FORM 38

Rule 60(2)

REDACTED FINDING INTO DEATH WITHOUT INQUEST

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

Court reference: 2254/10

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

Details of deceased:

Surname: H
First name: V
Address: Hampton Park, Victoria 3976

without holding an inquest:

find that the identity of the deceased was VH born on the 21st October, 1984

and that death occurred on the 15th June, 2010

at the base of the West Gate Bridge, Yarra River, Spotswood, Victoria 3015

from: 1(a) INJURIES SUSTAINED IN FALL FROM HEIGHT

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. VH was a 25 year old single woman who resided with her parents and older sister. As VH's family was understandably very distressed by her death, and asked not to be contacted by the investigating police member, or the staff of the Coroners Court of Victoria, all that is known of her past history and personal circumstances is what could be gleaned from medical records and the personal property found in her vehicle.[6]

2. However, it does appear that VH had been depressed for some time. Investigations revealed that in the two months immediately preceding her death she had attended some four general practitioners across two medical practices. Although VH had differing physical

6 This finding is based on the investigation (albeit limited due to the family's stated preference not to be involved) and the brief of evidence compiled by Sergeant Troy Andrews from the St Kilda Road Police Station.

complaints at these attendances and had given somewhat inconsistent accounts of her psychiatric history, a common theme was depression and/or anxiety. She was commenced on the antidepressant "Lexapro" (escitalopram, one of the SSRI[7] antidepressants) and referred to a psychologist for counselling but only attended once. VH appeared to have insight and did not appear to be at risk of self-harm or suicide to any of the health professionals she attended during this period.

3. Shortly after 7:00pm on 15 June 2010, police responded to a report that a female had been seen walking along the inbound side of the West Gate Bridge. Police drove across the bridge outbound but did not see anyone. As they approached the Williamstown Road exit, they saw a vehicle parked in the emergency lane. They ascertained that it was registered to VH. Upon closer inspection they found the vehicle unlocked, with a laptop and handbag on the front passenger seat. Initial enquiries revealed VH's mobile phone number and Constable Damon Abbey called the number and spoke to VH who was upset and crying. She would not say where she was and said that she 'just wanted to go, just wanted to jump' before the call was ended. VH on did not answer when Const Abbey tried to call again.

4. At about the same time, a second report was made to police by a man who had been fishing under the West Gate Bridge when he heard a 'female screaming really loud for about two seconds followed by a really big splash'. A VicRoads employee came to unlock an access gate so police could search behind the temporary safety barrier[8]. They found VH's mobile phone, keys and a pair of black thongs on the outbound side of the bridge, at or near its highest point. Additional police were tasked to attend the area, and after a search of the area beneath the bridge, VH's body was found in the water.

5. Police inspection of VH's laptop computer revealed a suicide note on the desktop addressed to her family ("My Final Note", apparently written at 6:43pm that day). Perusal of the browsing history on her laptop revealed that she had been accessing internet sites dealing with depression and antidepressant medications for some time, and had searched for directions to the West Gate Bridge, suggesting a degree of planning. Inspection of her mobile phone revealed a number of text messages sent by friends and family members over the afternoon and evening of 15 June 2010, indicating their concerns for her welfare. The conclusion of the police investigation was that VH had intentionally taken her own life.

6. There was no autopsy as Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (VIFM), conducted a preliminary/external examination in the mortuary, reviewed the circumstances as reported by the police and advised that the medical cause of death was apparent without the need for an autopsy, namely *injuries sustained in fall from a height.* Dr Lynch noted that toxicological analysis of postmortem samples, also undertaken at VIFM, revealed no alcohol or other commonly encountered drugs or poisons, apart from citalopram at a concentration of ~ 0.1mg, consistent with therapeutic use of "Lexapro".

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7 SSRI = selective serotonin reuptake inhibitor.

8 See "Comments" below re the installation of the temporary safety barrier and its efficacy.

7. I find that VH intentionally took her own life by jumping/falling from a height, namely the West Gate Bridge. I find no evidence that any other person was involved in her death.

COMMENTS:

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

1. In light of the circumstances of VH's death, and in the interests of prevention of other deaths in similar circumstances, I asked the Coroners Prevention Unit (CPU)[9] for a report on all jump from height suicides from the West Gate Bridge since installation of a temporary safety barrier in May 2009, including an assessment of the efficacy of the barrier in preventing suicides, insights into how the barrier was overcome and information about the proposed installation of a permanent safety barrier.

2. According to the report, between 1 May 2009 and 14 February 2011, VH was one of five to jump from height suicides from the West Gate Bridge. This represents a reduction of approximately 85% in the number of such suicides at this location, compared with the two-year period immediately preceding installation of the temporary safety barrier, without any apparent concomitant shift to other Victorian locations. This outcome is consistent with conclusions from several studies of interventions at landmark suicide locations throughout the world, and justifies the expenditure of public funds to improve public safety in this regard.

3. While it is not entirely clear how the temporary safety barrier was overcome on each occasion, only one person appears to have come equipped with a ladder to help him climb over the barrier, one appears to have found a gap in the barrier where works were being undertaken, and the others appear to have climbed over unaided, despite the razor wire at the top and the lack of footholds and handholds.

4. It follows that VicRoads is to be commended for installation of the temporary safety barriers on the West Gate Bridge which have proved an effective suicide prevention intervention.

5. The fact that the West Gate Bridge continues to attract a small number of vulnerable people who are intent on taking their own lives does not detract from, but rather reinforces, the need for better safety barriers. At the time of writing, installation of the permanent safety barrier is all but complete. This barrier is designed to be more difficult to overcome than the temporary

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9 The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the Coroner in formulating prevention recommendations and comments, and monitors and evaluates their effectiveness once published. The relevant reports dated 14 February and 4 March 2011 were was prepared by CPU Team Leader Jeremy Dwyer and Case Investigator Melanie Koo.

safety barrier which it replaces[10] and, it is hoped, will prove to be an even more efficacious suicide prevention intervention.

RECOMMENDATION:

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

1. For the reasons outlined in my comments above, I recommend that VicRoads monitors any incidents of jump from height suicides or attempts after completion of the permanent safety barrier on the West Gate Bridge, in order to assess the efficacy of the barrier as a suicide prevention intervention. Monitoring should include analysis of how the barrier was overcome or sought to be overcome, in order to ascertain if there are any design flaws which can be remedied, and to inform the design of new bridges and/or other roads infrastructure with the potential to attract jump from height suicide activity.

DISTRIBUTION OF FINDING

Apart from VicRoads to whom the above comments and recommendation are directed, I hereby direct the Principal Registrar of the Coroners Court of Victoria to provide a copy of this finding to the following, for their information:

1. The Honourable Robert William Clark, Attorney-General
2. The Honourable Terry Mulder, Minister for Public Transport & Minister for Roads
3. Mr Kevin Devlin, Director, West Gate Bridge Strengthening Alliance
4. Mr Michael Dudley, Chairperson, Suicide Prevention Australia
5. Inspector William Mathers, Hobsons Bay Police Service Area c/o Altona North Police
6. Officer-in-Charge, Altona North Police
7. Officer-in-Charge, Keilor Downs Police
8. Officer-in-Charge, St Kilda Road Police
9. Sergeant Troy Andrews (#30854), St Kilda Road Police Station

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 4 April, 2011

Coroners Court of Victoria

10 The safety features of the permanent barrier includes that it is approximately four metres high, twice as high as the temporary safety barrier; cantilevered out from the side of the bridge to thwart any attempt to climb over from say the roof of a vehicle; topped with wide smooth curved metal capping that does not provide a handhold; and, made of close-woven metal mesh that does not provide a handhold or foothold.