IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 5104

Linked Cases:[1] COR 2018 2583
COR 2018 4780
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 YN[2]**
Date of birth:	**24 October 1984**
Date of death:	**9 October 2018**
Cause of death:	**MULTIPLE INJURIES SUSTAINED IN A TRAIN INCIDENT**
Place of death:	**Approximately 150 metres south of Thomastown Railway Station, Thomastown, Victoria 3074**

[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

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

1. Ms YN was 33 years of age and resided in Thomastown at the time of her death. She lived with her husband Mr MU in a home owned by her husband's cousin Ms HJ. In 2016, Ms YN emigrated with her husband from Sri Lanka to Australia via Dubai; she had a student visa. In 2017, she commenced university studies and was scheduled to finish a master's degree in early 2019. Ms YN did not have a medical history of mental ill health.

2. On 9 October 2018 at approximately 12.29pm, Metro Train TD1683 departed Flinders Street Station on the Mernda Line. At approximately 1.12pm, Ms YN ran out on the train tracks approximately 150 metres south of Thomastown Railway Station. She lay down on the tracks, in the path of the oncoming TD1683. The train driver immediately activated the emergency brake and sounded the whistle, but the collision could not be avoided and TD1683 struck Ms YN. The train driver bought the train to an emergency stop and emergency services attended. Ms YN was pronounced deceased at the site of the collision.

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 YN'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 to have resulted, directly from 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

---

[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).

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 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 Linda Elizabeth Iles, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination upon the body of Ms YN, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Dr Iles noted that Ms YN had sustained catastrophic

---

[5] Above n 4, s 67(1).

[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.

injuries, including decapitation and right hip/thigh disruption. Toxicological analysis of post mortem blood did not detect any alcohol, common drugs or poisons. Dr Iles formulated the medical cause of Ms YN's death as multiple injuries sustained in a train incident.

Police investigation

9. Upon attending the site of the collision causing Ms YN's death, Victoria Police located an item which may be termed a "suicide note." It was found in the front left pocket of her jacket, alongside a photograph of Ms YN and a man. The note was handwritten and provided contact details for her husband. It stated that no one was responsible for her death and that she was extremely distressed by a personal issue that prevented her from having sexual intercourse with her husband. The note stated that this issue caused her husband to suffer and that she thought about it constantly. She wrote that she had been unable to concentrate on her university studies and consequently was distressed by the amount of money spent on her education by her husband and father. The note requested that her body not be repatriated to Sri Lanka and that her husband be allowed to remain in Australia for another two or three months to settle some bills.

10. Mr MU had come home and identified that a number of emergency services personnel were on the train tracks adjacent to his home. He came to the area and was met by police who identified him as the man in the photograph; Mr MU stated that Ms YN was his wife and that the photograph was from the day of their engagement. He was extremely distressed and treated by attending Ambulance Victoria paramedics. Police officers noted that he was unable to provide further information at that time.

11. Victoria Police processed the scene and then remained at the site of the collision until the coroners transport services attended and Ms YN's body was removed from the scene.

12. Acting Sergeant (AS) Jamie Clifford was the nominated Coroner's Investigator.[10] At my direction, AS Clifford investigated the circumstances surrounding Ms YN's death, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Mr MU, Mr MU cousin's Ms HJ, Mr MU's sister Ms NL 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 YN's colleague Ms MA. AS Clifford noted that the brief did not contain any statements from relations on Ms YN's side of the family; there was no one available in Australia to make such a statement.

13. During the investigation, police learned that Mr MU had sought the advice of his friend Consultant Psychiatrist Dr Dulip Dharmage in relation to a marital problem. Mr MU stated that they had never had sexual intercourse as Ms YN had a '*psychological issue*'.[11] Mr MU stated that they had consulted psychologists in Sri Lanka but there had been no resolution to the problem.

14. AS Clifford was informed that Dr Dharmage never treated the couple. In an email to my investigator,[12] Dr Dharmage stated that he did not take on the couple as patients owing to their personal connection. He referred them to a female psychologist of a similar cultural background in whom he hoped that Ms YN could comfortably confide. However, the pair never consulted the psychologist. Mr MU stated that Ms YN did not wish to attend the psychologist at that time as she feared it would disrupt her studies. He said that they planned to use the referral upon the completion of his wife's master's degree.

15. Mr MU also commented that his wife did not have many friends in Australia; she was connected to some *'wives of* (his) *friends'* but she did not have '*many of her own*'.[13] He stated that they did not really have '*money problems*'[14] and that his wife contributed to their finances occasionally but that he was the primary bread-winner.

16. In late September 2018, Ms YN and her husband went to Sri Lanka to celebrate a cousin's wedding. Mr MU stated that being in Sri Lanka and '*seeing the kids*' seemed to upset his wife.[15] During this time, Ms YN confided to her husband that she was finding her studies more difficult.

---

[11] Coronial Brief, *Statement of Mr MU*, dated 18 November 2018 p 1.

[12] Coronial Brief, *Email correspondence to informant from Doctor Dulip Dharmage,* dated 12 January 2019 Appendix D.

[13] Coronial Brief, *Statement of Mr MU*, dated 18 November 2018 p 1.

[14] Ibid.

[15] Ibid.

17. On 29 September 2018, Mr MU's sister Ms NL spoke to Ms YN. She stated that her sister-in-law's behaviour was '*absolutely normal*' on that occasion and that there was nothing unusual in Ms YN's behaviour earlier, at the wedding.[16] Ms NL said that she knows her brother very well and that his behaviour was not any different than usual. She said that the couple looked well and behaved lovingly. Ms NL also said that she did not associate with the couple often as she was closer with her friends and '(Ms YN) *and my brother are on their own*'.[17]

18. Approximately one week prior to Ms YN's death, the couple returned home from their trip. Mr MU said that his wife seemed '*flat*'[18] and he contributed this to the fact that they were unable to conceive their own children. He said that his wife slept more often and '*her personality changed a little bit*'[19] upon their return. He commented that he did not notice these things clearly at the time, but that he recognised them in hindsight as signs of mental ill-health.

19. At around this time, Mr MU's cousin Ms HJ visited Ms YN at home. Ms HJ stated that Ms YN was normally a slender person but that she appeared very thin to her on that occasion. She stated that she looked '*worn out*' and seemed '*a little jumpy*'.[20] Ms HJ said that Ms YN expressed excitement at the mention of her upcoming housewarming and said that she would be there; she did not say anything to indicate mental ill-health nor suicidality.

20. At around 5.00am on 9 October 2018, Ms YN said goodbye to her husband; she was leaving to do some cleaning at a warehouse in Somerton. She was to do a shift which finished at 7.30am and then she would return home. Mr MU said that there was nothing unusual in his wife's behaviour when she kissed him goodbye; he left for work before she returned.

21. Mr MU said that he spoke to Ms YN on three separate occasions that morning:

---

[16] Coronial Brief, *Statement of Ms NL*, dated 24 December 2018 p 9.

[17] Ibid.

[18] Above n 11, p 1.

[19] Ibid.

[20] Coronial Brief, *Statement of Ms HJ*, dated 14 February 2019 p 1.

I normally like to check in with her throughout the day. However, when I phoned her at 1221 in the afternoon she sounded lazy and dismissive, I asked her if she had cooked and she told me she hadn't, this was a little out of the ordinary but I didn't think much of it at the time. I told her we'd eat at Epping and then ended the call.[21]

22. Between 11.30pm and 12.00pm, a real estate agent attended Ms YN's home to discuss a broken gate at the property. Ms HJ stated that the agent telephoned her, as the property owner, to let her know she had looked at the gate. Ms HJ commented that the agent was likely the last one to see Ms YN alive but did not indicate that the agent said anything about her demeanour.

23. At 1.15pm, Mr MU arrived home from work. He stated that he noticed paramedics and police officers in the vicinity and that he became worried when his wife did not open the door for him. He stated that his worry increased when he found their front door key under the doormat as they only did this when they left the home. He said that *'she never goes out without informing (him) and not really ever without me.'*[22] Finally, Mr MU said that he found a note in their bedroom and that he only read a few words before he realised that it was intended to be a "suicide letter".

Further Investigation

24. On 18 November 2018, AS Clifford attended Ms YN's home. Mr MU was at the address and AS Clifford asked him to attend the Reservoir Police Station to make a statement. Mr MU complied with my investigators' request and his cousin Ms HJ also attended as a support person and to assist with translation if required.

25. After the statement was completed, AS Clifford drove Mr MU home. He stated that he wanted to show the police officer text messages on his wife's mobile telephone. The messages were photographed by AS Clifford.[23] The relevant message was dated 1 September 2018 and was sent to Ms YN's manager: '*I don't like to work bethal because Mr LM coming wrong way I have a good husband'*.[24]

---

[21] Above n 11.

[22] Above n 11, p 2.

[23] Coronial Brief, Photograph 17.

[24] The coronial investigation has not identified the full name.

26. Mr MU said that Ms YN worked as a kitchen hand at Bethel Aged Care about three or four days each week. He said that she seemed to like working there but there was a '*man that bothered her.*'[25] Mr MU said that he saw messages from "Mr LM" on his wife's mobile phone in August 2018. He said that it appeared that this man asked her where she was, what she was doing and to send pictures of herself to him. Mr MU stated that his wife told him '*he is troubling me and I don't like working with him.*'[26] Mr MU said that he telephoned Ms YN's manager at the aged care facility. He said that the manager told him he would '*get rid of Mr LM and that it would take two weeks, he never did get rid of him*'.[27]

27. On the same day, Mr MU provided AS Clifford with three letters. Two of the letters were written in one of the languages of Sri Lanka and one letter was written in English. The latter was directed to the university where Ms YN had studied and it was dated 9 October 2018, the date of her death. It indicated that Ms YN was extremely concerned about the money spent for her education by her father and husband. The letter to the university requested a refund to her husband in light of Ms YN's inability to attend university lectures and examinations due to mental ill health.

28. AS Clifford stated that Ms HJ disputed the veracity of each letter provided on 18 November 2018; she had indicated that her cousin had not told anyone else about them and that she believed that he had written them himself.[28]

Allegations of Family Violence[29]

29. AS Clifford took statements from two of Ms YN's colleagues at the aged care facility. Each statement detailed serious, specific instances of alleged family violence by Mr MU against Ms YN. My investigator has not provided any formal, corroborating evidence in relation to these matters.

---

[25] Above n 11, p 2.

[26] Ibid.

[27] Ibid.

[28] Coronial Brief Exhibit 1, Appendix A, Appendix B, Appendix C.

[29] Please see the definition contained in section 5 of the *Family Violence Protection Act 2008* (Vic).

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).*[30]

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)[31] to identify previous and monitor subsequent suspected suicides of South Asian women in the City of Whittlesea.

---

[30] 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).

[31] 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.

Analysis of suspected suicides

33. The CPU used the Victorian Suicide Register[32] 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.[33]

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 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.

---

[32] 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.

[33] *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).

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.[34]

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 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.

---

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

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.*[35]
>
> *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.*[36]

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.

---

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

[36] Ibid.

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.

9. At the conclusion of my investigation, the evidence before me does not provide a comfortable level of satisfaction to find that family violence was a precipitating factor in Ms YN'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 YN's husband or his relatives; 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. 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.

10. The 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.

11. 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*'.[37] 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.

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.

---

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

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 YN, born 24 October 1984, died on 9 October 2018 at approximately 150 metres south of Thomastown Railway Station, Thomastown, Victoria 3074.

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

3. I am unable to make definitive finding on all of the precise precipitating factors leading Ms YN to end her own life. However, I find that her prolonged distress in relation to an unresolved personal issue which prevented her from having sexual intercourse with her husband was a precipitating factor to her death.

4. I further find that Ms YN was socially isolated, financially dependent, unemployed and distressed about the cost of her education to her husband and father at the time of her death.

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

6. I accept and adopt the cause of death formulated by Dr Linda Elizabeth Iles and I find that the cause of Ms YN's death was multiple injuries sustained in a train incident, in circumstances where I find that Ms YN 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:
Mr MU
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

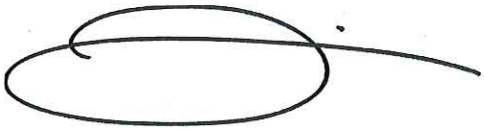
Berry Street Incorporated

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**