IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 4780

Linked Cases:[1] COR 2018 2583
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 TP[2]**
Date of birth:	**6 April 1981**
Date of death:	**21 September 2018**
Cause of death:	**1(a) Hypoxic ischaemic encephalopathy** **1(b) Neck compression**
Place of death:	**Northern Hospital Epping | 185 Cooper Street, Epping, Victoria 3076**

[1] Coronial investigations 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.

TABLE OF CONTENTS

FINDING INTO DEATH WITHOUT INQUEST **1**

REPORTABILITY **4**

PURPOSE OF THE CORONIAL INVESTIGATION **4**

INVESTIGATIONS **5**

FORENSIC PATHOLOGY INVESTIGATION 5

POLICE INVESTIGATION 6

COMMUNITY ENGAGEMENT 9

Whittlesea Community Concerns 10

Analysis of suspected suicides 10

Round-table meeting and submissions 11

Vulnerabilities of South Asian women in the City of Whittlesea 12

The Crossroads to Community Wellbeing Group 13

COMMENTS **13**

RECOMMENDATIONS **16**

FINDINGS **17**

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

1. Ms TP was 37 years of age at the time of her death. She lived in South Morang with her husband Mr XK and their young son. She emigrated from India in 2013. Ms TP had a master's degree and was employed in Information Technology. She had a history of depression and suicidality.

2. On 12 September 2018 at approximately 10.05pm, Mr XK woke and saw that his wife was not in their bed. Mr XK found Ms TP hanged by a dupatta[3] attached to the ceiling fan in the living room. He was ultimately able to cut the dupatta and move his wife to the floor. Emergency services were contacted, and cardiopulmonary resuscitation administered under the instruction of the emergency call-takers.

3. South Morang Country Fire Authority (CFA) members and Ambulance Victoria (AV) paramedics attended the home and continued resuscitative efforts. Victoria Police were not initially informed of the incident and did not attend at that time. Paramedics transported Ms TP to the Northern Hospital Epping (Northern Hospital) where she was admitted to the Intensive Care Unit (ICU) with a Pulseless Electrical Activity (PEA) cardiac arrest.

4. Northern Hospital medical staff reviewed a computed tomography (CT) scan of Ms TP's brain and cervical spine and did not identify any fractures or vascular injury but did identify significant oedema.[4] Medical staff noted that Ms TP displayed progressive signs of brain death. An electroencephalogram (EEG)[5] confirmed that Ms TP had suffered a catastrophic brain injury with no electrical activity.

5. Northern Hospital staff made repeated recommendations to withdraw medical care as Ms TP had suffered an unsurvivable injury, but her family were unwilling to accept withdrawal of medical intervention.

---

[3] A dupatta is a long scarf-like garment that is used in traditional Indian dress.

[4] Oedema is fluid retention.

[5] An electroencephalogram (EEG) is a test that measures the electrical activity of the brain.

6. On 21 September 2018, Ms TP developed circulatory failure consistent with physiology associated with her severe brain injury. She received ongoing mechanical ventilation at her family's request. Ms TP died from circulatory arrest at 6.10pm.

REPORTABILITY

7. Northern Hospital ICU Resident Dr Emily Robson completed the E-Medical Deposition Form (E-Med Dep) to report Ms TP's death to the Coroners Court of Victoria. Ms TP's death was reportable pursuant to section 4 of the *Coroners Act 2008* (Vic) ('the Act'), because it occurred in Victoria, and was considered unexpected, unnatural and it resulted directly from injury.

PURPOSE OF THE CORONIAL INVESTIGATION

8. The Coroners Court of Victoria is an inquisitorial jurisdiction.[6] 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.[7] 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 and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death. [8]

9. 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.[9] 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

---

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

[7] Ibid 67(1).

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

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

public health or safety or the administration of justice.[10] These are effectively the vehicles by which the prevention role may be advanced.[11]

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

INVESTIGATIONS

Forensic pathology investigation

11. Dr Melanie Archer, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an autopsy upon the body of Ms TP, reviewed a post mortem CT scan and referred to the Victoria Police Report of Death, Form 83. Post mortem toxicological analysis was not performed. Dr Archer summarised her autopsy findings in the following manner:

    I. Signs of Injury:
        a. Healing ligature mark,
        b. Bilateral fractures of the greater cornua of the upper thyroid cartilage,[12] and
        c. Minor bruising over the upper limbs and abdomen.
    II. Changes of global cerebral ischaemia.
    III. Aspiration bronchopneumonia.
    IV. Adenomyosis.[13]
    V. Lymphocytic thyroiditis.[14]

12. Dr Archer stated that her examination was limited by the elapsed eight-day-period between the initial cardiac arrest and Ms TP's death. She stated that there is potential that some injuries may have fully healed in that period.

---

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

[11] 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.

[12] This is part of the larynx.

[13] Adenomyosis is a condition in which the inner lining of the uterus (the endometrium) breaks through the muscle wall of the uterus (the myometrium). Adenomyosis can cause menstrual cramps, lower abdominal pressure, and bloating before menstrual periods and can result in heavy periods.

[14] Also known as "Hashimoto's disease": where the immune system attacks the thyroid gland.

13. Dr Archer explained that aspiration bronchopneumonia is a common complication of cardiac arrest and ventilator assisted life support, due to aspiration of stomach contents. Dr Archer stated that there was no significant naturally occurring disease which caused or contributed to Ms TP's death. Dr Archer formulated the medical cause of Ms TP's death as hypoxic ischaemic encephalopathy[15] as a direct result of neck compression.

Police investigation

14. After Ms TP had been transported to the Northern Hospital, a medical practitioner informed Victoria Police of the hanging incident. Victoria Police Officers attended Northern Hospital and Ms TP's home, however, the *'site had been rehabilitated'*[16] by that time. Victoria Police contacted the CFA to enquire as to why they were not notified of the hanging and were informed it was because CFA members did not believe the incident to be of a *'suspicious nature'*.[17]

15. Senior Constable (SC) Jessica Moloney was the nominated Coroner's Investigator.[18] At my direction, SC Moloney investigated the circumstances surrounding Ms TP's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Mr XK and Ms TP's treating General Practitioner (GP) Dr Mehul Zaveri.

16. During the investigation, police learned that Ms TP had a history of depression and suicidality. In 2008, she had confided to her husband that she had attempted to end her own life by mixing *'something in her drink'*.[19] Mr XK did not probe further into the issue as he did not wish to upset his wife. Subsequent to her death, he asked his father-in-law about the incident. Mr XK was informed that the episode of suicidality and self-harm occurred while Ms TP studied in India, away from her family. After that episode, Ms TP received one month of treatment for depression.

---

[15] Hypoxic ischemic encephalopathy (HIE) is a type of dysfunction that occurs when the brain doesn't receive enough oxygen or blood flow for a period of time.

[16] Coronial Brief, *Summary of Evidence by Senior Constable Jessica Moloney*, paragraph 27.

[17] Ibid.

[18] 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.

[19] Coronial Brief, *Statement of Mr XK*, dated 25 February 2019, p 2 of 9.

17. Although Mr XK stated that overall, they lived a happy life, he stated that his wife was '*a very emotional girl*'[20] and extremely sensitive. He commented that she was prone to being homesick and would sometimes '*cry all night*' in response to being isolated from her family in India. Mr XK informed me that Ms TP had graduated at the top of her class in her master's degree but that she had found it difficult to gain employment in India. He stated that she found the rejection during job-seeking very difficult.

18. In 2012, Ms TP suffered a miscarriage at 13 weeks' gestation. Mr XK said that there was no foetal heartbeat at the second ultrasound they attended, and that the loss deeply affected Ms TP.

19. In 2013 Mr XK emigrated to Australia as a Permanent Resident on a skilled migrant visa. He stated that, as his spouse, Ms TP was able to come as a resident too. Ms TP's brother Mr ND already lived in Australia and she was initially happy to emigrate and to be close to her brother. Within a few months, Mr XK was employed but Ms TP had difficulty finding employment; she remained financially dependent for a prolonged period.

20. In 2014, Ms TP became pregnant and she returned to her family in India for about three months of her pregnancy. Mr XK stated that she had not liked remaining at home for most of the day whilst he, her brother and sister-in-law went to work; her homesickness was very strong during this period. Mr XK stated that he convinced a reluctant Ms TP to return home to have their baby so that their child could be an Australian Citizen.

21. Upon her return from India, Mr XK said his wife was deeply depressed and '*crying almost every day*'.[21] Mr XK stated that he attempted to convince his wife to engage with some programs and assistance offered by their chosen birthing-hospital for pregnant women with depression. Ms TP did not attend and programs; Mr XK believed that she was opposed to seeking assistance because she ultimately wanted to return to India.

22. On 16 September 2014, Ms TP gave birth to a son. Mr XK said that she was the primary caregiver for their child and that she was a very loving and attentive mother. Ms TP's mother stayed with the family for about three months. Mr XK said that the responsibility

---

[20] Above n 19, p 2 of 9.

[21] Ibid, p 3 of 9.

of their son helped his wife to overcome her depression for a time and that although she was tired at times, she coped very well with motherhood.

23. In 2015, Ms TP and her family moved into her brother-in-law's home. During this year, Ms TP had a pregnancy termination. In his statement, Dr Mehul Saveri stated that the termination occurred during the first trimester of pregnancy in August. There are no further details in relation to this medical procedure.

24. In 2016, Ms TP consulted Dr Saveri and reported:

> *...one episode of tiredness low mood on 31/05/16. She mentioned the following*
> - *Missing India*
> - *Gaining weight*
> - *Not enjoying as much as before*
> - *Nil suicidal ideation*[22]

25. Dr Saveri did not indicate whether he mentioned or pursued any mental health treatment for Ms TP. He said that Ms TP '*never reported or expressed any kind of mental health concerns including suicidal/homicidal ideation or domestic violence*'[23] after that time.

26. During 2016, Ms TP learned to drive in order to increase her independence. She also studied online to increase her employability and after about seven months of job-seeking she found a role in Information Technology. Mr XK stated that they had a big celebration and that the subsequent eighteen months marked a very positive period in his wife's mental health: '*she was driving, she had her job and she was busy with our son. She was becoming depressed less often. She had some minor quarrels with family but overall, she was well. We were close and she would share even small things with me...* '[24]

27. In the months preceding her death, Ms TP and Mr XK bought land in Mernda and had designed their home together. Ms TP would sometimes '*get upset if the builder told us that things weren't possible. She wasn't able to put certain things out of her mind, but overall, she was happy.*'[25]

---

[22] Coronial Brief, *Unsigned Statement of Dr Mehul Zaveri*, dated 24 January 2019 p 2 of 2.

[23] Ibid.

[24] Above n 19, p 4 of 9.

[25] Ibid.

28. In September 2018, Ms TP and her husband prepared to have a party celebrating their son's fourth birthday. They briefly stayed with Mr ND's family while cleaning the carpets in preparation for the party. Mr XK stated that his brother-in-law was happy to have them stay.

29. On 12 September 2018, Ms TP, Mr XK and their son had dinner with Mr ND and his family. During dinner, Ms TP made a comment about her husband's meal portions. Mr XK stated that they did not have an argument at that time but Ms TP '*knew I didn't like it.*[26] They left to drive home at approximately 9.25pm.

30. During the car ride home, Ms TP and Mr XK had an argument about the comment she had made at dinner. Mr XK stated that it started with a normal conversation and that Ms TP became more and more upset and that she also *'brought up a few things and said that I wouldn't be upset if my mother told me not to eat the extra food.'*[27] The conversation lasted about three minutes as drive was short and they had arrived home.

31. Ms TP took their son to their bedroom. At approximately 9.45pm, Mr XK came into the master bedroom where his wife and son were in bed. The couple had a brief conversation; Mr XK stated that he felt his wife was still upset with him when he went to sleep.

32. After Mr XK awoke and Ms TP was not in their bed, he went to the second bedroom and saw his wife's mobile phone, a water bottle and that the bed coverings had been moved. Shortly thereafter, he moved to the living room and located Ms TP.

Community Engagement

33. 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:

---

[26] Above n 19, p 5 of 9.

[27] Ibid.

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).[28]

Whittlesea Community Concerns

34. 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.

35. Following this notification, I directed the Coroners Prevention Unit (CPU)[29] to identify previous and monitor subsequent suspected suicides of South Asian women in the City of Whittlesea.

Analysis of suspected suicides

36. The CPU used the Victorian Suicide Register[30] 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.

37. This retrospective examination showed that during 2018, the City of Whittlesea experienced an elevated frequency of suspected suicide amongst South Asian women

---

[28] 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).

[29] 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.

[30] 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.

and that this met the Centres for Disease Control and Prevention's definition of a suicide cluster.[31]

38. 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.

39. 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 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

40. 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.

41. 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.

---

[31] *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).

42. 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

43. 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.

44. 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.

45. 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

46. 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.[32]

47. 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 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

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

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.*[33]
>
> *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.*[34]

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. There is no evidence to suggest family violence is a precipitating factor in the circumstances leading to Ms TP's death. However, family violence has been relevant to the circumstances of other linked cases. I consider it appropriate to maintain continuity in my comments and recommendations in the linked matters in light of my decision to consider them as a suicide cluster. Therefore, I have included these comments and a

---

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

[34] Ibid.

general recommendation in relation to family violence and the intentional deaths of South Asian women in the City of Whittlesea.

8. I am informed 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*'.[35] 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, which may, in turn, assist in suicide prevention. Pertinent recommendations will follow.

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

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

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 TP, born 6 April 1981, died on 21 September 2018 at the Intensive Care Unit of the Northern Hospital, 185 Cooper Street, Epping, Victoria 3075.

2. I find that Ms TP had a history of mental ill health, including depression, suicidality and self-harm.

3. I find that Ms TP had been treated for depression in India and I further find that she had no medical record of mental ill health and had not received treatment for mental ill health in Australia.

4. I find that the care and treatment provided by the Northern Hospital, following her admission on 12 September 2018, was reasonable and appropriate in the circumstances.

5. I accept and adopt the cause of death ascribed by Dr Melanie Archer and I find that the cause of Ms TP's death was hypoxic ischaemic encephalopathy which occurred as a direct result of neck compression, in circumstances where I find Ms TP intended to end her own life.

6. I am unable to find the precise precipitating factors leading Ms TP to adopt the course of action leading to her death.

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:

Mr XK

Mr ND

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

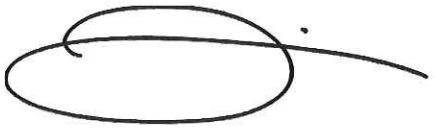
Berry Street Incorporated

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**