IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 2583
Linked Cases:[1] COR 2018 4780
COR 2018 5104
COR 2019 3839

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	**AUDREY JAMIESON, CORONER**
Deceased:	**Ms WX[2]**
Date of birth:	**10 February 1978**
Date of death:	**1 June 2018**
Cause of death:	**Injuries sustained when struck by a train**
Place of death:	**Approximately 160 metres east of Epping Railway Station, Epping, Victoria 3076**

[1] Coronial Findings may be linked where deaths are connected by precipitating events or by data which indicates key similarities, i.e. cluster analysis. The nominated linked coronial investigations represent a "suicide cluster", which has been defined as a group of suicides that occur closer together in time and/or space than would normally be expected.

[2] The names of the deceased person and their family members have been redacted and replaced with pseudonyms of randomly generated two letter sequences to protect their identity.

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

1. Ms WX was 40 years of age at the time of her death. In around 2010, Ms WX immigrated to Australia from India to live with her husband Mr WI and their son Mr CF. At the time of her death, they lived in Epping with their adult son and niece. Ms WX worked full-time in quality control at a food company. She had no documented medical history of mental ill-health.

2. At about 6.21pm, Ms WX was struck by a South Morang Service train, approximately 160 metres from the Epping Railway Station. At approximately 6.32pm, emergency services arrived and commenced cardiopulmonary resuscitation (CPR). Ms WX could not be revived and was pronounced deceased by paramedics at 6.46pm.

3. Pursuant to section 126 of the *Rail Safety National Law* (Victoria),[3] the train driver completed a preliminary breath test and a negative result was returned.

REPORTABILITY

4. Ms WX's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act'), because it occurred in Victoria, was considered unexpected, unnatural and to have resulted, directly or indirectly, from an accident or injury.

PURPOSE OF THE CORONIAL INVESTIGATION

5. The Coroners Court of Victoria is an inquisitorial jurisdiction.[4] The purpose of a coronial investigation is to independently 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.[5] The cause of death refers to the medical cause of death, incorporating where possible 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

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[3] *Rail Safety National Law Act 2012* (South Australia); *see Rail Safety National Law Application Act 2013* (Victoria) s 6.

[4] *Coroners Act 2008* (Vic) s 89(4).

[5] Ibid 67(1).

and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death. [6]

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, generally referred to as the 'prevention' role.[7] 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 and 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.[8] These are effectively the vehicles by which the prevention role may be advanced.[9]

7. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation.

INVESTIGATIONS

Forensic pathology investigation

8. Dr Joanna Moira Glengarry, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Ms WX, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Dr Glengarry reported that post mortem CT scanning identified multiple injuries; including severe injuries to the chest. Toxicological analysis to post mortem blood identified no common drugs, poisons or alcohol. Dr Glengarry formulated the medical cause of Ms WX's death as injuries sustained when struck by a train.

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

[7] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

[8] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[9] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

Police investigation

9. Upon attending Epping Railway Station subsequent to Ms WX's death, Victoria Police Crime Scene Officers photographed the scene. Victoria Police Officers also coordinated with Metro Trains Melbourne (MTM) safety Investigator Stacey Chumbley. Ms Chumbley produced a Suspected / Actual Self-Harm Investigation Report (MTM Report) in relation to Ms WX's death on 19 June 2018.

10. The MTM Report indicated that Ms WX had probably accessed the railway tracks by a nearby, unlocked gate and that she had waited for the train near Darebin Bridge, approximately 160 metres from Epping Railway Station; Ms WX's mobile telephone was located near the gate after her death. She ran onto the railway tracks and into the path of the oncoming train, the train driver engaged the emergency brakes but was unable to avoid the collision. The train was travelling between 60 and 65 kilometres per hour when it struck Ms WX, less than the relevant speed limit of 80 kilometres per hour.

11. First Constable (FC) Lili Vay was the nominated Coroner's Investigator.[10] At my direction, FC Vay investigated the circumstances surrounding Ms WX's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, the MTM Report, as well as statements made by Ms WX's family members, treating General Practitioners (GPs) and Victoria Police Officers.

12. During the investigation, police learned that Ms WX had no known Australian medical history of mental ill health nor suicidal ideation. Her husband provided the details of three medical practitioners whom she had consulted: Dr Chaudhary Panwar of the Danaher Drive Medical Centre, Dr Prabhjot Khanna of Epping Healthcare and Dr Santokh Singh of Epping Clinic. Each medical practitioner provided statements to the effect that they had treated Ms WX for general medical issues but that there had been no indication of mental ill health.

13. Ms WX's husband Mr WI stated that his marriage with Ms WX was arranged and that they had married in 1997. He informed me that this was a regular practice in their culture. Mr WI said that they '*had a good relationship. I had a full-time job and*

[10] 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.

(Ms WX) *was a stay at home wife. We lived with our extended family together.* (Ms WX) *had a very good relationship with my family*'.[11]

14. In 2008, Mr WI made an application for a "family visa" to Australia. Mr WI immigrated to Australia in April 2010. Mr WI stated that Ms WX was excited to emigrate. He said that he left India first to find employment and subsequently sent for her and their son. Ms WX and a young Mr CF came to Australia in September 2010.

15. The family gained Australian citizenship in 2015. Later that same year, Mr WI's niece, Ms HB, came to live with their family in their two-bedroom apartment in Epping. He stated that Ms WX '*was the one who encouraged her to move in with us as she felt there was no future in India'*.[12] Ms WX and Mr WI slept on a mattress on the living room floor and their son and niece slept in the bedrooms.

16. Mr WI stated that he could not '*imagine why she would take her own life. She had a good life and a good job.*'[13] However, he also said that Ms WX was not happy with their home. On three or four occasions, Ms WX had left '*the gas on in the house...we asked her to go get checked out but she would always smile and say she's just forgotten.* '[14] Mr WI stated that they had purchased land in Craigieburn and had designed a house with a project-home company. He said that construction delays caused his wife distress; she '*was depressed that the house wasn't built on time*'.[15]

17. Mr WI commented that Ms WX worked too much and that '*she knew we didn't like her working too much*'.[16] He said that Ms WX worked two or three times a week but that she would take on more overtime and earlier shifts to pay for new furniture. Due to the house-construction delays, Ms WX was unable to arrange for the collection of furniture she had purchased. Mr WI cancelled the order as the retailer had indicated that they would be charged $150 for each month it remained uncollected.

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[11] Coronial Brief, *Statement of Mr WI*, dated 29 July 2018, p 11.

[12] Ibid, p 10.

[13] Ibid, p 11.

[14] Ibid, p 10.

[15] Ibid, p 11.

[16] Ibid.

18. Ms WX's son stated that she worked in a permanent, full-time capacity from 7.30am to 3.30pm Monday to Friday. My investigator established with Ms WX's workplace Human Relations (HR) that this was accurate. Mr CF stated that she was doing a lot of overtime work. He said that his mother did not sleep well; '*she sometimes only got two hours sleep and on average 4 – 5 hours' sleep'*.[17] He echoed his father's impression that Ms WX was deeply affected by the delay in the construction of their home; especially as she had already bought all of the furniture for their future home.

19. Ms HB reiterated that her aunt worked a lot of overtime, '*even when her boss called and asked her to work early even at 3 AM, she would accept the overtime. I felt like she wasn't getting enough rest. She was also a restless sleeper'*.[18] Ms HB also stated that her aunt was stressed by the delays in construction of their new home, particularly due to the storage fees for furniture that she had already purchased.

20. Mr CF said that Ms WX was regularly using pain medication, which she said was for back-aches and headaches. He said that he encouraged his mother to speak to a GP in light of his discovery that she was regularly using pain medication; Mr CF intimated that he believed his mother was using the medication due to her high stress levels. He stated that he had tried to encourage his mother to speak to a psychologist. He also said that Mr WI had tried to discuss seeking professional medical assistance for mental health with Ms WX, to no avail.

21. Mr CF stated that he '*had no idea why* (his mother) *would commit suicide. She never mentioned suicide and our family wouldn't support it. We don't have a family history of it. I believe our family was happy. Everything was falling into place because the house was getting built and furniture was getting delivered to our rental home.'*[19]

22. Approximately one week prior to Ms WX's death, she was on a train with her husband when it suddenly stopped; someone had apparently jumped in front of the train to end their own life. Mr WI had said that his wife had criticised the actions of the unknown person, stating: '*stupid people, why are people idiots'?*[20]

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[17] Coronial Brief, *Statement of Mr CF*, dated 29 July 2018, p 14.

[18] Coronial Brief, *Statement of Ms HB*, dated 29 July 2018, p 14.

[19] Coronial Brief, *Statement of Mr CF*, dated 29 July 2018, p 15.

[20] Above n 11.

23. On 1 June 2018 during the afternoon, Ms WX returned home from work and asked Mr CF if he wanted something to eat. There were no others in the family home. Mr CF stated that he had been sleeping and resumed doing so shortly after informing his mother that he had already eaten.

24. At approximately 6.33pm, Mr CF received a telephone call from his paternal uncle[21] who stated that he had been speaking to Ms WX '*when the call got cut off.*'[22] Mr CF said that he went into the living room and realised at that point that his mother had left the home.

25. Mr CF stated that he spoke with his paternal uncle again several days after his mother's death. He was informed that, during their telephone conversation on the evening of her death, Ms WX had said nothing to his uncle but was constantly crying. His uncle stated that he asked Ms WX what was wrong and whether he could help but that she ended the call.

26. During the evening after Ms WX's death, her cousin Ms VS came to the Epping apartment. Ms VS said that Ms HB asked her to come due to the police presence. She said that she spoke to Mr CF who told her that this mother had *'thrown all her bank cards on the floor as she walked out at around 5.30 to 6PM.'*[23] Ms VS opined that Ms WX '*thought she worked a lot but still didn't have any money'*.[24]

Allegations of Family Violence & Economic Abuse[25]

27. FC Vay informed me that Ms WX's father, Mr HT, had lodged a '*murder complaint*'[26] with Ludhiana District Police in Punjab, India, against Mr WI and his family. Ms VS provided a copy of the report to the police which had been translated to English. The report made general and specific allegations of family violence and economic abuse by Mr WI and his family against Ms WX. Additionally, Ms VS made a detailed statement

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[21] The name of Ms WX's brother in law is not identified in the coronial brief.

[22] Above n 17, p 15.

[23] Coronial Brief, *Statement of Ms VS,* dated 2 August 2018, p 21.

[24] Ibid, p 22.

[25] Please see the definitions contained in sections 5 and 6 of the *Family Violence Protection Act 2008* (Vic).

[26] Coronial Brief, *First Constable Lili Vay,* dated 18 September 2018, 4 of 5.

alleging general and specific instances of family violence and economic abuse by Mr WI and his family against Ms WX.

Further Investigation

28. LC Vay informed me that Ms WX was not recorded in the Victoria Police LEAP[27] database and that there were no police-recorded family violence incidents involving Ms WX.[28]

29. Indian Authorities have not contacted the Coroners Court of Victoria in relation to Ms WX's death.

Community Engagement

30. The City of Whittlesea is located approximately 20 kilometres north of Melbourne Central Business District. The City of Whittlesea is one of the largest municipalities in metropolitan Melbourne, covering an area of approximately 489 square kilometres. About 70 per cent of the City is classified as a rural area and 30 percent is urban. The City's council website states that it is one of the fastest growing municipalities in Australia:

> *In the 2016/17 financial year, the City of Whittlesea was the fourth largest growing local government area in Victoria. We currently welcome around 8,000 new residents per year (about 156 a week)... Our current population is approximately 223,566. This is expected to grow to 382,896 by 2041.*
>
> *We are one of the most multicultural municipalities in Victoria. In 2016, almost half of all local residents (over 86,000 residents) spoke a language other than English at home. In previous decades, a higher proportion of our overseas-born residents were of European heritage, particularly Italy, Macedonia and Greece. Between 2011-2016, emerging communities in the City of Whittlesea included residents born in India (+5,866 persons), China (+1,780), Iran (+1,300) and Sri Lanka (+1,211).*[29]

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[27] "Law Enforcement Assistance Program"; Victoria Police information database.

[28] Above n 26, p 5 of 5.

[29] Whittlesea Council, *Suburbs and Residents,* City of Whittlesea <https://www.whittlesea.vic.gov.au/about-us/our-city/suburbs-and-residents/> (date accessed 31 August 2020).

Whittlesea Community Concerns

31. In early 2019, Victoria Police and the Crossroads to Community Wellbeing Group, through Whittlesea Community Connections, contacted the Coroners Court of Victoria (CCOV) to convey concern about a perceived increased frequency of suicides of South Asian women in the City of Whittlesea.

32. Following this notification, I directed the Coroners Prevention Unit (CPU)[30] to identify previous and monitor subsequent suspected suicides of South Asian women in the City of Whittlesea.

Analysis of suspected suicides

33. The CPU used the Victorian Suicide Register[31] to conduct a retrospective case series examination of suspected suicides amongst South Asian women in the City of Whittlesea. The CPU identified four suspected suicides of South Asian women in the City of Whittlesea in 2018, compared to one relevant death for the period 2009 to 2015.

34. This retrospective examination showed that during 2018, the City of Whittlesea experienced an elevated frequency of suspected suicide amongst South Asian women and that this met the Centres for Disease Control and Prevention's definition of a suicide cluster.[32]

35. I also note that through the course of this retrospective examination, the CPU identified a further death of a South Asian woman that occurred in the City of Whittlesea during 2018, though in this closed matter, the death was determined to be due to natural causes. Despite this, the circumstances of this matter were reviewed in the context of this cluster and common themes have been found.

36. Additionally, in monitoring subsequent suspected suicides of South Asian women in the City of Whittlesea, the CPU identified a further two possibly relevant deaths that

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[30] The Coroners Prevention Unit is a specialist service created for coroners to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

[31] The Victorian Suicide Register (VSR) is a database containing information on coroner-determined and suspected suicides reported to and investigated by Victorian Coroners between 1 January 2000 and the present.

[32] *A group of suicides or acts of deliberate self-harm that occur closer together in space and time than would normally be expected on the basis of statistical prediction and/or community expectation* (Centres for Disease Control, 1994).

occurred in 2019. This brings the total number of suspected suicides of South Asian women in the City of Whittlesea for the period 2018 to 2019 to six.

Round-table meeting and submissions

37. Given this elevated frequency of suicides, I further directed the assistance of the CPU to seek input from relevant agencies and community leaders by convening a round-table meeting. The aim of the round-table meeting was to obtain informed input regarding the vulnerabilities of South Asian women in the Whittlesea area, with the aim of assisting me to make prevention focused and, if possible, consensus comments and/or recommendations.

38. I held a round-table meeting on 24 July 2019 at the CCOV. Representatives from Whittlesea Community Connections, Victoria Police, Eastern Melbourne Primary Health Network, Berry Street, Whittlesea Council Health Planning and Community Safety Planning teams, the Department of Health and Human Services and the Coroners Prevention Unit participated, as well as expert psychiatrist, community leader and South Asian Communities Ministerial Advisory Council member Dr Manjula O'Connor. All participants were invited to openly discuss vulnerabilities faced by South Asian women in the Whittlesea community and barriers to these women in accessing supports.

39. To explore any opportunities for recommendations I invited attendees of the roundtable meeting to provide submissions in relation to their knowledge and observations of the vulnerabilities of South Asian women in the Whittlesea area, what services are currently available in the Whittlesea area and what more could be done to prevent such deaths. I would like to acknowledge and thank all the parties and organisations that provided submissions to me as part of this investigation.

Vulnerabilities of South Asian women in the City of Whittlesea

40. I received submissions from Whittlesea Community Connections, Victoria Police, Eastern Melbourne Primary Health Network, Berry Street, Whittlesea Council Health Planning, Community Safety Planning and Maternal and Child Health teams, and Dr Manjula O'Connor.

41. There was consensus amongst all submissions that many South Asian women living in Australia may be significantly affected by several stressors including: family violence,

including extreme financial control and social isolation; dowry demands; language and cultural barriers in understanding women's rights and accessing services; concerns regarding immigration status; and the stigma of divorce in South Asian culture. It was widely accepted that violence and control can be compounded by South Asian patriarchal culture, including in situations where extended families are living together as this can create additional oppression of the woman. The submissions highlighted that due to these issues, South Asian women often lack agency and experience a sense of powerlessness, making them extremely vulnerable and unlikely to be able to access support services.

42. Whilst the submissions highlighted a range of supports and services currently available to vulnerable women in the Whittlesea area, there was consensus amongst the submissions of all persons and agencies that: the City of Whittlesea is disproportionately affected by lack of access to mental health and family violence services, compared with other municipalities; new and existing services need to be more culturally appropriate, which could be facilitated by further research and engagement with community members; and that vulnerable women often can't access existing services due to cultural barriers, experience of family violence including extreme controlling behaviours, and the geographical isolation of existing services compounded by the lack of public transport infrastructure in the Whittlesea area.

The Crossroads to Community Wellbeing Group

43. The Crossroads to Community Wellbeing Group was established in response to the emerging concern of a perceived increased frequency of suicides of South Asian women in the City of Whittlesea. The working group is comprised of those agencies and community leaders from whom the Court received submissions in this matter, and its purpose is "to prevent suicide of South Asian women, by reducing social isolation and increasing access to support and services" through engagement with the South Asian community to develop community-based solutions.[33]

44. Through the collaboration of stakeholders across the City of Whittlesea service system and the South Asian community, the Crossroads to Community Wellbeing Group has worked effectively in identifying gaps in services available to vulnerable South Asian

[33] Submission of Victoria Police dated 11 November 2019.

women in the City of Whittlesea. In doing this, the Crossroads Group have identified a range of early intervention, prevention and postvention opportunities including: expansion of mental health, family violence, perinatal and other support services in the City of Whittlesea; the establishment of additional South Asian women's support groups, including increased use of religious leaders and survivors of abuse as mentors; increased education for South Asian women regarding women's rights, Australian law and accessing services; increased education regarding cultural sensitisation and appropriateness of service providers; and improved processes for information sharing and data collection across organisations.

COMMENTS

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

1. Round-table meeting attendees submitted that many South Asian women living in Australia may be affected by a number of particular stressors, including, *inter alia*: social isolation, family violence and financial dependence. I do not discount that these stressors can affect other women. Further, the available evidence cannot be held to state that these issues affect all South Asian women living in Australia. However, research undertaken at my direction has identified an elevated frequency of suspected suicide amongst South Asian women in the City of Whittlesea in 2018. It is evident that more must be done to identify appropriate public health and safety measures to prevent like-deaths.

2. I commend the actions of the Crossroads to Community Wellbeing Group in promptly responding to concerns in the community, and for working collaboratively to identify service gaps and subsequent prevention opportunities that would help to reduce isolation and increase access to services for South Asian women in the Whittlesea area. The Crossroads to Community Wellbeing Group is well placed to progress the necessary research and planning required to inform future work, including further inquiries into the broader issues faced by South Asian women in the City of Whittlesea that do not form part of the coronial jurisdiction.

3. I acknowledge that the elevated frequency of suspected suicides of South Asian women in the City of Whittlesea was first noticed by Sergeant Damian Lehmann of Mill Park

Police Station. Sergeant Lehmann's notification of his observations to regional command triggered both community input through the establishment of the Crossroads to Community Wellbeing Group and the subsequent attention of this Court, to systemic issues affecting South Asian women in the Whittlesea region and the urgent need to help them. I commend the astute judgement and timely action of Sergeant Lehmann. Similarly, I acknowledge the efforts of Whittlesea Community Legal Service's Principal Solicitor Chris Howse who coordinated much of the community input into my investigation.

4. It is apparent to me that further investigation into the deaths of South Asian women in the Whittlesea area is warranted. Principally, the Victorian Department of Health and Human Services ought to liaise with Whittlesea community groups and appropriate stakeholders to further the knowledge gleaned in my investigation concerning the three core questions considered in the 2019 CCOV and Whittlesea Community Stakeholders roundtable meeting and corresponding written submissions:

   a. What are the concerns that exist regarding South Asian women in the Whittlesea area that make them vulnerable and possibly at risk of self-harm?

   b. What supports or services are available to vulnerable South Asian women in the Whittlesea area?

   c. What gaps exist regarding supports or services available to vulnerable South Asian women in the Whittlesea area?

5. During my investigation, I learned that the Murray Primary Health Network have engaged Wesley Mission to establish a Life Force Suicide Prevention Network in the Mildura area. Wesley Mission's Life Force Suicide Prevention Networks are described as:

   ...a coming together of people and organisations, a voluntary collaboration working together to influence outcomes of a specific problem. A suicide prevention network, addressing the specific needs of a local area, is one of the most effective ways of

raising community awareness of the issue of suicide, while empowering its members to develop appropriate suicide prevention strategies at a grassroots level.[34]

Member networks are provided with expert advice during establishment, initial funding, and 'hands on' support in planning and delivering suicide prevention projects in their local community.[35]

6. This type of approach seems consistent with the solutions advocated in the submissions. However, further research into the most appropriate solutions are clearly warranted. Supporting vulnerable South Asian women in the City of Whittlesea may require initiatives from a number of government departments. At this juncture, it is clear that the Department of Health and Human Services ought to identify opportunities to improve South Asian women's access to and engagement with support services. A pertinent recommendation will follow.

7. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw (1938)* 60 CLR 336. These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:
    - the nature and consequence of the facts to be proved;
    - the seriousness of any allegations made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

8. The effect of the 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.

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[34] <https://www.wesleymission.org.au/find-a-service/mental-health-and-hospitals/suicide-prevention/wesley-lifeforce-networks/>, accessed 9 June 2020.

[35] Ibid.

9. The available evidence affords me a comfortable level of satisfaction to find that Ms WX was distressed in relation to her financial circumstances, including: the delay in the construction of her home and issues associated with the return of furniture which she had purchased. She had increased her work hours significantly during the period proximate to her death.

10. At the conclusion of my investigation, the evidence before me does not provide a comfortable level of satisfaction to find that family violence or economic abuse was a precipitating factor in Ms WX's death. I am certainly cognisant of the serious allegations of family violence contained in the coronial brief. These allegations cannot be reconciled with the statements of Ms WX's husband, son, niece or other family members; the available evidence on that point is disputed and untested. Additionally, there has not been any formal, corroborating evidence presented to me by Victoria Police. Thus, there is nothing to substantiate the anecdotal evidence of family violence nor economic abuse. I have determined that seeking further, oral evidence in the context of an Inquest is unlikely to provide the necessary clarity to make a finding on this point.

11. Round-table meeting submissions have highlighted family violence as a broader public health and safety issue for South Asian women in Australia. Therefore, I have included a general comment and recommendation in relation to family violence and the intentional deaths of South Asian women in the City of Whittlesea.

12. During my investigation, it was brought to my attention that Victoria Police Family Violence Investigation Units (FVIU) '*are now staffed by detectives and have primacy of investigation for incidents involving people from priority communities with increased likelihood of future family violence*'.[36] Consequently, the FVIUs are uniquely placed to investigate the deaths of women from culturally and linguistically diverse backgrounds in the Whittlesea area: to consider the relevance of any family violence issues and potential common themes in these deaths, including *inter alia* social isolation and family violence, which may, in turn, assist in suicide prevention. Pertinent recommendations will follow.

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[36] Submission of Victoria Police dated 11 November 2019.

RECOMMENDATIONS

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

1. With the aim of promoting public health and safety and preventing like deaths, I recommend that the Secretary of the Department of Health and Human Services review current services that support the health and wellbeing of South Asian women in the City of Whittlesea, and consult with relevant service providers and other stakeholders, to identify opportunities to improve South Asian women's access to and engagement with such services.

2. With the aim of promoting public health and safety and preventing like deaths, I recommend that Victoria Police allocate Family Violence Investigation Units to investigations into suspected intentional deaths of women in the City of Whittlesea who are from culturally and linguistically diverse communities, in circumstances where there is any indication that previous family violence incidents may have contributed to the death.

3. With the aim of promoting public health and safety and preventing like deaths, I recommend that Victoria Police allocate Family Violence Investigation Units to investigations into suspected intentional deaths of women in the City of Whittlesea who are from culturally and linguistically diverse communities, in circumstances where there is any indication that social isolation may have contributed to the death.

FINDINGS

1. I find that Ms WX, born 10 February 1978, died on 1 June 2018 approximately 160 metres east of Epping Railway Station, Epping, Victoria 3076.

2. I find that Ms WX had no known medical history of mental ill health in Australia.

3. The precise precipitating factors leading Ms WX to end her own life may never be known with any degree of certainty. However, I find that Ms WX was in a state of distress in relation to her financial circumstances at the time of her death.

4. I find that the train driver responded reasonably and appropriately in the circumstances and that it was not possible to avoid striking Ms WX when she ran onto the train tracks.

5. I accept and adopt the cause of death formulated by Dr Glengarry and I find that Ms WX died from injuries sustained when struck by a train, in circumstances where I find that Ms WX 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:

Carolyn Kovac of Maurice Blackburn Lawyers on behalf of Mr WI

Ms VS

The Hon. Ros Spence MP, in her capacity as Minister for Multicultural Affairs

The Hon. Jenny Mikakos MP, in her capacity as Minister for Health

Kym Peake, Secretary, Department of Health and Human Services

Shane Patton APM, Chief Commissioner Victoria Police

Eastern Melbourne Primary Health Network

Whittlesea City Council

- Health Planning and Community Safety Planning
- Maternal and Child Health

Whittlesea Community Connections

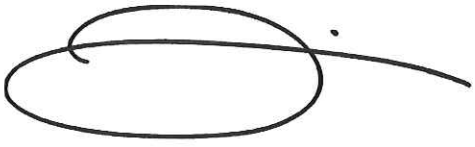
Berry Street Incorporated

Dr Manjula O'Connor

Principal Solicitor of Whittlesea Community Legal Service Chris Howse

Sergeant Damian Lehmann of Mill Park Police Station

Signature:



AUDREY JAMIESON

CORONER

Date: **7 September 2020**