



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 3223

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Findings of:	JUDGE SARA HINCHEY, STATE CORONER
Deceased:	SHRIHAN GANNARAM , born 22 February 2016
Delivered on:	10 July 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	9 July 2018
Counsel assisting the Coroner:	Rebecca Johnston-Ryan, State Coroner's Legal Officer

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HER HONOUR:

BACKGROUND

1. Shrihan Gannaram (**Shrihan**) was 4 months old and resided with his mother, Supraja Sreeram (**Supraja**), his father, Srinivas Gannaram (**Srinivas**), and 5 year old sister, Vedashasra (known as **Veda**), at 602/668 Bourke Street at the time of his (and his mother's) death.
2. Supraja and Srinivas had an arranged marriage in India in 2009. They then lived in the United Kingdom for the first 10 months of marriage. Supraja fell pregnant with Veda and so they returned to India.¹
3. In India, Supraja obtained employment with YASH technologies, whilst Srinivas obtained employment with Tech Mahindra. Srinivas' employment would eventually lead to the family relocating to Australia.²
4. Supraja gave birth to Veda in India on 26 April 2011. The family was very happy. In addition to her husband, Supraja had the support of family and friends. Her parents moved closer to them to offer greater support.³
5. Srinivas' employment with Tech Mahindra offered him the opportunity to work in Australia. In 2012, he came alone to Melbourne to work. While in Melbourne, he would Skype call Supraja and Veda daily. At that time, Supraja was visited and supported by family members. On at least one occasion, Supraja came out to Melbourne to visit Srinivas.⁴
6. Also in 2012, Srinivas purchased a plot of land in Hyderabad, which he registered in Supraja's name.⁵ In 2013, Srinivas returned to India. The family was happy and Supraja and Srinivas were both working.⁶
7. In 2014, Srinivas was asked again by his company to return to Melbourne. He accepted and returned in November. In February 2015, Supraja and Veda came out to live in Melbourne.⁷ The family lived in a one bedroom unit at 668 Bourke Street.

¹ Coronial Brief, Statement by Srinivas Gannaram, Appendix 1, 210-1

² *ibid*, 212-214

³ *ibid*, 214

⁴ *ibid*, 215-216

⁵ *ibid*, 216-7

⁶ *ibid*, 219

⁷ *ibid*, 224-225

8. YASH technology continued to employ Supraja, who worked remotely. Srinivas described the family as a very happy family.⁸ Consequently, they began the process of applying for permanent residency in Australia. In November 2015, they were granted a visa.⁹
9. The couple had been trying for another child and learnt that Supraja was then pregnant with a boy, due to be born in February 2016. In December 2015, Srinivas successfully applied for 6 month visitor visas for his parents, in part to support Supraja when their son was born.¹⁰ Srinivas' parents arrived in Australia on 30 December 2015.
10. On 22 February 2016, Shrihan was born at Frances Perry Hospital. The birth was normal and Supraja and Shrihan were discharged from the hospital on 26 February 2016.
11. In line with protocols in place at the time, nurses from the Maternal and Child Health Service (MCHS) from the City of Melbourne visited the family home. The family also visited the MCHS nurses at the Docklands Prescribed Hub. The MCHS nurses saw Supraja and Shrihan on 1 March (one week post-birth), 10 March (two weeks post-birth), 23 March (four weeks post-birth), 19 April (eight weeks post-birth) and 22 June (four months post-birth).¹¹
12. No issues were identified as a result of those visits, regarding Supraja's mental health or Shrihan's health. On 22 June, Shrihan was "*unwell with cold.*" At that consultation, it was reported that Supraja said that the family would be returning to live in India in a couple of months. The various MCHS nurses commented that Supraja appeared to interact well with Shrihan and that Srinivas (and his parents) appeared to be supportive. No family violence questions were asked due to family members being present at the various visits.¹²
13. On 5 April 2016, Supraja and Shrihan attended their General Practitioner, Dr Lisa Amir, at Medical One at the QV centre, following a referral from a MCHS nurse who identified that Shrihan had tongue tie. A frenotomy was conducted to release Shrihan's tongue and Supraja was subsequently seen breastfeeding. Those medical records did not indicate that there were any post partem problems with either Supraja or Shrihan.
14. On 11 July 2016, Srinivas and Supraja took Shrihan to Dr Greg Saville of Medical One QV regarding a facial rash of approximately one week, which was not improving. Prior to the appointment, Supraja had told Srinivas that she was not sleeping properly and wanted to ask

⁸ *ibid*, 225

⁹ *ibid*, 228

¹⁰ *ibid*, 231-2

¹¹ Coronial Brief, Statement of Lynne Trudy Smith, dated 29 September 2016, 54

¹² *ibid*

the doctor for sleeping tablets.¹³ Srinivas told her that she would not get sleeping tablets in Australia and instead should just wake him up and talk to him.

15. Dr Saville saw Shrihan, who was asleep when Dr Saville examined him. He diagnosed mild eczema and prescribed cream.¹⁴
16. The family's finances were good. They were not in debt. They owned land in India and had some savings in Australia. They had an adequate disposable income after expenses. Supraja had access to funds and also had her own accounts.¹⁵
17. Supraja was not diagnosed with any medical conditions.¹⁶ She had not told Srinivas that she was not coping.¹⁷ Srinivas described his wife as someone who loved the children and never made threats or attempted to hurt them.¹⁸
18. In May 2016, Supraja resigned from her job. In June 2016, Srinivas' parents returned to India.
19. Supraja's daily routine started at around 6.30am. She would make Veda's lunch and then get Veda ready for school. She would then care for Shrihan and cook lunch for Srinivas, who would usually come home from work for lunch. She would then prepare dinner, whilst continuing to care for Shrihan. Srinivas would bring Veda home and the family would then eat and go to sleep.¹⁹
20. Supraja had very few friends in Australia. She had one friend who she saw once before her son was born and once after.²⁰ Otherwise, she was socially isolated during the day. At the time of her and Shrihan's deaths, Srinivas noticed that Supraja had a decreased appetite.
21. In the week of Supraja and Shrihan's death, Srinivas reported that his wife looked "*a little bit distressed*" all week. He attributed this to her having to do all the work herself without familial support (as compared to when Veda was born, when Supraja had the support of her parents who were living with her).²¹

¹³ Above, n 1, 314

¹⁴ Coronial Brief, statement of Doctor Mark Saville, dated 12 October 2016, 80

¹⁵ Above, n 1, 325-328

¹⁶ Above, n 1, 314

¹⁷ *ibid*, 329

¹⁸ *ibid*, 330

¹⁹ *ibid*, 315-319

²⁰ *ibid*, 321-322

²¹ *ibid*, 314-315

THE PURPOSE OF A CORONIAL INVESTIGATION

22. Shrihan's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic) (**the Act**), as the death occurred in Victoria and was unexpected, from injury and not from natural causes.²²
23. The jurisdiction of the Coroners Court of Victoria is inquisitorial.²³ The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.
24. It is not the role of the coroner to lay or apportion blame, but to establish the facts.²⁴ It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.
25. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.
26. For coronial purposes, the phrase "*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.
27. 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 Court's "*prevention*" role.
28. 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

²² Section 4 *Coroners Act 2008*.

²³ Section 89(4) *Coroners Act 2008*.

²⁴ *Keown v Khan* (1999) 1 VR 69.

- (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.
29. 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*.²⁵ 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.
30. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide (and no person or persons have been charged with an indictable offence in respect of the death), or the deceased was immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.
31. While Shrihan's identity was not in dispute and he was not a person placed in "*custody or care*" as defined by section 3 of the Act, his death is considered to be a homicide. Therefore, it is mandatory to conduct an inquest into the circumstances of his death as no person or persons have been charged with an indictable offence in respect of the death.

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

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

32. On 15 July 2016, Srinivas Gannaram formally identified the body of the deceased to be that of his son, Shrihan Gannaram, born 22 February 2016.
33. Identity is not in dispute in this matter and requires no further investigation.

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

34. On 15 July 2016, Dr Malcolm Dodd (**Dr Dodd**), a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Shrihan's body. Dr Dodd provided a written report, dated 5 October 2016, which concluded that Shrihan died from multiple injuries sustained from impact with the ground from an extended height in together with abdominal stab wounds.

²⁵ (1938) 60 CLR 336.

35. Dr Dodd commented that while the injuries caused by the four stab wounds were significant, these injuries would not be deemed to be immediately lethal and would be amenable to immediate surgical intervention. The fall from a height, however, led to significant musculoskeletal trauma.
36. Post mortem toxicological analysis specimens taken from Shrihan were negative for common drugs or poisons.
37. I accept the cause of death proposed by Dr Dodd.

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

38. On the evening of 13 July 2016, Srinivas returned home and was in pain due to sciatica in his back. He was also preoccupied with a presentation he was due to give at work the next day. He saw Supraja reading with Veda, which she did daily.²⁶
39. Srinivas ate some dinner with his family, but noticed that Supraja was not eating. He tried to make her eat more.²⁷
40. Srinivas was still in pain and so Supraja gave him a hot water bottle. After a short time, Supraja said to him “*you are not hugging me, you are not hugging me.*”²⁸ She later said to him, “*you are not giving me hugs.*” Given his pain, Srinivas asked her to come closer and gave her a hug.²⁹ After this, they discussed arrangements for a trip to India that they were planning, as well as having a general discussion about their children’s future professions.³⁰
41. Subsequently, the family then got ready for bed. They all slept together on bedding on the floor in bedroom. As they lay in bed, Supraja said that “*I got very skinny in the hands and the legs, but waist will be same now, it doesn’t change.*”³¹ Srinivas did not really respond but held her hand and replied “*ok.*” Srinivas went to sleep, even though Supraja wanted to talk further about Shrihan.³²
42. The next morning, Srinivas awoke and his mind was “*filled with that presentation*” for work. Consequently, Supraja woke up Veda and then started making Veda’s breakfast. Veda did not get out of bed and so Srinivas took her to the bathroom to get her ready. He was running late.

²⁶ *ibid*, 278

²⁷ *ibid*, 283-7

²⁸ *ibid*, 280

²⁹ *ibid*, 285-6

³⁰ *ibid*, 289

³¹ *ibid*, 294

³² *ibid*, 295

Supraja gave Veda her breakfast. Srinivas then ate his breakfast quickly, put on Veda's shoes and he and Veda left for the day. He left without saying goodbye to Supraja and without seeing Shrihan.³³ As he left his building, he realised he did not have Veda's Myki travel card, and so they went back to collect it. Supraja gave him Veda's Myki card and he left. It was the last time he saw her alive.

43. Srinivas then dropped off Veda at school. Usually, he would then return to work and telephone Supraja to see if everything was ok. On this day, he was still thinking about his presentation and did not telephone her.³⁴ At some point after 10.00am, he called Supraja but she did not pick up the call. He assumed she was bathing.³⁵ He tried to call her again a short time later, this time on both her mobile telephone and their landline. Supraja did not answer either telephone. Srinivas thought she was perhaps bathing Shrihan and would return his call later.³⁶
44. Toby Pfeffer (**Mr T Pfeffer**), a glazier, was working on the 3rd floor of the Mail Exchange Building, which neighbours 668 Bourke Street. At around 10.40am, he was putting a window and so had a view of the balconies of 668 Bourke Street. He saw an Indian lady with a baby in her arms.³⁷ They were later identified as Supraja and Shrihan. He thought she was acting strangely by lurking around the balustrade. It appeared to Mr T Pfeffer that she was either on the outside of the balustrade or looking to move onto it. He carried on working and when he next looked over, she was not there.³⁸
45. A short time later, Mr T Pfeffer heard a scream. He looked out and saw a baby falling. He ran over to a colleague, Thomas Colley (**Mr Colley**), and told him that someone had just jumped from the balcony. He telephoned emergency services as he ran downstairs. Mr Colley looked down and saw a female lying on the ground.³⁹
46. Mr T Pfeffer was not the only person to telephone emergency services. Several other bystanders also called the emergency services after seeing Supraja and Shrihan lying on the ground.
47. Mr Colley ran to the Chocolate Frog Café and spoke to the owner, Gregory Pfeffer (**Mr G Pfeffer**), in order to gain access to the female he had seen on the ground. Mr Colley

³³ *ibid*, 301

³⁴ *ibid*, 304

³⁵ *ibid*, 305

³⁶ *ibid*, 307

³⁷ Coronial Brief, Statement of Toby Pfeffer, dated 14 July 2016, 5

³⁸ *ibid*, 5

³⁹ Coronial Brief, Statement of Thomas Colley, dated 14 July 2016, 22

and Mr G Pfeffer accessed the court yard where Supraja and Shrihan lay. Mr Colley checked Supraja for a pulse. He could not find one. He noticed an obvious injury to her foot.⁴⁰

48. Mr G Pfeffer checked Shrihan for a pulse but could not find one. He also checked Supraja with the same result.⁴¹ Mr G Pfeffer also saw that Supraja had some horizontal wounds on her left wrist.⁴² Both men observed that Shrihan had a major injury to his abdomen.
49. Ambulance Victoria paramedics attended at 10.50am and pronounced both Supraja and Shrihan dead at 11.14am. Victoria Police attended and created a crime scene, cordoning off the area.
50. On this day, Srinivas had a work lunch at the Docklands Centre. He had previously told Supraja that he would not be returning home for lunch. Srinivas and his work colleagues walked toward the lunch location via his home address. As they walked past, they noticed the crime scene. They learnt that a female and child had fallen from the building. Srinivas immediately tried to call his wife, but she did not answer. He then went into his building and up to his unit. He was accompanied by his colleagues. He entered and shouted for Supraja but got no response. He saw the balcony door open and ran out. He looked over and saw Supraja and Shrihan on the ground below.⁴³ He immediately broke down.
51. Almost immediately after this, Victoria Police entered the unit and met Srinivas. He identified the two deceased people on the ground as his wife and son.⁴⁴
52. Victoria Police officers searched the unit. Two small knives were found on the kitchen floor, which appeared to have blood on them.⁴⁵ There were blood droplets around the knives.⁴⁶ The police did not note any fault or damage to the balcony/balustrade to indicate an accidental fall. The only way a person could get over the balustrade was by deliberate act of climbing over.⁴⁷
53. Based upon the evidence before me, Srhihan was the victim of Maternal Filicide.

⁴⁰ *ibid*, 23-24

⁴¹ Coronial Brief, Statement of Gregory Pfeffer, dated 14 July 2016, 44-45

⁴² *ibid*, 45

⁴³ Above, n1, 309-312; Also, Coronial Brief, statement of Carmel Milone, dated 14 July 2016, 47-49

⁴⁴ Coronial Brief, statement of Detective Senior Constable Nicole Walker, dated 30 November 2016, 84

⁴⁵ *ibid*

⁴⁶ *ibid*, 140 & 142

⁴⁷ Coronial Brief, Summary, 6

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

54. The deaths of Supraja and Shrihan, in such tragic circumstances, highlight the vulnerability of mothers and their infants in the period after childbirth.
55. One of the Act's purposes is to contribute to the reduction of the number of preventable deaths and fires through the coroners' findings and recommendations.⁴⁸
56. Post-natal depression (**PND**) is the most common form of mental disorder experienced in the twelve-month period after birth. Due to its relative frequency (approximately one in seven mothers⁴⁹), health professionals routinely screen for PND.
57. The available evidence suggests that Supraja was experiencing psychological distress, most likely in the form of PND. She was not eating well and made comments that indicated she was unhappy with her appearance, suggesting a loss of appetite and loss of self-esteem. Supraja was also having difficulty sleeping.
58. Supraja had a limited social network in Australia, consisting of one friend that she had limited contact with. It is highly likely that Supraja was experiencing social isolation, particularly after Shrihan's birth. This would have been exacerbated by Srinivas' parents returning to India in June, as well as Srinivas' work commitments. Supraja no longer had familial support in Australia to assist with household and parenting responsibilities. This likely resulted in higher stress levels and may have negatively impacted her mood and mental state.
59. There was no evidence to suggest there was any family violence, prior to Shrihan's death. MCHS records indicated that Supraja interacted well with Shrihan and comforted him appropriately when necessary. Srinivas stated that Supraja loved her children and gave her children priority.⁵⁰
60. The City of Melbourne's MCHS is governed by practice guidelines and a resource manual developed by the Department of Education and Training. In accordance with the *Maternal and Child Service: Practice Guidelines (2009)*, which were in force at the time of this tragic incident, the four-week check-up was when particular focus was given to maternal mental health and family violence. Standard practice was to ask a series of screening questions and administer an Edinburgh Postnatal Depression Scale (**EPDS**) only if the mother answered yes to any of the screening questions.

⁴⁸ *Coroners Act 2008* (Vic) s 1(c)

⁴⁹ <https://www.betterhealth.vic.gov.au/health/healthyliving/postnatal-depression-pnd>

⁵⁰ Above, n 1, 329-330

61. On 28 August 2016, following Supraja and Shrihan’s deaths, the City of Melbourne changed its practice. Lynne Trudy Smith, Coordinator of Family Health, City of Melbourne Maternal Child Health Service confirmed:

*“instead of only administering or using the EPDS in circumstances where at any of the consultations the mother discloses at least one of the experiences or it is apparent to the City of Melbourne MCH nurse that at least one of the experiences has occurred or is being exhibited, it now runs the EPDS on every mother at the four-week consultation, regardless.”*⁵¹

62. It should be noted that even if the EPDS was had been administered to Supraja at the four-week visit, it is not possible to conclude that any mental health issues would have been identified. At that time, Supraja had the support and social connection provided by Srinivas’ parents. Her deterioration appears to have occurred rapidly following their return to India. It follows that the only opportunity to identify any mental health issues would have been at the four-month visit. It is not known if Supraja was exhibiting any of the symptoms that would have triggered an EPDS prior to her four-month visit on 22 June 2016.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

63. The City of Melbourne monitors mothers in circumstances where an indicator of vulnerability has been identified. One of the thirteen identified alert categories listed by the City of Melbourne Risk Assessment Guide is *“health and well-being issues.”*⁵² However, there is no particular factor relating to social isolation or reduced support.
64. Although the City of Melbourne MCHS appropriately screens for physical and emotional wellbeing and monitors clients who report any one of the thirteen identified risk factors that increase family vulnerability, there are no prompts to screen for social support. Given that poor social support is a known, strong predictor of postpartum maternal mental health issues,⁵³ an increased focus on social support may improve MCHS practice in the area of mental health.
65. For that purpose, I RECOMMEND that the City of Melbourne MCHS consider adding *“lack of social support/isolation”* to the list of risk factors contained in their Risk Assessment Guide.

⁵¹ Coronial Brief, Second Statement of Lynne Trudy Smith, dated 18 May 2017, unpaginated

⁵² *ibid*, Attachment F

⁵³ See for example, World Health Organisation, Maternal Mental Health

FINDINGS AND CONCLUSION

66. Having investigated the death of Shrihan Gannaram and having held an Inquest in relation to his death on 9 July 2018, at Melbourne, I make the following findings, pursuant to section 67(1) of the Act:

- (a) that the identity of the deceased was Shrihan Gannaram, born 22 February 2016;
- (b) that Shrihan Gannaram died on 14 July 2016, at 620/668 Bourke Street, Melbourne, Victoria from multiple injuries sustained from impact with the ground from an extended height in tandem with abdominal stab wounds; and
- (c) that the death occurred in the circumstances set out above.

67. I convey my sincerest sympathy to Shrihan's family and friends.

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

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

- (a) Srinivas Gannaram, Senior Next of Kin;
- (b) Senior Constable Nicole Walker, Coroner's Investigator, Victoria Police;
- (c) City of Melbourne; and
- (d) Department of Education and Training.

Signature:



JUDGE SARA HINCHEY

STATE CORONER

Date: 10 July 2018