IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 2910

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**JOLANTA BOYD**
Date of birth:	**18 September 1969**
Date of death:	**18 June 2018**
Cause of death:	**Multiple Injuries Sustained When Struck by a Train**
Place of death:	**Windsor Railway Station, Windsor, Victoria 3181**

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Jolanta Boyd was 48 years of age and resided in Geelong at the time of her death. Ms Boyd had a young son, Aidan, with her ex-husband Jeremy Boyd. She was a successful, self-employed recruiter. Ms Boyd had been diagnosed with substance use disorder (alcohol), adjustment disorder and anxiety. She had a history of suicidality and suicide attempts. Ms Boyd had been treated in a number of public and private Victorian hospitals.

2. On 18 June 2018 at approximately 9.40am, Ms Boyd lay down on the train tracks of the Sandringham Line between Middle Brighton and Brighton Beach train stations. Victoria Police attended but Ms Boyd had left the area and was unable to be located. At approximately 12.30pm, Ms Boyd was seen at Windsor Train Station. She sat at the southern end of the platform with her legs over the edge and was drinking from a bottle of vodka. Ms Boyd sat in that way for less than five minutes before jumping in front of an approaching train, instantly ending her own life. Emergency Services were contacted and confirmed that Ms Boyd was deceased.

INVESTIGATIONS

Forensic pathology investigation

3. Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Jolanta Boyd, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Dr Parsons commented that CT scanning identified injuries which were consistent with the known mechanism of injury. Toxicological analysis of post mortem blood detected: alcohol (0.17 g/100mL);[1] diazepam (~0.7 mg/L) and its metabolite nordiazepam (~0.06 mg/L);[2] fluoxetine (~0.03 mg/L) and its metabolite

[1] This may be compared to the legal blood alcohol limit for fully licenced car drivers: 0.05 mg/L.

[2] Diazepam is a sedative/hypnotic drug of the benzodiazepines class and is predominantly used in the treatment of anxiety.

norfluoxetine (~0.06 mg/L);[3] temazepam (~0.1 mg/L) and its metabolite oxazepam (~0.09 mg/L);[4] quetiapine (~0.2 mg/L).[5]

4. Dr Parsons ascribed the medical cause of Ms Boyd's death to multiple injuries sustained when struck by a train.

Police investigation

5. Upon attending the Windsor Train Station area after Ms Boyd's death, Victoria Police processed the scene, including: taking photographic evidence, obtaining statements and contact details from witnesses, conducting a preliminary breath test (PBT) on the train driver and coordinating with Metro Investigators.

6. Acting Sergeant (A/Sgt) Robert Hickey was the nominated Coroner's investigator.[6] At my direction, A/Sgt Hickey investigated the circumstances surrounding Ms Boyd's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by: witnesses Roqiyya Khan and Julie Duncan; three Metro Trains Melbourne drivers; Ms Boyd's friend Albert Pietrzak; Ms Boyd's ex-husband Jeremy Boyd; Consultant Psychiatrist of Barwon Health Dr Scott Hall; Consultant Psychiatrist of Albert Health Dr Rosario Forlano.

7. During the investigation, police learned that Ms Boyd had attempted to end her own life by placing herself in the path of an oncoming train on a number of occasions. On each of these occasions, Ms Boyd was at train stations on the Sandringham line.

8. On 23 May 2018 at approximately 6.45pm, Ms Boyd spoke to Victoria Police Protective Services Officers (PSOs) at Gardenvale train station. PSO Dimitrios Modiotis stated that Ms Boyd spoke to him in a friendly manner before leaving the train station on foot. While on patrol approximately 30 minutes later, PSO Modiotis and PSO Tyler Huisman saw Ms Boyd drinking alone at a local bar. At approximately 7.50pm, the

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[3] Fluoxetine is a substitute propylamine indicated for the treatment of major depressive disorders and obsessive-compulsive disorders.

[4] Temazepam is a sedative/hypnotic drug of the benzodiazepines class and is predominantly used in the treatment of insomnia.

[5] Quetiapine is an antipsychotic drug used in the treatment of schizophrenia.

[6] A Coroner's Investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the Coroner to assist the coroner with his/her investigation into a reportable death. The Coroner's Investigator receives directions from a Coroner and carries out the role subject to those directions.

PSOs exited the Gardenvale PSO Pod upon hearing the sound of a train's emergency brakes and whistle. They saw Ms Boyd was standing on the train tracks, approximately one metre from the front of the stationary train. Ms Boyd was taken into custody by the PSOs as they awaited emergency services. During this time, they noted that she was heavily intoxicated. Ms Boyd told the PSOs that she wanted to end her life and talked about her difficult relationship with her ex-husband and the custody battle for her young son.

9. At 8.25pm, Ambulance Victoria paramedics attended Gardenvale train station. Paramedic James Ho stated that Ms Boyd was uninjured, alert and talkative, however, she appeared to be suffering from an '*acute psychiatric problem*.'[7] Paramedic Ho transported Ms Boyd by ambulance for psychiatric assessment at the Emergency Department (ED) of the Alfred Hospital. Ms Boyd was escorted by Victoria Police pursuant to section 351 of the *Mental Health Act 2014* (Vic) [*Mental Health Act*]. ED staff assessed Ms Boyd and determined that she was intoxicated from alcohol use, so she was admitted overnight.

10. On 24 May 2018, Alfred Hospital Emergency Psychiatric Services assessed Ms Boyd. During the assessment, Ms Boyd reported significant psychosocial stressors and acknowledged heavy alcohol use. Ms Boyd stated that she felt suicidal while intoxicated but, now that she was sober, she said that she had no plans to end her own life. Ms Boyd was discharged from Alfred Health that morning.

11. On 25 May 2018, Ms Boyd went to the Windsor train station and sat on the end of the platform with her knees bent over the edge of the painted white line. At approximately 11.35am, a train bound for Flinders Street train station struck Ms Boyd's leg. The train's driver stated that Ms Boyd seemed to want to move onto the train tracks but could not completely commit to the act. He said that Ms Boyd was looking at him as the train approached; he applied the emergency brakes. Emergency Services were contacted, and AV paramedics provided treatment to Ms Boyd's leg injuries. At 11.42am, Victoria Police attended Windsor train station; they interviewed the train driver and conducted a PBT which produced a negative result. Mrs Boyd was transported by ambulance to the

[7] Coronial Brief, *Statement of Paramedic James Ho*, dated 5 August 2018, p 157.

Alfred Hospital to treat her injuries and for psychiatric assessment, pursuant to section 351 of the *Mental Health Act*.

12. At the Alfred Hospital ED, Ms Boyd's blood alcohol level was detected at 0.184 mg/L.[8] She informed medical staff that she had attempted to move out of the way at the final moment, but her ankle had been "clipped" by the moving train. Ms Boyd was admitted to the Trauma Service of the Hospital and had surgery to pin an ankle fracture.

13. On 26 May 2018, the Consultant Liaison Psychiatry (CLP) team reviewed Ms Boyd. During the review, Ms Boyd described significant social stressors, including: a volatile relationship with her ex-husband, extreme frustration and sadness due to having limited access to her son, and her father's ill health. Ms Boyd stated that she had been drinking heavily over the past month and that she had committed to a short, unsuccessful stint in rehabilitation during that time. She acknowledged being intoxicated at the train station the previous day. However, Ms Boyd stated that she did not go there intending to suicide.

14. On 28 May 2018, Ms Boyd was ready to be discharged from the Trauma Service; she had been cooperative with all orthopaedic treatment. She was offered voluntary admission to the psychiatric ward for ongoing assessment of her mental state. Ms Boyd declined admission stating that she was no longer suicidal. However, in light of the seriousness the incident leading to her injuries, Ms Boyd was placed on a Temporary Treatment Order (TTO) and admitted to the Psychiatry Acute Inpatient Unit on 29 May 2018.

15. Between 29 May 2018 and 12 June 2018, Ms Boyd was treated as a psychiatric inpatient at Alfred Hospital. She was prescribed diazepam to mitigate the effects of alcohol withdrawal and agitation, as well as analgesia for her ankle fracture. Initially, Ms Boyd refused to discuss her mental health; she insisted that she was there due to an injury. She began to engage with treating clinicians during the first week of her admission. Ms Boyd reiterated that her difficult relationship with her ex-husband, limited access to her son and her father's ailing health were stressors impacting her mental wellbeing. She initially downplayed the effect of alcohol on her mental health but eventually agreed to consult

[8] Coronial Brief, *Statement of Consultant Psychiatrist of Alfred Health Dr Rosaria Forlano*, dated 21 September 2019, p 182.

with specialist inpatient drug and alcohol clinicians. Ms Boyd was prescribed an antidepressant, fluoxetine, and she indicated that this drug had been helpful in the past. Ms Boyd also received support from a Department of Health and Human Services (DHHS) social worker.

16. On 12 June 2018, Ms Boyd's TTO was revoked as her mood and engagement with clinicians had substantially improved. She continued to receive treatment as a voluntary patient until 15 June 2018. Ms Boyd was discharged and went to live with her friend Albert Pietrzak who had a meeting with Alfred Health staff prior to discharge, during which he indicated that he had a longstanding awareness of Ms Boyd's mental health and alcohol misuse diagnoses.

17. Alfred Health staff referred Ms Boyd to Bayside Services for drug and alcohol support. Her mental health plan included consulting her General Practitioner (GP) to access a psychologist. Ms Boyd agreed to follow up with Alfred HOPE to assist her in linking with drug, alcohol and psychological services in the community. On the date of discharge, Ms Boyd had a psychiatric review where she presented appropriately for release from the hospital.

18. On 16 June 2018 and 17 June 2018, Mr Pietrzak said that Ms Boyd stayed in his home without any issues. She told him that she was concentrating on catching up on her work and which he considered a positive sign. On 18 June 2018, Mr Pietrzak suggested that they go for a walk together, but Ms Boyd stated that she wanted some time on her own and that it would be therapeutic after being '*locked away in Geelong and the Hospital*.'[9] Ms Boyd left Mr Pietrzak's home. He said that he was unable to contact her after this point. Ms Boyd's father called and indicated his concern as he was no longer able to contact his daughter. Mr Pietrzak said that he left a "firm" message on Ms Boyd's telephone, requesting that she contact him, but he received no response.

19. Witnesses Roqiyya Rhan and Julie Duncan provided statements to Victoria Police after Ms Boyd's death. The witnesses confirmed that Ms Boyd had sat at the southern end of the platform with her legs over the white painted coping. Ms Duncan stated that Ms Boyd was drinking from a bottle; she was unsure about the contents of the bottle.

[9] Coronial Brief, *Statement of Albert Pietrzak*, dated 18 August 2018, p. 168.

After an announcement indicated that the train was one minute away, Ms Boyd moved from the southern-end of the platform onto the ground near train tracks. She stood aside and then leapt underneath the train at the last moment. Closed circuit television (CCTV) footage confirms the events recounted by Ms Duncan and Ms Rhan.

20. Metro Trains Melbourne have provided the Court with a copy of their Detailed Incident Investigation Report in relation to Ms Boyd's death. The Report indicated that the train driver was appropriately qualified and medically fit to operate an electric train at the time of the incident in which Ms Boyd died. The report detailed that the train driver applied the emergency brake and sounded his horn immediately after perceiving Ms Boyd standing underneath the bridge. Victoria Police administered a PBT test to the train driver which produced a negative result in compliance with relevant safety legislation. There were no maintenance issues with the train which were identified as potentially causing or contributing to the collision.

Further Investigation

21. In light of Ms Boyd's recent contact with health services prior to her death, I requested that the coronial investigator provide details about Ms Boyd's engagement with other welfare services.

Barwon Health Service (BHS)

22. Consultant Psychiatrist Dr Scott Hall provided a statement in relation to Ms Boyd's contact with the BHS. Ms Boyd had many instances of contact with BHS between January 2017 and May 2018.

Contact in 2017

23. On 28 January 2017, Ms Boyd presented to the Barwon Health Emergency Department (ED) with symptoms of alcohol withdrawal, including: tremors, agitation and generally feeling unwell. She was admitted to Barwon Health's Short Stay Unit and prescribed diazepam to assist with withdrawal symptoms.

24. Between 27 February 2017 and 11 May 2017, Ms Boyd presented to Barwon Health Service on six occasions complaining of chest pain and anxiety. On the first occasion, Ms Boyd was referred to her GP for follow up. She left the ED before a review could be

conducted on the second occasion. On 27 March 2017, Ms Boyd presented to the ED a third time and was admitted to the Short Stay Unit and received a mental health assessment. The medical record states that she did not show suicidal ideation nor intent at that time. Ms Boyd said that she had a history of heavy alcohol consumption and financial stressors. The assessing clinician documented a provisional diagnosis of anxiety and alcohol dependence; Ms Boyd refused referrals to services that may be able to help her with these diagnoses and was ultimately discharged from the service. On 12 April 2017 and 10 May 2017, Ms Boyd re-presented to the ED with the same complaints of chest pain and anxiety but left before she was able to be reviewed by a mental health clinician. On 11 May 2017, Ms Boyd was admitted to the Short Stay Unit and had another mental health assessment. On that occasion, the assessing clinician found her to be displaying fair judgement and insight (albeit impaired by alcohol use) and she denied suicidal ideation, planning and intent. Ms Boyd was discharged back to her residential address with advice to engage with her GP and "walk in" drug and alcohol services.

25. On 21 May 2017, Ms Boyd was transferred to the BHS by ambulance; she reported anxiety, distress, suicidal ideation and she was intoxicated. Ms Boyd was assessed by a mental health clinician to whom she reported drinking heavily, recently using cocaine and conflict with her ex-husband. The mental health clinician noted that Ms Boyd had experienced '*fleeting suicidal thoughts (esp when needs not met)*'.[10] At the time of assessment, the clinician concluded that Ms Boyd's suicidal risk was low. They discussed strategies for Ms Boyd to deal with her alcohol dependence and other treatment options; she expressed a desire to attend the BHS drug and alcohol clinic in the following week. Ms Boyd was discharged, and the assessing clinician arranged for a follow-up phone call the following day. On 22 May 2017, Ms Boyd informed the BHS staff member that she intended to seek admission to the Wyndham Clinic Private Hospital with the support and assistance of her father.

Ms Boyd's contact with BHS in 2018

26. On 26 April 2018, Ms Boyd presented to the BHS ED by ambulance. The medical record indicates that she felt threatened at home and she was seeking shelter. However,

[10] Coronial Brief, *Statement of Dr Scott Hall on behalf of Barwon Health Service*, dated 24 September 2018, p 177.

she left hospital of her own volition, before an assessment could be completed. There were no attempts to follow-up Ms Boyd on this occasion.

27. On 29 April 2018, Ms Boyd presented to the BHS ED by ambulance after an event of alleged domestic violence involving her ex-husband. Ms Boyd was referred to the BHS mental health services but refused to wait to be seen by clinicians. BHS staff attempted contact Ms Boyd after she had left the health service, but their telephone call was unanswered. The medical record states that the Mental Health Triage were to follow up during business hours. This was reportedly because Ms Boyd had not expressed suicidal ideation or thoughts of deliberate self-harm at the time of her presentation.

28. On 30 April 2018, a BHS access liaison officer telephoned Ms Boyd. The officer noted that Ms Boyd's speech was slurred, and she stated that she had been drinking alcohol. Ms Boyd stated that she was planning on being admitted to the Geelong Private Hospital the following day and she was informed that further follow-up would be conducted at that time. On 1 May 2018, a BHS access liaison officer contacted Geelong Private Hospital and ascertained that Ms Boyd had been admitted as an inpatient.

29. On 12 May 2018, Ms Boyd was transported by ambulance to BHS ED pursuant to section 351 of the *Mental Health Act 2014* (Vic) [the *Mental Health Act*].[11] Ms Boyd had a number of lacerations on her arms which did not require any medical treatment and she denied ongoing suicidal ideation. Ms Boyd was made subject to an assessment order under the *Mental Health Act* and was admitted to the Swanston Centre (BHS' acute inpatient psychiatric ward), pending assessment from the on-call psychiatrist the following morning. On 13 May 2018, Dr Hall was the on-call psychiatrist and he assessed Ms Boyd with the on-call psychiatric registrar Dr Marina Caulfield. During the assessment, Ms Boyd expressed regret about the episode of self-harm. Ms Boyd wanted to pursue admission to the Wyndham Clinic Private Hospital and indicated that she would remain a voluntary patient at the Swanston Centre until that could be arranged.

30. Dr Hall stated that Ms Boyd did not appear to be psychotic or severely depressed. She denied further suicidal ideation or thoughts of self-harm. Dr Hall revoked the assessment

[11] Section 351 of the *Mental Health Act 2014* (Vic) enables Victoria Police officers to apprehend a person who appears to have a mental illness *and* who appears to be an imminent risk to themselves or others, in order to transport them for mental health assessment.

order as he formed the view that Ms Boyd did not meet the criteria under the *Mental Health Act*. She indicated that she would go home to gather some belongings and return to the Swanston Centre as a voluntary patient. However, it became evident that Ms Boyd was not going to return. Later in the day, the Community Mental Health (CMH) clinician contacted Ms Boyd and ascertained that she had recommenced drinking, was not suicidal and did not intend to return to the Swanston Centre.

31. On 14 May 2018, the CMH team organised a home visit for Ms Boyd. A CMH clinician informed Dr Hall that Ms Boyd had appeared intoxicated with alcohol. She said that she had experienced suicidal ideation and that she wanted to be admitted to the Wyndham Private Clinic Hospital (Wyndham Clinic). Ms Boyd said that she had been offered a bed at the Wyndham Clinic and she would attend for an assessment. A CMH clinician independently confirmed this information with Wyndham Clinic staff. A CMH clinician organised a taxi for Ms Boyd to attend Wyndham Clinic, pursuant to Dr Hall's approval. A short time later, a CMH clinician confirmed that Ms Boyd had been admitted to the Wyndham Clinic.

32. On 16 May 2018 and 17 May 2018, BHS mental health services staff contacted the Wyndham Clinic to keep abreast of Ms Boyd's progress. They were informed that Ms Boyd had discharged herself from the Wyndham Clinic, returned home and recommenced consuming alcohol on 17 May 2018.

33. On 18 May 2018, BHS community mental health services visited Ms Boyd at home. She continued to drink alcohol and declined support from the team. A CMH clinician consulted Dr Hall who formed the opinion that Ms Boyd did not meet the criteria for treatment under the *Mental Health Act*. On 21 May 2018, the BHS community mental health team held a multidisciplinary meeting during which they discussed Ms Boyd's case. The team agreed not to pursue active follow-up as Ms Boyd was refusing to engage with the health service and she did not meet the criteria for involuntary treatment under the *Mental Health Act.* Ms Boyd had no further contact with BHS.

Coroners Prevention Unit – Family Violence Team Review

34. On 19 December 2019, I requested that the Coroners Prevention Unit (CPU)[12] Family Violence Team review the adequacy of the support provided by agencies in response to Ms Jolanta Boyd's disclosures of family violence prior to her death.

35. Following review of the coronial brief and additional documents, the CPU Family Violence Team noted the following key points:

- Ms Boyd died in circumstances indicating suicide on 18 June 2018.
- Following concerns for her mental health, Ms Boyd was engaged with BHS from 12 May 2018 to 18 May 2018. During her engagement with the hospital, staff were made aware that she had disclosed alleged family violence perpetrated towards he by her ex-partner, Mr Jeremy Boyd.
- Ms Boyd's experiences of family violence do not appear to have been addressed by staff and it was noted staff continued to share information regarding Ms Boyd's health with Mr Boyd.
- In review of BHS policies and procedures, the CPU Family Violence Team found that the service had recently introduced the Strengthening Health Service Response to Family Violence (SHRFV) in early 2018, following recommendations from the Royal Commission into Family Violence. In review of these materials, the CPU Family Violence Team raised concerns that family violence training was not mandatory for hospital staff under this program.
- It was also identified that the relevant policies and procedures in place at the time of Ms Boyd's death, and those that have since been introduced, fail to provide guidance on sharing of patient information with the Next of Kin in circumstances where family violence has been identified in the relationship.

[12] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

- On 23 May 2018, Ms Boyd disclosed to PSOs that she was experiencing family violence and requested the assistance of Victoria Police. A review of the relevant statements and records indicate that attending PSOs took no further action in relation to these disclosures and failed to comply with relevant policies and procedures by reporting the incident to police.

36. Following the identification of these concerns, I directed the CPU Family Violence Team to undertake the following steps to obtain a statement from:

    - The creators of the SHRFV querying why mandatory family violence training for hospital staff or sub-groups of staff was not recommended in their implementation guides.

    - BHS regarding the voluntary nature of their family violence training and what format the training was offered to staff.

    - Victoria Police as to whether PSOs in attendance on 23 May 2018 were obligated under the Victoria Police Manual – Crime and event reporting and recording policy to record the family violence reported by Ms Boyd on 23 May 2018.

    - Victoria Police Civil Litigation as to whether PSOs are provided with training in relation to understanding and responding to disclosures of family violence.

37. The CPU Family Violence Team have since received the requested statements from BHS and Victoria Police and have provided a review of these responses below.

<u>Barwon Health Service</u>

38. In response to queries regarding the voluntary nature of their family violence training, BHS advised that staff in management positions are currently required to undertake Module 1 - Family Violence a Shared Understanding (Module 1) and the Workplace Support Education Module. In addition, '*clinical staff are directed by their line manager to include SHRFV training in their annual education programs*'[13] and must undertake both Module 1 and '*one or multiple of the SHRFV specialist education models where*

[13] Coronial File, *Statement of K. Todd of Barwon Health*, 1.

applicable to the staff member's role'.[14] Attendance at these training sessions forms part of staff performance appraisals and can be monitored by managers via an online attendance certificate.

39. In addition to the Module 1 training, a range of specialised training modules are being delivered by BHS, who advised that several of these training packages have been customised to meet the individual needs of various clinical specialties. BHS also advised that they are currently planning to integrate Module 1 into the hospital's orientation program so that all new staff are educated in relation to the presentation of family violence and the supports available to patients.

40. In response to queries regarding the delivery of this training, BHS advised that the Module 1 is available online for all staff and is also delivered face to face at staff forums and upon request. BHS advised that the majority of staff members who have undertaken the Model 1 training have attended face to face training. BHS indicated that due to Covid-19 pandemic, all face to face training has been suspended, but that lecture notes and presentations have remained available via the organisation's Intranet.

41. BHS provided privacy and health information policies shared which include protocol for the dissemination of patient information with Next of Kin and approved parties. However, the policies do not consider the appropriateness of this in the setting of (alleged) family violence. The BHS *Family Inclusive Practic*e procedure requires clinicians to seek permission from patients regarding the disclosure of health information but fails to provide guidance in incidents of family violence and focuses largely on encouraging family involvement. The BHS *Recognising and Responding to Family Violence* policy, currently approved by the hospital board and awaiting dissemination, aims to support Barwon Health in improving responses to family violence. This policy provides some consideration of confidentiality and family violence by advising staff to '*not record information about disclosures of violence in records or alerts that are accessible by spouses/carers/family members without the individual's permission to do so*'.[15] The policy does not consider whether other forms of information about a patient's

[14] Coronial File, *Statement of K. Todd of Barwon Health*, 2.

[15] Barwon Health, *Recognising and Responding to Family Violence Policy*, 9.

health or condition should be shared with family members who may be responsible for perpetrating family violence and the potential risks associated with this.

Victoria Police

42. Victoria Police advised that they were '*satisfied that Ms Boyd did make a complaint to PSOs regarding family violence offences when she was spoken to*'[16] on 23 May 2018. However, they noted that they were unsure whether attending PSOs had relayed this information to the attending Sergeant or if there were any reports made by the PSOs regarding the disclosed family violence offences.

43. Victoria Police further advised that under the Victoria Police Manual (VPM) *Crime Event and Reporting and Recording Policy*, PSOs are required to record a crime or event such as family violence. However, the VPM *PSOs of Railway Network Policy* only directs PSOs to report/record incidents such as family violence (in instances where the offender is not present) when the incident or crime has '*occurred at or in the vicinity of the designated place*'.[17] Given that Ms Boyd's reports of family violence on 23 May 2018 did not refer to violence that had occurred "at or in the vicinity" of where the PSOs were on duty and that the alleged offender was not present, Victoria Police advised that PSOs were not obligated to make a report.

44. Victoria Police conceded in their statement that '*in the course of addressing the Coroner's query, it has become clear that there is unfortunately a potential for a discrepancy in the requirements imposed by the VPM- Crime and event reporting and recording policy and the VPM- PSOs on railway network policy*'.[18] It was also acknowledged that the role of PSOs in incidents of family violence was not detailed in police family violence related policies and procedures and that no further guidance regarding how PSOs should respond to family violence is documented in the VPM.

45. Victoria Police conceded that the VPM *PSOs on Transport Networks Policy* does not make '*specific mention of family violence*'[19] and that '*whilst required actions are*

[16] Coronial File, *Statement of J Rose of Victoria Police*.

[17] Ibid, 4.

[18] Ibid, 5.

[19] Ibid 10.

detailed elsewhere…opportunity to ensure absolute clarity for PSOs exists'.[20] As such, Victoria Police advise that the Transit Safety Division will be '*progressing a recommended change to this policy*'[21] to include instructions for PSOs in instances where family violence becomes known.

46. Victoria Police advised that PSOs undertake a range of training in relation to family violence during their recruitment training and that as of late, PSOs are also required to undertake family violence training during their induction phase and this training has become a mandatory requirement for all PSOs. Additionally, Victoria Police advised that PSOs are also able to access further family violence training via the Victoria Police Learning Hub.

COMMENTS

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

1. I endorse and commend Victoria Police's proposed policy changes for their *PSOs on Transport Networks Policy*. However, I remain concerned that guidance appears to only mandate that PSOs report incidents of family violence when it has occurred *'at or in the vicinity of the designated place*' and does not, therefore, stipulate the responsibilities of a PSO when they become aware of an incident of family violence that occurs outside of the vicinity of the designated place. It appears sensible and prudent that the updated policy should be broadened to include provisions for how PSO's should respond when they are advised of family violence incidents that have not occurred at or in the vicinity of the designated place. A pertinent recommendation will follow.

2. The training measures implemented by BHS appear comprehensive and tailored to the differing needs of hospital staff. I also commend BHS' decision to deliver Module 1 to all incoming staff, both face to face and online for all other staff members. However, BHS' policies and procedures do not appear to completely account for the presence of family violence in their information sharing protocols. Given the apparent absence of guidance regarding the risks associated with establishing an alleged perpetrator of

[20] Above n 16, 10.

[21] Ibid.

family violence as a victim's Next of Kin, a recommendation is required to support a more fulsome and explicit consideration of risk in sharing patient health information relating to a victim of family violence with the alleged perpetrator.

3. The investigation has identified that Ms Boyd had referred to alleged family violence incidents to both Barwon Health Service staff as well as Victoria Police Officers and Protective Services Officers during the period proximate to her death. These instances clearly call for improvement in processes of both institutions. However, they cannot be definitively stated as "opportunities lost" to prevent Ms Boyd's death. I do not intend to make a finding to that effect.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendations:

1. In the interests of promoting public health and safety and preventing like deaths, **I recommend** that Victoria Police update its Protective Services Officers on Transport Networks Policy to include provisions for how PSO's should respond when they are advised of family violence incidents that have not occurred at or in the vicinity of the designated place.

2. In the interests of promoting public health and safety and preventing like deaths, **I recommend** that Barwon Health Service update its Use and Disclosure of Information Procedure, the Family Inclusive Practice Procedure, the Recognizing and Responding to Family Violence Procedure Manual and all other relevant policies and training so that it is explicit that staff must consider the risks of sharing patient health information relating to a victim of family violence with the alleged perpetrator.

FINDINGS

1. I find that Jolanta Boyd, born 18 September 1969, died on 18 June 2018 at Windsor Railway Station, Windsor, Victoria 3181.

2. I find that Jolanta Boyd had a complex medical history of mental ill health, including suicidality.

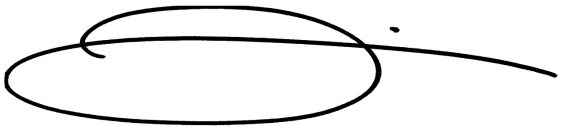
3. I find that Jolanta Boyd received medical services from Barwon Health Service proximate to the time of her death and that these services were reasonable and appropriate in the circumstances.

4. I accept and adopt the cause of death ascribed by Dr Sarah Parsons and I find that the cause of Jolanta Boyd's death was multiple injuries sustained when struck by a train, in circumstances where I find that she intended to end her own life.

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

I direct that a copy of this finding be provided to the following:
Miroslaw Olszewski
Daniela Olszewski
Ms Vanja Obradovic, Alfred Health
Ms Lorraine Judd, Barwon Health
Dr Neil Coventry, Office of the Chief Psychiatrist
Acting Sergeant Robert Douglas Hickey

Signature:



AUDREY JAMIESON
CORONER
Date**: 11 May 2020**