Humrany for advice, then contacted Mr Miles to provide him with reassurance that his deterioration was likely secondary to the olanzapine and should be short lived.[1]

9 Dr Perera stated that Mr Miles seemed to settle and stabilise with his treatment plan after this appointment, and she continued to review him regularly.

10 At his second appointment with Dr Al Humrany on 2 December, Mr Miles reported improvement in his mental state. His anxiety, depressive and psychotic symptoms had all improved. He again denied symptoms of major anxiety or depression, worthless or helpless symptoms or suicidal thoughts. He was then discharged back to the care of Dr Perera. Dr Al Humrany stated that Mr Miles "*was engaging with his psychologist and after the second meeting when his mental state was good and he was making plans for the future I released him back to the care of his GP, due to lack of risk taking behaviour.*"

[1] Christopher Miles stated that Mr Miles consumed alcohol and his antipsychotic medication together on 20 November 2014, and that Christopher had difficulty waking him and therefore took him to see his GP.

11 Dr Perera's last appointment with Mr Miles was on 11 December 2015, when he consulted her for a physical ailment. Mr Miles had relocated to his father's home and sought to have his care transferred to another GP.

12 Dr Kafayat Lee of the Dundas Street Medical Centre saw Mr Miles on one occasion only, on 12 December 2014. She stated that Mr Miles attended with a letter from his father that set out his social history, and that he reported his main symptom of anxiety and stated that he was prescribed medication by a psychiatrist to treat his visual hallucinations. Dr Lee stated that Mr Miles denied any suicidal thoughts, ideas or plans. She encouraged him to see his psychologist the following week and ongoing as planned, and she asked him to sign a release form so that she could obtain his medical history from his previous treating practitioners. A review appointment was made for three weeks' time. Mr Miles was encouraged to return earlier if he needed to. Dr Lee stated that she had no concern about suicide risk in the interim.

13 A ninth appointment with Dr Guducu had been made for 8 January 2015, but Mr Miles did not attend. Dr Guducu contacted Mr Miles by phone and he told her that he was at his GP clinic, had food poisoning and was unable to attend but would reschedule his appointment when he felt better. It does not appear that Mr Miles attended either Dr Lee or Dr Perera on that date.

14 Mr Miles and Christopher had experienced some conflict in the weeks prior to Mr Miles' death, in relation to money owed by him to Christopher. Mr Russell Miles intervened and assisted his sons, and Mr Miles moved in with his father for a short time before returning to live with his brothers.

THE PURPOSE OF A CORONIAL INVESTIGATION

15 Mr Miles' death is a reportable death within the meaning of the *Coroners Act 2008* because it was both unexpected and arose from injury.

16 The jurisdiction of the Coroners Court of Victoria is inquisitorial[2]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

[2] Section 89(4) *Coroners Act 2008.*

17 It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

18 The 'cause of death' refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

19 For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

20 The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

21 Coroners are also empowered:

(a) to report to the Attorney-General on a death;

(b) 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

(c) 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 powers are the vehicles by which the prevention role may be advanced.

22 All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[4] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

23 In conducting this investigation, I have made a thorough forensic examination of the evidence including reading and considering the witness statements and other documents in the coronial brief.

[3] *Keown v Khan* (1999) 1 VR 69.

[4] (1938) 60 CLR 336.

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

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

24 On 14 January 2015, the Deceased was visually identified by Nigel Ian Allan George Brand, to be Nicolas Russell Miles, born 13 June 1992.

25 Identity is not in dispute and therefore requires no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

26 On 13 January 2015, Dr Linda Iles (**Dr Iles**), Forensic Pathologist, Victorian Institute of Forensic Medicine, conducted an external examination of Mr Miles' body and a post mortem CT scan. She provided a written report, dated 27 January 2015, which concluded that a reasonable cause of death was *'head and neck injuries sustained in a train incident.'*

27 Post mortem toxicological analysis of blood did not reveal the presence of ethanol (alcohol), any of Mr Miles' prescribed medications or any other common drugs or poisons.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

28 Liam Miles stated that he last saw his brother at home on the Sunday night before his death, 11 January 2015. He said goodnight to him and stated that Mr Miles "*seemed a bit happier than normal."* Christopher Miles stated that he last saw Mr Miles on 11 January 2015, at their home, at about 10.00pm.

29 Liam woke up at about 6.00am the next day, 12 January 2015 and left shortly afterwards for TAFE, believing that Mr Miles was still asleep.

30 At about 8.15pm on 12 January 2015, a Flinders Street bound train departed from Glenroy station towards Oak Park station. The train driver stated that they were travelling under the speed limit. The driver saw a person, Mr Miles, to their left about 50 to 100 metres from the train, walking towards the track. The driver applied the emergency brake and observed Mr Miles lie over the track with his neck on the rail. The driver was unable to avoid a collision and the train struck Mr Miles, who died instantly.

31 Police officers attended the scene and the driver underwent a preliminary breath test, which returned a negative result. At the time of the incident, the track was dry, visibility was clear and the weather was fine. The train was running on time. The driver stated that he was rested and alert at the time and that his general eyesight is good.

32 The coronial investigation did not identify any note or other communication from Mr Miles to his loved ones regarding the reasons for his actions.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

33 Mr Russell Miles wrote to the Court on 13 February 2015 and 5 January 2016. In these letters, he provided his observations to the Court and some background about his son's life and his stressors. Russell Miles also provided the Court with some family photographs of his son. The submissions reveal Mr Miles to be a much-loved son and brother, whose death has significantly affected his death his family. I thank Russell Miles for providing these reflections and acknowledge the family's grief and loss. Importantly, Russell Miles identified a numbers of matters that could be implemented to prevent similar deaths. I am grateful for Russell Miles' input and I have taken it into consideration when making recommendations in this matter.

34 A finding of suicide can impact upon the memory of a deceased person and can reverberate throughout a family for generations. Such a finding should only be made on the basis of compelling evidence, rather than indirect inferences or speculation. While the exact reasons for Mr Miles' actions remain unknown, having considered the evidence before me, I am comfortably satisfied, to the coronial standard of proof that Mr Miles intended to take his own life. Despite Mr Miles' denials of being suicidal, the evidence is compelling, including him laying on the railway tracks, in the path of the moving train with the intention of ending his life.

35 The evidence before me indicates that the clinical management and care provided to Mr Miles by his treating practitioners was appropriate. He was well engaged with a GP and psychologist. My investigation revealed that Mr Miles' various treating clinicians communicated well with each other and actively considered his risk of suicide and they were all satisfied that he was not at high risk of taking his life.

36 It appears that Mr Miles was not taking his prescribed medications at the time of his death, given his negative toxicology results. Despite this, my investigation revealed that Mr Miles was committed to his therapy, was well supported by Russell, Christopher and Liam Miles and that they were doing all they could to assist him to manage his mental health.

FINDINGS AND CONCLUSIONS

37 Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

(a) the identity of the deceased was Nicolas Russell Miles, born 13 June 1992; and

(b) Mr Miles died from head and neck injuries sustained in a train incident, on 12 January 2015, at the railway track adjacent to Waterloo Road, Glenroy Victoria 3046, in the circumstances set out above.

RECOMMENDATIONS

38 Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with Mr Miles' death:

(a) **THAT** the Department of Economic Development, Jobs, Transport and Resources together with Public Transport Victoria, Metro Trains Victoria and Victoria Police (in its capacity as employer for Public Service Officers) ensure that all relevant staff, be trained in identifying and responding to persons whose pattern of behaviour is out of the ordinary when around a train track to ensure vulnerable persons are not at risk of injury or death.

(b) **THAT** the Department of Economic Development, Jobs, Transport and Resources together with Public Transport Victoria and Metro Trains Victoria implement, at all train stations, billboards or signs advising people, if they are concerned about a person's risk taking behaviour around a train station, to either call '000' or to press the red button in the safety zone at train stations or the red button on board a train.

39 I convey my sincerest condolences to Mr Miles' family and friends.

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

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

(a) Mr Russell Miles, Senior Next of Kin.

(b) Emergency Services Telecommunications Authority.

(c) LSC Craig Sanderson, Victoria Police, Coroner's Investigator.

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

(a) Ms Louise Johnson, Department of Economic Development, Jobs, Transport and Resources.

(b) Public Transport Victoria.

(c) Metro Trains Victoria.

(d) Mr Graham Ashton AM, Chief Commissioner of Police.

Signature:

JUDGE SARA HINCHEY

STATE CORONER

Date: 9 August 2016