Rule 63(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2021 2298

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the ***Coroners Act 2008***

Amended pursuant to section 76 of the ***Coroners Act 2008***

Inquest into the death of: NATASHA STOJKOSKI

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	22 April 2026
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria 3006
Hearing Dates:	25 - 27 November 2025, 11 December 2025.
Appearances:	Mr Rob O'Neill SC with Mr D Chisholm of Counsel on behalf of The Good Guys Discount Warehouse (Seyfarth Shaw LLP)

	Mr Rob Shepherd on behalf of Allianz Workers Compensation Victoria (Wisewould Mahony Lawyers)
	Mr Colin Almond on behalf of Mr SEM (submissions only) (HWL Ebsworth)
Counsel Assisting the Coroner:	Ms Kelly McKay of Counsel

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I, AUDREY JAMIESON, Coroner having investigated the death of NATASHA STOJKOSKI AND having held an Inquest in relation to this death on 25 – 27 November 2025 & 11 December 2025

At the Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006

find that the identity of the deceased was NATASHA STOJKOSKI

born on 4 May 1982

died on 2 May 2021

at approximately 400 metres north of the Thomastown Railway Station

from:

1 (a) MULTIPLE INJURIES SUSTAINED WHEN STRUCK BY A TRAIN

In the following summary of circumstances:

On 9 October 2018, NATASHA STOJKOSKI sustained injury to her back, shoulders and neck while acting in the course of her employment with The Good Guys in Thomastown. She later developed mental health issues which she stated were related to bullying and isolation from her colleagues and members of the management team. In December 2019, she was referred to a psychologist who she continued to see until 18 March 2021. In the evening of 2 May 2021, Natasha Stojkoski left her family home after returning from an extended family event. She was subsequently located near the Thomastown Railway Station having been struck and killed by a train.

BACKGROUND CIRCUMSTANCES

1. Natasha Stojkoski (**Natasha**)[1] was born on 4 May 1982 in Melbourne, the daughter of Zora and Risto Naumoviski. She was 38 years old at the time of her death.

2. Natasha's parents had migrated from Macedonia in the late 1970s. Natasha was said to have had a happy childhood with her brother and sister, completing school in Year 11

[1] With the permission of her husband, George Stojkoski, Natasha Stojkoski was referred to as "Natasha" only during the running of the Inquest. For consistency, I have also referred to her as "Natasha" in the writing of this Finding, save where formality has influenced me to use her full name.

before working in various jobs as a sales assistant through her life. She had a solid work history commencing her career at Westco Jeans where she worked for 9 years.

3. Natasha married George Stojkoski (**George**) when she was 17 and they resided in Thomastown where they raised two children who were about to turn 11 and 8 years of age at the time of Natasha's death. Regular family activities involved George and Natasha taking their children to AFL games, to the beach and to dance classes. They also spent time with their extended family.

4. From May 2009 until the time of her death, Natasha was employed at The Good Guys store in Dalton Road, Thomastown as a sales assistant. Her role included assisting customers, replenishing and moving stock and managing store displays. She became a permanent part time sales assistant after the birth of her children and in the initial years Natasha loved her job and enjoyed working in retail with customers.

5. In 2021 the family sold their home and moved to live with Natasha's mother, Zora. Natasha's father had passed away a few years prior. The move was said to have caused Natasha some anxiety, but she had a strong family network with relatives living close by and regular family get togethers. George described their life together as whole and happy and they enjoyed time going to the football to support Richmond, going to the beach and taking the children to their dance classes and other activities.

SURROUNDING CIRCUMSTANCES

6. In the afternoon of 9 October 2018, Natasha was at her place of work, placing stock up on racks using a Work Assisted Vehicle known as a 'WAV'. It is a four-wheeled vehicle used to move stock and reach high shelves in The Good Guys warehouse. Natasha stated that she had received a brief overview of how to operate the machine from a sales assistant in the Tech Zone Department, but that she had not received any formal training in its use.

7. As Natasha reversed the vehicle she collided with an overhanging bulkhead where she was crushed underneath the wall, pressing onto her shoulders and neck for approximately five to ten seconds. The incident was not witnessed by any other staff, but Natasha was able to free herself, and spoke to another staff member about what had

happened. That staff member stated that Natasha looked like she was in shock when he spoke to her. Natasha reported the incident the Sales Floor Manager. No incident report was completed at the time.

8. Natasha continued her duties that day but went home that evening feeling stiff and sore with a severe headache and reported vomiting due to the pain. The next day Natasha was not rostered to work and continued to experience pain in her back, neck and shoulders but decided to attend an evening product training session. She returned to work on a rostered shift on 11 October 2018 and spoke to the Sales Floor Manager, informing him that she was still in pain. She undertook to complete her normal hours and duties but advised the Sales Floor Manager that she might be slower and require assistance from her colleagues.

9. Natasha felt that the Sales Floor Manager 'appeared to brush this off' and when querying if she should complete an incident report, he reportedly told her that he was not rostered at the time of the incident and that he did not want to take responsibility for completing the incident report. An incident report was completed approximately two weeks after the incident and Natasha was spoken to about performing light duties.

10. Natasha continued to experience pain after the incident but was at first trying to self-manage her injury. She was attending work and trying to complete her duties. However, seeing no resolution to her pain, Natasha sought medical advice on 24 October 2018. Natasha attended on general practitioner Dr Kanapathipillai at the Northend Medical Clinic reporting the incident and back injury. Natasha also attended a session with a physiotherapist which was reimbursed by The Good Guys.

11. Over the next few months Natasha continued to attend work but found the physical demands of some of her work tasks difficult due to ongoing pain.

12. In January 2019, Natasha saw general practitioner, Dr Vivek Patel (**Dr Patel**), for worsening bilateral shoulder and back pain and to obtain a Certificate of Capacity requested by her employer.

13. Through January to September 2019 Natasha continued to attend work but experienced difficulties performing the physical requirements of her job. She also stated that since

June 2019 she was subject to ongoing bullying and isolation from her colleagues and members of the management team who had stopped talking to her, failed to provide her with assistance and had made sarcastic comments to her about her having to undertake light duties since her injury.

14. Natasha informed the Sales Manager, to whom she reported, of the bullying and named several staff who she felt were treating her unfairly. Natasha stated that she felt very stressed, anxious and had difficulty sleeping, eating and was emotionally drained and exhausted. She stated that this had also placed stress on her home life; that her husband was worried about her and with her children had commented that she was not working.

15. During August 2019, the White Goods Coordinator spoke to Natasha about her stress levels. Around the same period, Store Executive Manager, Mr SEM, met with her. Natasha reported to Mr SEM that she felt bullied and isolated on the shop floor. She was visibly distressed during this meeting and cried throughout. She told Mr SEM that she was losing sleep and was anxious to come to work. Mr SEM undertook to address these issues with staff. He spoke to each of the alleged perpetrators of the bullying individually.

16. On 8 September 2019, Natasha attended on Dr Patel reporting feeling stressed and unsafe at work stating that the bullying had got worse and that she wanted to go on stress leave. Dr Patel provided Natasha with a certificate declaring her unfit for work for the period 5 September 2019 to 19 September 2019. In that period Natasha underwent a CT scan of her cervical spine, ultrasound of both shoulders and Dr Patel prescribed her anti-inflammatories and referred her to physiotherapy for her physical symptoms.

17. Natasha returned to work on 23 September 2019. She had a further discussion with Mr SEM about her medical condition and the alleged bullying. Mr SEM informed Natasha that that he had undertaken an investigation into her allegations of bullying and that he had arrived at the view that both Natasha and those colleagues she had named, were responsible for the breakdown of their relationship. Mr SEM asked Natasha what duties she was able to undertake and informed Natasha that he required a certificate of capacity from her doctor.

18. On 3 October 2019 there was a further meeting between Mr SEM and Natasha. Details of her back and neck injury were sought by Mr SEM as he informed Natasha that he needed the information to formulate a return-to-work plan. Natasha asked for a copy of the Incident Report filed after the incident in October 2018. Mr SEM informed Natasha that she would have to request this from the Human Resources Department (**HR**). She subsequently made the request to HR for the Incident Report but did not receive a response.

19. Shortly thereafter Natasha attended on Dr Patel informing him that she felt she had been interrogated at the meeting with Mr SEM. A WorkCover claim was discussed.

20. From 4 October 2019 to 23 February 2021, Natasha attended physiotherapist Rachel Neate at Preston Physiotherapy on 28 occasions.

21. Natasha ceased work again on 10 October and lodged a WorkCover claim for compensation on 7 November 2019. She remained off work between 8 and 21 November 2019.

22. On 13 November 2019, the Group Injury Management Lead for The Good Guys held a Case Conference with Dr Patel and Natasha. A return-to-work plan was formulated and agreed upon resulting in Natasha returning to perform light duties in the Thomastown store 3 days per week. In that same meeting Natasha provided the Group Injury Management Lead with some details of the bullying she was experiencing and of the names she alleged to be involved. He asked Natasha if she wanted a formal investigation into this and she informed him that she did. The Group Injury Management Lead advised Natasha that Mr SEM could help her with this process.

23. On 18 November 2019 the Group Injury Management Lead wrote to The Good Guys' WorkCover insurer, Allianz Australia (**Allianz**), and instructed that The Good Guys disputed both Natasha's physical and psychological claims.

24. On 25 November 2019 there was an attempt to return Natasha to work. She was given duties in the administrative department. Mr SEM met with Natasha on that morning to review her return-to-work plan. Ultimately Natasha's return to work was not successful. She ceased work on 16 December 2019.

25. In or around December 2019, investigator Andrew Baldock of Cygnus Higgins Shaw was engaged by Allianz to interview Natasha and other staff members about Natasha's reported injury and her allegations of bullying. Staff provided varying accounts of their interactions with Natasha and denied any bullying or unfair treatment.

26. Allianz also made arrangements for Natasha to be examined by Psychiatrist Dr Mary Power-Connon (**Dr Power-Connon**) and Occupational Physician Dr Catherine Bones (**Dr Bones**) for the purposes of assessing her claims of physical and psychological injury.

27. Following her examination of Natasha, Dr Bones reported that she noted marked muscle tension in the neck but that there were *no abnormal neurological findings.* Dr Bones stated that she was *uncertain how this* (muscle tension) *related to injury*.

28. Natasha was subsequently informed by Allianz that there had been a partial acceptance of her WorkCover claim for the period 9 October 2019 to 5 December 2019 only, and it had been rejected on an ongoing basis because she had been assessed as having physically recovered from her injuries. Reference was made to the assessment of Dr Bones and of the report of Dr Power-Connon who had opined that Natasha presented with an adjustment disorder with mixed depression and anxious mood, in partial remission, developed in the context of the incident on 9 October 2018, and her subsequent interactions with colleagues. Her secondary claim for psychological injury was approved.

29. On 19 December 2019, Dr Patel referred Natasha to Clinical Psychologist, Mr Andy Prodromidis (**Mr Prodromidis**) at the Lalor Allied Health Centre, with her first consultation being in February 2020. During this first consultation Natasha was administered the Depression, Anxiety and Stress Scale and results reported *extremely severe levels of anxiety, moderate levels of depression and severe levels of stress*.

30. Both Dr Patel and Mr Prodromidis formed the view that Natasha's psychological presentation was connected to her work environment. Dr Patel prescribed her Lexapro (escitalopram), an SSRI antidepressant.

31. Between February 2020 and 18 March 2021 Natasha attended eight consultations with Mr Prodromidis during which she described bullying at work following her injury, feeling isolated, staff not talking to her, questioning when she would perform certain activities, not helping with heavy tasks and being excluded from a group Facebook chat. Mr Prodromidis opined, *It is my view that her psychiatric disorder is significantly and materially caused by her workplace injury and the behaviour she was subjected to by staff in the workplace.*

32. In February 2020, for an Accident Compensation Conciliation Service (**ACCS**) review of Natasha's WorkCover entitlements, Dr Patel prepared a report in which he noted that Natasha continued to complain of pain in her cervical and lumbar spine as well as bilateral shoulders and headaches since suffering her workplace injury. He remarked that *her stress levels are pretty high which might be a major contributor of her symptoms of muscle spasms*. Dr Patel also noted that Natasha *also stated that due to a lack of support and understanding from her workplace she faced discrimination, harassment and bullying by her work colleagues.* He said that Natasha *has been psychologically impacted due to the alleged bullying at work following her physical injury.* Dr Patel's diagnosis was that Natasha was suffering from an adjustment disorder with severe anxiety and depression. While he considered that she was physically fit to work with modified duties he cautioned that she *is dealing with a great deal of stress and might be a major contributor to her MSK* (Musculo-skeletal) *symptoms. She would need a safe return to work environment with ongoing support and psychology sessions via a psychologist*.

33. Between March and December 2020 Natasha continued consultations with Mr Prodromidis and Dr Patel via telehealth due to the COVID-19 pandemic restrictions limiting direct contact.

34. In May 2020 Dr Patel wrote to Allianz outlining his opinion about Natasha's capacity to return to work. He said: *Prognosis is excellent if her case is managed appropriately and an appropriate return to work is designed*. In August 2020 Dr Patel replied to a request from Occupation Rehabilitation Consultants, Carti, outlining Natasha's future employment suitability estimating a time frame *in coming months*.

35. Natasha continued to report headaches, neck and back pain. Mr Prodromidis noted that Natasha reported that driving past her work location created tension, negative thoughts and bad memories as to how she was treated and a perceived lack of support from her management. Natasha discussed hopes of returning to work in time with treatment but feared seeing the same people she alleged caused her stress and made her fear humiliated and embarrassed.

36. Around this time, Natasha also sought legal advice in relation to the ACCS review and appeal of the partial rejection of the physical injury component of her WorkCover claim. Natasha continued to report feeling anxious, stressed, tired and overwhelmed by the WorkCover process and dealing with Allianz.

Interspersed domestic and social circumstances

37. Natasha also reported that she was experiencing additional stress from isolation and home schooling during the pandemic lockdowns. She stated that she required assistance with household duties and shopping and it was all placing a strain on her relationship with George.

38. In January 2021 Natasha and George sold the family home and moved to live with Natasha's mother, Zora. Natasha appeared to struggle with the sale of their home which had memories associated with her father.

39. On 7 March 2021 Natasha told George she was feeling low and unwell. Concerned for her welfare, George suggested he take her to the Northern Hospital Emergency Department (**NHED**) which she willingly agreed to, arriving at approximately 7.00 pm. Doctors noted that she presented as feeling unwell, tired, lethargic and had loss of appetite and with increased sleeplessness worsening over the past week. She was diagnosed with *biological symptoms of depression*. Natasha denied suicidal ideation. She was discharged the same evening and advised to continue escitalopram (Lexapro) 10 mgs daily for two weeks and advised that the therapeutic effects could potentially take weeks to appear. She was also advised to follow up with her GP and psychologist.

40. 18 March 2021 was Natasha’s final consultation with Mr Prodromidis. She reported feeling depressed with low energy and motivation, she was not eating or sleeping well,

was inactive and reported significant anhedonia. Mr Prodromidis reported that Natasha appeared compliant with her medication, but she also appeared disinterested during this consultation.

41. Natasha continued to attend Dr Patel and complained of constant pain, poor sleep and headaches. She continued to take medication, and a discussion was had about a return-to-work plan and trying to go back to work in a stress-free environment. During February 2021 Natasha reported to Dr Patel feeling tired, stressed, anxious and that she was eating less.

Ongoing impact to Natasha's domestic and social circumstances

42. Natasha continued to be unsettled at home and in conversations with George stated, *I'm useless. I don't want to be here*. George said that she repeatedly asked him if he still loved her. Natasha had ceased using her mobile phone in about February 2021 and on George's recollection, was still not coping with the WorkCover issues, having been bullied and excluded by work colleagues and the work environment.

43. Natasha's family described her as withdrawn, worried, paranoid and there being a cumulative effect of her anxiety. Family also confirmed that Natasha had no previous mental health issues before her workplace accident.

44. Natasha made several personal notes through her experience. For example, she wrote: *No one took my injury seriously. This behaviour didn't just affect my workplace. It had a big impact on me at home due to the way I was feeling in the workplace.*

45. George made several efforts to help Natasha work through her feelings and difficulties with the WorkCover claim. They had made plans to take some time off work and spend it together to try and improve her mental health.

46. Leading up to May 2021 George stated that Natasha had continued to be anxious, but the family did not believe she was any risk of self-harm or that she had had suicidal thoughts.

IMMEDIATE SURROUNDING CIRCUMSTANCES

47. May is a significant month for Natasha’s family with multiple birthdays and events. Natasha's own birthday, 4 May was followed by those of her children.

48. On 2 May 2021, Orthodox Easter, the family spent the day together visiting relatives for lunch and then changed venues to attend George's parents' home for dinner with about 15 family and friends. Natasha appeared happy during the day, talking to relatives and playing with children during the gatherings.

49. At approximately 9.50 pm Natasha and George returned home. While George was putting the children to bed Natasha left the house. George looked for Natasha and when he was unable to locate her, he telephoned his brother. Multiple family members joined the search for her over the following hour. George reported Natasha missing to Police. He also drove around the suburb in an attempt to find her.

50. At approximately 11 pm, e*n route* to the family home, Police received a call advising them of a pedestrian having been struck and killed by a train approximately 400 metres north of the Thomastown Railway Station. Emergency services attended the scene.

51. George, who was driving around looking for his wife, also came upon the scene having seen the red and blue lights and fearing the worst. Speaking to Police and providing a description, Natasha was identified as the pedestrian struck by the train.

52. Natasha was declared deceased at the scene.

JURISDICTION

53. Natasha’s death was a reportable death under section 4 of the Coroners Act 2008 (‘the Act’), because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury.

PURPOSE OF THE CORONIAL INVESTIGATION

54. The Coroners Court of Victoria is an inquisitorial jurisdiction.[2] 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.[3] 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. [4]

55. 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.[5] 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.[6] These are effectively the vehicles by which the prevention role may be advanced.[7]

56. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

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[2] Section 89(4) Coroners Act 2008.

[3] Section 67(1) of the *Coroners Act 2008*.

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

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

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

[7] 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.

57. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

58. The circumstances surrounding Natasha's death did not render it a mandatory Inquest. Nevertheless, Coroners have absolute discretion as to whether to hold an inquest into any death they are investigating. A Coroner must exercise that discretion in a manner consistent with the preamble and purposes of the Act. In deciding whether to conduct an Inquest, a Coroner should consider factors such as (although not limited to), whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process; whether there is a likelihood that an inquest will uncover important systemic defects or risks not already known about and, the likelihood that an Inquest will assist to maintain public confidence in the administration of justice, health services or public agencies.

STANDARD OF PROOF

59. 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. [8] 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

[8] (1938) 60 CLR 336.

- 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.

60. 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.

SOURCES OF EVIDENCE

61. This Finding draws on the totality of the material the product of the coronial investigation into Natasha Stojkoski's death. That is, the court records maintained during the coronial investigation, the Coronial Brief prepared by Leading Senior Constable Theo Tsichrintzis, further material sought and obtained by the Court, evidence garnished during the Inquest and submissions made on behalf of The Good Guys, Allianz, Mr SEM and Counsel Assisting.

62. In writing this Finding, I do not purport to summarise all the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does not imply that it has not been considered.

POST MORTEM INVESTIGATIONS

Identity

63. On 5 May 2021, George Stojkoski visually identified his wife, Natasha Stojkoski born 4 May 1982, at the Victorian Institute of Forensic Medicine and completed a Statement of Identification.

64. Identity was not in dispute and required no further investigation.

Medical Cause of Death

65. On 4 May 2021, Forensic Pathologist, Dr Sarah Parsons (**Dr Parsons**) from the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination

of the body of Natasha Stojkoski. Dr Parsons also had regard to the Victoria Police Report of Death for the Coroner Form 83, and the post mortem computed tomography (**PMCT**) scan and completed her report for the Coroner on 7 May 2021.

Post mortem examination

66. Dr Parsons commented on the findings of her external examination including multiple injuries and also noted that the PMCT identified significant internal injuries enabling Dr Parsons to formulate a reasonable cause of death without the need for an autopsy.

Toxicology

67. Toxicological analysis of post mortem specimens did not identify any alcohol or common drugs or poisons.

Forensic pathology opinion

68. Dr Parsons ascribed the cause of Natasha Stojkoski's death to **1(a) Multiple Injuries when struck by a train**.

INVESTIGATIONS PRECEDING THE INQUEST

69. An investigation of the circumstances of Natasha's death was commenced by coronial investigator, Leading Senior Constable Theo Tsichrintzis of the Transit Safety Division.

70. The coronial investigation revealed allegations that Natasha was the victim of workplace bullying and evidence contained in the Coronial Brief suggested that this contributed to the decline in her mental health.

71. In July 2022 George Stojkoski filed with the Court a Form 26 Request for Inquest into Natasha's death.

72. Upon receiving this application I made further enquiries, including with WorkSafe Victoria who at that time had not commenced an investigation into Natasha's death. They cited the reason that Natasha had reported the bullying incidents to WorkSafe by phone on 9 October 2019 and they had in turn forwarded relevant 'case initiation' documents to her to complete and lodge. As Natasha had not completed and returned

the forms to WorkSafe, they informed me that this prevented them from initiating an investigation into the bullying claims.

73. I assessed the circumstances on the evidence available to me at the time and formed a view that the available evidence did tend to support the family's contention that Natasha's workplace injury, the process relating to her WorkCover claim and her allegations of bullying related to her death. I also referred the matter to the Director of Public Prosecutions (**DPP**) having formed a belief that an indictable offence may have been committed. The DPP considered the matter and declined to prosecute.

74. As there remained unanswered questions about the impact of Natasha's reported physical and psychological injuries and her decision to take her own life, I determined that it was appropriate to hold an Inquest.

DIRECTIONS HEARING/S

75. A Directions Hearing was held on 21 November 2023 in which I was assisted by Acting Sergeant Danielle Lord of the Police Coronial Support Unit (**PCSU**). George, The Good Guys, WorkSafe and Allianz were all legally represented.

76. At this Directions Hearing I indicated my intention to hold an Inquest into the death of Natasha Stojkoski. I had not, at that stage, determined the scope of the Inquest but that I might be influenced about the scope on receipt of a Court appointed expert opinion from Consultant Psychiatrist, Dr Gregory White.

77. At this same Directions Hearing, WorkSafe, who were represented by Ms Kirsten Hughes (**Ms Hughes**) (WorkSafe's In-House Counsel), advised the Court that they intended to commence their own investigation into Natasha's death. Ms Hughes stated that the investigation would be *into the use of the wave* [sic] *machine which is an elevating work platform. And into the allegations of bullying that have led to - potentially led to Natasha's death.*[9]

[9] Transcript (**T**) – Directions Hearing 21 November 2023 @ p 18.

78. In accordance with my statutory obligations to avoid unnecessary duplication of investigations and to minimise jeopardising any potential prosecution under the *Occupational Health and Safety Act 2004*, I determined to place the coronial investigation in abeyance.

79. During the period awaiting the outcome of the WorkSafe investigation, the Court appointed expert opinion from Consultant Psychiatrist, Dr Gregory White (**Dr White**) had been received and distributed to the Interested Parties.

80. In September 2024, WorkSafe informed the Court, and Natasha's family, that following their investigation, the decision had been made not to lay any charges against any person or employer.[10]

81. A second Directions Hearing was held on 6 March 2025. On this occasion I was assisted by Ms Anna Pejnovic (**Ms Pejnovic**), In-House Lawyer of the Coroners Court of Victoria.

82. George, The Good Guys and WorkSafe were all legally represented. Representatives of Allianz were in the body of the Court, not at the Bar table.

83. Given the passage of time, Ms Pejnovic reiterated the known circumstances surrounding Natasha's death, including an overview of events related to the investigation. Ms Pejnovic took the opportunity to confirm the distribution of Dr White's expert opinion and noted that he had stated in his report:

    There appears to have been a temporal and causal link between the initial physical workplace-related injury on 9 October 2018 and Ms Stojkoski's suicide on 2 May 2021, via a combination of physical and psychological symptomatology in a setting of ongoing chronic pain and physical disability as well as perceived and reported workplace bullying.

84. As my investigation remained largely in the same position as it was prior to the WorkSafe investigation, and there had been no concessions received from The Good

[10] T – Directions Hearing 6 March 2025 @ p 16.

Guys, I indicated my intention to still proceed to Inquest. Having regard to the passage of time and acknowledging the likely trauma associated with a public hearing, for George and Natasha's family and witnesses who might be called to give evidence, I did however afford some time to the Interested Parties to make written submissions to me on whether an Inquest should proceed and if so, the potential scope.

85. On 26 August 2025 a third Directions Hearing was held. Ms Kelly McKay of Counsel appeared as Counsel Assisting the Coroner. The scope of the Inquest and the witness list were settled. The scope included:

    1) What is the correct diagnosis of Natasha's mental health in the period between her workplace accident on 9 October 2018 and her death on 2 May 2021;

    2) The response of the Good Guys to Natasha's complaints that she was being bullied in the workplace, including what steps were taken by the Good Guys to:

        a) Investigate the conduct alleged by Natasha against other employees;

        b) Address Natasha's complaint that she was being bullied in the workplace; and

        c) Provide Natasha with support given her complaint.

    3) Was there a nexus between:

        a) Natasha's perception or concern that she was being bullied in the workplace and/or

        b) The response of the Good Guys to her complaint of bullying

    and her ultimate decision to take her own life.

    4) Were there any other factors or matters that may have impacted Natasha's mental health and her ultimate decision to take her own life.

    5) Were there any prevention opportunities.

EXPERT OPINIONS

Dr Gregory White

86. As indicated above, the Court commissioned an expert opinion/report from Consultant Psychiatrist, Dr Gregory White.

87. Dr White opined that Natasha developed a psychological workplace injury, being an adjustment disorder with mixed anxiety and depressed mood as a result of physical (the WAV accident) and psychological stressors. He said *it is likely that the psychological condition developed gradually and insidiously.* This adjustment disorder would have impacted Natasha's attempts to return to work.

88. Dr White said that the history suggested that Natasha's mental state was *significantly negatively impacted by her perception that she was bullied* and pointed to the significant consistency in her reports of bullying to the practitioners on whom she consulted. He noted that there were *some hints* in the investigation report of Cygnus Higgins Shaw that suggested colleagues and management were aware of Natasha's thoughts and feelings in this regard.

89. Dr White noted that modern views about bullying highlight that bullying is about the perception of that behaviour rather than intention. In the case of Natasha she *loudly, clearly and repeatedly* alleged she was bullied, was not believed and was regarded as "difficult". He said that *denial, trivialisation, abdication of responsibility and false conciliation* are inappropriate responses from an employer that can aggravate one's mental state and psychiatric disorder.

90. On the issue of The Good Guys' response to Natasha's complaints, Dr White opined that the available information *does not suggest* she was proactively supported. There was no evidence that The Good *Guys dealt with her perceptions within a restricted timeframe or via the use of proactive measures … rather than a passive, rationalising or even blaming approach*.

91. As stated earlier in my Finding, Dr White opined that there appeared to have been a temporal and causal link between the injury sustained on 9 October 2018 and Natasha's

suicide, *via a combination of physical and psychological symptomatology in a setting of ongoing chronic pain and physical disability, as well as perceived and reported workplace bullying.*

Professor Matthew Large

92. The Good Guys provided an expert opinion of Professor Matthew Large on 2 April 2025.

93. Professor Large, in short, disagreed with the assertions of Dr White and took a more 'academic'/technical angle in his report in which he provided an overview of academic research and literature around suicide, its aetiology and predictability.

94. Professor Large explained that the causes of suicide are the subject of ongoing research and remain controversial but that there is consensus that it is multifactorial and associated with complexity and uncertainty. He said: *No risk factor, collection of risk factors, or pathways towards suicide has been demonstrated to be either necessary or sufficient for a suicide to occur. While there are known associations with suicide, not all these associations are likely to be causal. Suicides are almost never attributed to a single risk factor.* Discussing those various risk factors, he said: *the strongest statistical risk factor for suicide is a mental illness of sufficient severity to bring the patient into contact with health services.*

95. Professor Large opined that Natasha lacked the most substantial risk factors for suicide, including having been admitted to a psychiatric hospital and having previous evidence of suicidal behaviour. His opinion was that her only known suicide risk factor was her psychiatric condition(s), which he opined that from 2018 until her death was a Somatic Symptom Disorder, and a mood disorder, likely diagnoseable in 2021 as Major Depressive Disorder. He disagreed with Dr White's opinion that she had suffered from an Adjustment Disorder. He said that Major Depression confers a moderate statistical risk of suicide.

96. Professor Large did not think that Natasha's death by suicide could have been predicted, and said that her interpersonal issues at work, the WorkCover claim and return-to-work

cannot be considered to be likely causal factors of her suicide in 2021, being *simply too distal.*

97. Professor Large was asked to provide an opinion on the connection between Natasha's experience in her workplace and her mental health condition, to which is said it was *not reasonable to believe* that either the WAV incident or the "interpersonal issues" caused her to have an Adjustment Disorder at the time of her death. He said: *[Natasha] had a Major Depressive episode in the weeks before her death. Major Depressive Disorder has many possible causes, including genetic causes, social causes and losses as psychological vulnerabilities. The events at her work can only have had modest and indirect links to her depressive disorder and later suicide.*

98. Professor Large said *events just before any form of self-harm are likely to be more determinative than longer-term factors* and noted that very little was known about the events before Natasha's suicide. He did not consider that her suicide was related to the conditions of Somatic Symptom Disorder or Adjustment Disorder *but was much more likely to have been a result of a worsening depressive episode or other unknown factors.*

99. As to the conduct of The Good Guys, Professor Large opined that no conduct or omission on their part could have resulted in Natasha's psychiatric conditions, and that the behaviour of The Good Guys or its employees did not contribute in a meaningful way to her suicide. He said there were no rational steps that they could have taken that would have prevented or minimised her risk of suicide.

100. Professor Large summarised his opinion as follows:

After examining all the available material, I conclude that [Natasha] suffered from Somatic Symptom Disorder and, in probability, a Major Depressive Disorder at the time of her death. Expert knowledge about the causes of suicide, the lack of predictability of suicide in general, and the specific consideration of the nature of the WAV incident in 2018 and interpersonal issues at work in 2019 suggest that a causal relationship between events at The Good Guys and Natasha's suicide in 2021 is unlikely.

Supplementary report of Dr Gregory White

101. Dr White was asked to provide a supplementary report addressing/responding to the report of Dr Large. In addition, Dr White was provided with the transcripts of recorded conversations between George and Chris Mrmacovski (George's cousin) and my coronial investigator Leading Senior Constable Tsichrintzis and was asked if these transcripts altered his initial opinion.

102. Dr White did not challenge Dr Large's interpretation of the academic research and literature with regards to suicide but *respond[ed] as a medical practitioner and psychiatrist whose nearly 50 years of experience in a variety of settings has been focussed on individual patients and their biological, psychological and social circumstances*, *as opposed to [his] being immersed in academic or administrative psychiatry with its focus on cohorts of patients.*

103. In short, Dr White did not deviate from his initial opinion. He remained of the opinion that *the evidence suggests that the psychiatric disorder occurred as a result of the chronic pain, physical disability and [Natasha's] perceptions that she was being unreasonably treated by colleagues and inadequately supported by management* and *the perceived bullying by colleagues was precipitated by the physical workplace-related injury and its impacts upon [Natasha's] work capacity.*

104. Dr White opined that it was somewhat academic as to the diagnostic label applied to Natasha's symptomology and regardless of the label, he remained of the view that *the totality of the history available suggests that [Natasha's] mental state leading up to her death was significantly and negatively impacted by her perception that she was bullied.*

105. The transcripts provided did not alter Dr White's opinion. He noted that they referred to reports by Natasha of her being bullied, and not to other causative factors in relation to her suicide.

INQUEST

106. An Inquest was held on 25 to 27 November 2025 & 11 December 2025.

Viva Voce Evidence at the Inquest

107. Viva voce evidence was obtained from the following witnesses:

- Mr SEM, Store Executive Manager, The Good Guys Thomastown.
- Ms HBP, Human Resources Business Partner, The Good Guys.[11],[12]
- Professor Matthew Large, The Good Guys appointed expert.[13]
- Dr Gregory White, Psychiatrist, Court appointed expert.[14],[15]

EVIDENCE ADDUCED AT THE INQUEST

108. Mr SEM had known Natasha from approximately late 2017 and from the outset had quite a friendly relationship with her, they had the commonality of both being Richmond supporters.[16] Up until the incident with the WAV there had been no conflicts or major issues involving Natasha.

109. At the time of the incident with the WAV, Mr SEM was not working at the Thomastown store of The Good Guys. When he returned to the store, he believes he received a briefing from one of the sales managers on what had been going on in his absence[17] and he understood that *the matter had resolved* and that Natasha had returned to full duties

[11] Exhibit 4 - Statement of Ms HBP dated 25 November 2025 with two attachments at tab 133 and 135 CB – this was an unsigned version of Ms HBP statement.

[12] Exhibit 7 – Statement of Ms HBP signed and dated 26 November 2026.

[13] Exhibit 8 – Report of Professor Matthew Large dated 1 April 2025.

[14] Exhibit 9 – Report of Dr Gregory White dated 19 January 2024.

[15] Exhibit 10 – Supplementary report of Dr Gregory White dated 17 October 2025.

[16] T16.

[17] T69.

so there was not anything he had to address.[18] He could not recall if he was shown an Incident Report at that time.[19]

110. Mr SEM said that it was not until 2 September 2019 that he was alerted to the possibility that there may have been an ongoing physical problem for Natasha related to the WAV incident on 9 October 2018[20] when another employee mentioned to him that Natasha was not lifting certain stock due to a problem with her back. He asked to speak to her in his office to explore these issues and although the conversation started as an *informal chat*, as the conversation unfolded and Mr SEM was learning more about Natasha's ongoing physical issues, she also mentioned to him about the bullying she was experiencing. She told Mr SEM it had been going on for some time.[21] At that point in the conversation, Mr SEM said Natasha became quite emotional, *started breaking down, crying*.[22] He said she made it clear how uncomfortable she was feeling at work, losing sleep, feeling stressed out *and so on*.[23]

111. Natasha provided Mr SEM with the names of five of her team members from the portable appliances team who she said had been subjecting her to the behaviour that was emotionally affecting her.

112. Mr SEM said that he reassured Natasha and told her that *I'd certainly address the matter and start an investigation to find out what's going on and help her through it*.[24] He also offered for her to access the Employee Assistance Program (EAP) and asked her to start

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[18] T18, 68.

[19] T69.

[20] T83, 84.

[21] T87 – Mr SEM did not recollect if Natasha told him that the bullying had been going on since approximately June 2019 (which she claimed in her statement to Allianz appointed investigator Andrew Baldock of Cygnus Higgins Shaw) – only that she told him it had been going on for some time.

[22] T21.

[23] T22.

[24] T23.

a dialogue with her doctor about what restrictions her back injury had on her performing her work.[25]

113. On the same day, 2 September 2019, within an hour or two of the conversation with Natasha, and before Mr SEM could commence his investigation, one of the team members named by Natasha, came to speak to Mr SEM about his own *frustrations* with Natasha. He told Mr SEM how *frustrated he had been getting with her in recent months because, in his view, he felt she was taking advantage of the situation and - and not helping out the team particularly*.[26] Effectively, Natasha was not pulling her weight within the team.[27]

114. Mr SEM took the opportunity of this unplanned discussion to inform this team member of Natasha's feelings about working with him and the other team members. Mr SEM said that he did not deny it and indeed acknowledged that he had been quite cold and distant to Natasha in recent times.[28] Mr SEM also said that once he *unpacked* the extent of how Natasha said she was being impacted, the team member was visibly remorseful and knew, in hindsight, that he had been behaving inappropriately.[29] The team member indicated that he wanted to clear the air with Natasha and Mr SEM said that he suggested that perhaps they could have an informal chat while having a "smoko" together. The chat did occur and both the team member and Natasha reported back to Mr SEM that it had been productive – she said that *she felt good about it* and happy they were able to talk about it.[30]

115. Mr SEM said that he did speak individually to the other team members named by Natasha and they all gave similar accounts of having felt let down and not supported by

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[25] Mr SEM took some notes of this conversation on 2 September 2019 and although he did not retain his notes, he later created a Word document (see Exhibit 1) which he continued to add subsequent discussions with Natasha to.

[26] T24, 99.

[27] T100.

[28] T26.

[29] T27.

[30] T28.

her with the workload but like the team member that approached Mr SEM, most were remorseful of their behaviour and wanting to *clear the air* with Natasha. One of the five team members named by Natasha was not as conciliatory as the other four, responding to Mr SEM that she had *known Natasha for years and that's just how it is with her, I don't even bother, let's just get on with it* ….[31] Overall, Mr SEM said *The whole purpose of my conversation (with the individual team members) was to, (a), find out from their point of view what had happened and what they recall about their behaviour, why their behaviour was the way it was, and also to draw a line in the sand and say we cannot tolerate this*.[32]

116. On 4 September 2019, Mr SEM received a text message from Natasha advising him that she would not be in at work until 19 September 2019 as she was feeling affected by what was going on at work, that she was not coping. She sent through a medical certificate for the planned time off work. Mr SEM sent a lengthy text message[33] in response in which he informed Natasha that he had indeed spoken to the team members she had named, and he also told Natasha that they had expressed frustrations with her that they wanted to talk about. His personal view was that this breakdown of relationship was as a result of all parties involved, including Natasha, not behaving in a supportive manner towards each other.[34] He encouraged Natasha to come into work for a chat and *check in with each other,* but Natasha declined. In her lengthy response Mr SEM said she was *just again reiterating her feelings, and her mental sort of anxiety and so on … and how just sort of shaken up she was*.[35]

117. The text message from Natasha was quite explicit about how she was feeling emotionally and physically, stating that nobody deserved to be bullied in the workplace,

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[31] T29.

[32] T102.

[33] See Exhibit 2 - Text message exchange between Mr SEM and Natasha dated 4 September 2019 to 26 October 2019. (Tab 164CB).

[34] T113.

[35] T30 - 31, 109 - 110

that she did not realise that bullying would have such a strong impact and effect on her.[36]

118. However, by the end of this dialogue Mr SEM had the sense that they were still on track to resolve the issues informally through continued open dialogue with the team.[37] Although he was concerned for Natasha's welfare he said that he was dealing with a dispute with *a group of people who had grievances with one person*, Natasha and he therefore *had to treat it holistically rather than just an isolated matter*.[38]

119. Mr SEM said that he would have informed Ms HBP in HR within the first couple of days after the discussion with Natasha and her team members to give Ms HBP *the heads up* about what was going on but that so far it was positively progressing.[39]

120. At this stage, early September 2019, Mr SEM said he was not aware of a group "chat" going on between the team members named by Natasha.[40] Similarly, he was not aware that one of his sales managers had some knowledge that something was "brewing" within the team, that there was some "unhappiness" – this was not conveyed to Mr SEM – he speculated that his manager thought it would blow over, saying *I don't think in his eyes it was as serious as what it actually was becoming*.[41]

121. Natasha worked between 23 September and 3 October 2019. On 3 October 2019 she had a meeting with Mr SEM in his office. He wanted Natasha to obtain a letter from her GP addressing her physical limitations to perform her normal duties. Mr SEM said that he needed some basic information so he could provide it to HR.

122. Natasha later reported that she was aggrieved that she was not provided with a support person at that meeting and that she felt interrogated by Mr SEM. In his *viva voce*

[36] Exhibit 2.

[37] T31.

[38] T34.

[39] T107 – 108.

[40] T88.

[41] T89 – 90.

evidence, Mr SEM responded that he did not believe that to be the case – it was a fact-finding meeting intended to obtain information from her doctor so as to provide her with support.[42]

123. On 8 October 2019 and in the absence of Mr SEM, Natasha had a lengthy meeting with her direct line manager and Sales Manager and Natasha's direct line manager, who provided Natasha with a letter drafted by Ms HBP of HR, for Natasha's GP to complete. She reported back to Mr SEM that Natasha had been quite upset in the meeting and that she had stated to her that she felt that the issue of bullying had not yet been resolved.[43]

124. On 22 October 2019 upon his return to work, Mr SEM telephoned Natasha to chase up the return of the letter from the GP. He informed Natasha that she could not return to work until they had the medical information about her back – for her own safety, because they could not risk aggravating her back injury any further.

125. By 29 October 2019, and after Mr SEM had made attempts to speak to Natasha, he said that it had become apparent to him that the *situation* had deteriorated – Natasha had informed him via a text message that she was not coming into work until further notice and in response to his message of "Please call me Tash" she texted "Just text me".[44] Mr SEM however continued to reach out to Natasha because he wanted her to attend a meeting with the Group Injury Management Lead and the Safety Consultant. Mr SEM said he would have reached out to the Group Injury Management Lead and the Safety Consultant after Natasha mentioned stress leave although he was unclear whether it had been him or Ms HBP that initiated this escalation.[45]

126. The Group Injury Management Lead had also emailed Natasha about a meeting and in response she indicated her preparedness to chat and provide her side of events regarding the bullying in the workplace but she was upset because she understood that the meeting

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[42] T41.

[43] T42.

[44] T44-45.

[45] T46. Mr SEM said that it was Ms HBP who drafted the letter for Natasha's GP and that she had been aware of the situation with Natasha from *quite early on*.

Mr SEM was trying to set up with her was for a one on one with him, whereas she was now aware that it was to include the Group Injury Management Lead and the Safety Consultant. She wrote that she believed this to be unprofessional of Mr SEM and was intended to ambush her.[46]

127. Mr SEM said that from this point, his personal involvement with Natasha became less and less. He could not understand Natasha's lack of cooperation with him including her refusal to speak to him verbally and he started to believe that *she was gearing towards a compensation claim of some sort*.[47] Mr SEM agreed with Counsel Assisting that he had become somewhat suspicious of Natasha's motives.[48]

128. Ms HBP's evidence was somewhat disrupted and disjointed by her personal commitments however, she was unequivocal that it was not Mr SEM who had brought Natasha's injury and allegations of bullying to HR but the *Health and Safety Team letting me know that there was a back injury, a neck and back injury lodged, and that the reason for that was due to a stress*.[49] The notification to Ms HBP also appears to have been prompted by Natasha seeking a copy of the Incident Report completed in relation to the injury sustained with the WAV in 9 October 2018. This notification to Ms HBP occurred on 4 October 2019.[50]

129. Ms HBP stated that it was she who reached out to Mr SEM on 14 October 2019 about ensuring he was going to be speaking to Natasha about her concerns when she returned to work. She said that she did not have the details of her allegations of bullying and neither did the Health and Safety Team who had been trying to obtain those details from the insurance company after Natasha lodged her secondary claim related to her psychological condition. Ms HBP was trying to obtain details about the *stress* Natasha

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[46] See Tab 107 CB.

[47] T49 – 50.

[48] T77.

[49] T140.

[50] T159.

was experiencing and she had no information about Natasha's allegations of bullying. She said: *I'm not aware of any direct conversation Mr SEM had with Natasha*.[51]

130. Ms HBP's evidence is that she was thwarted in her attempts to obtain details of Natasha's complaints of bullying. In her statement she said: *I consider that I acted in line with my obligations and did everything under my power to obtain the details of the stress and bullying allegations to enable me to undertake further investigation. Unfortunately, on all occasions, when I attempted to obtain the details, I was unsuccessful, which resulted in no investigation occurring and the allegations never being substantiated. This was due to Ms Stojkoski choosing or not being able to take part in the process and Allianz not providing the relevant information I needed*.[52]

131. On 14 November 2019 Ms HBP received an email from the Group Injury Management Lead the day after he had attended an appointment with Natasha's GP, Dr Patel. The email to Ms HBP addresses Natasha's physical injuries from October 2018, how she was being treated by her team members, that she had taken her concerns to Mr SEM and that he had said that this was "bullying" if what Natasha was alleging was actually happening. This correspondence also reflects that the Group Injury Management Lead had asked Natasha if she wanted a formal investigation into her allegations of bullying to which she responded in the affirmative. The team members alleged by Natasha to be adversely treating her are also named in the email to Ms HBP. But Ms HBP maintained that she did not have specific details to enable the commencement of a formal – or informal – investigation.[53]

132. On 19 December 2019 Ms HBP had a 45-minute telephone conversation with Natasha. Natasha was upset about the bullying and provided Ms HBP with some of the information Ms HBP had already received from the Group Injury Management Lead one month earlier.[54] Ms HBP took contemporaneous handwritten notes of the telephone

[51] T143, 162, 178.

[52] Exhibit 4, T152.

[53] T169.

[54] T174 – 175.

conversation in which she wrote *upset with the bullying* and *very emotional & kept crying + referring to bullying* and recorded the names of some the alleged "bullies" alongside quotes Natasha alleged they had said.[55] Nevertheless, Ms HBP still did not consider that she had enough "detail" to commence an HR investigation and she had planned to speak to Natasha again the following day but this did not occur.

Expert evidence

133. Dr Gregory White and Dr[56] Matthew Large gave concurrent evidence as part of a conclave. The questions posed to the experts are repeated here for the ease of the reader and their opinion responses summarised and referenced.

1. *Is there any evidence to indicate that Natasha had a preexisting mental health condition (that is, before the WAV vehicle incident on 9 October 2018)?*

   Response: There is very slight evidence – a suggestion that Natasha may have had postpartum depression *of some sort*. If that were the case, that would be a predisposing factor.[57]

2. *When does the documentation indicate a deterioration in Natasha's mental health?*

   Response: In the last third or quarter of 2019.[58]

3. *What was the correct diagnosis for Natasha's mental health condition at the time of her death?*

   Response: Quite a severe major depression, bounding on loss of reality.[59] Dr Large said that *she might have had psychotic depression, but we don't know that*[60] and noted that

[55] Tab 125 CB.

[56] Dr Large indicated at Inquest that he preferred to be addressed as Dr.

[57] T225.

[58] T225.

[59] T225.

[60] T227.

psychotic depression often has a better prognosis than major depression but requires antipsychotic treatment as well as antidepressants.[61]

4. *Was that diagnosis consistent throughout her presentation or did it change over time?*

   Response: The diagnosis changed over time. Dr White believed that Natasha had a chronic pain syndrome. In response the chronic pain syndrome she developed an adjustment disorder that was *either the precipitant, or the beginning, or transformed somehow into a major depression;*[62] *the major depression evolved from an adjustment disorder.*[63] Dr Large thought that, in the year after the WAV accident, Natasha developed progressively severe somatoform disorder[64] encompassing emotional disturbance and *at some point and we're not entirely sure when*, a major depression developed.[65] Dr White opined that the main difference in their opinions was that he did not believe it is possible to easily diagnose somatic symptom disorder, particularly when neither of them saw Natasha or had received information from other medical practitioners that she suffered from the condition.[66]

5. *How does chronic pain impact mental health?*

   Response: Chronic pain has an impact on all sorts of cognitive and emotional factors and is broadly detrimental to mental health.[67]

6. *Could Natasha have been experiencing chronic pain and Somatic Symptom Disorder simultaneously?*

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[61] T228.

[62] T226. This quote is attributable to Dr Large, speaking on behalf of Dr White.

[63] T230.

[64] Dr Large explained that the more modern term is 'somatic symptom disorder' and it occurs where there is persistent complaints of physical symptoms with emotional and cognitive concomitant symptoms that are not explained by the examination, investigation and natural history of any underlying medical condition.

[65] T228.

[66] T230.

[67] T231.

Response: Yes, they are strongly overlapping concepts.[68] Dr Large explained *a patient with pain as a central symptom in somatic symptom disorder … you wouldn't say they didn't have chronic pain*. Dr White said that the response to the chronic pain, psychologically, is where the somatic symptoms disorder comes into discussion.[69]

7. *Can an Adjustment Disorder progress to a Major Depressive Disorder?*

   Response: Yes, and probably by lots of different routes. It's very unlikely for someone to have a major depression without some actual precipitant.[70]

8. *Would the appropriate treatment for Natasha have been the same regardless of the formal mental health diagnosis?*

   Response: Yes, psychiatric treatment is largely symptomatic rather than syndromal. *We treat people, not illnesses.*[71]

9. *Can a perception of social isolation from one's peers cause or exacerbate ill mental health?*

   Response: Yes. Whether it can 'cause' ill mental health is less certain than whether it can exacerbate it, because mental disorders have lots of components and diagnostic symptoms are fairly agnostic as to cause. The DSM[72] is almost without causation in it, with the exception of post-traumatic stress disorder.

10. *Is the informal manner in which Natasha's bullying complaint was handled by her employer at first instance likely to have negatively psychologically impacted her?*

    Dr Large's response: The initial period of the complaint being dealt with informally was unlikely to have adversely affected Natasha – to start things off formally can

[68] T231.

[69] T232.

[70] T233.

[71] T234.

[72] Diagnostic and Statistical Manual of Mental Disorders.

actually make things worse. From his experience in managing a hundred psychiatrists, interpersonal issues between employees are *an inevitable part of workplace culture* and a degree of trust can be placed between people to sort things out. He noted that there was a lot of uncertainty about what actually happened, and that it was a difficult question to answer.[73]

Dr White's response: He agreed that it was a difficult question to answer. He drew the Court's attention to the Safe Work Australia Guide for Preventing and Responding to Workplace Bullying 2016.[74] He said that most individuals complain about bullying because they believe they have been bullied. The critical thing is what occurs in the first instance following that complaint, because it sticks in their mind. There was a significant possibility that Mr SEM's initial handling of her complaint may have adversely affected her. He said *when an employee reports that their bullying complaint is not being dealt with adequately, they're usually – they're usually correct.*[75]

11. *The Store Manager gave evidence that Natasha and four of her alleged bullies were encouraged to meet and resolve their differences informally – would you consider this an appropriate approach?*

Dr Large's response: It would definitely be inappropriate if Natasha was asked to meet with them collectively and it may be inadequate if it was the sole solution. It would not be necessarily inappropriate, at least initially, to encourage individuals to work it out.[76]

Dr White's response: It was not an appropriate response and it is akin to victim blaming, saying to the individual *you're a part of the problem, an equal part of the problem, all go away and sort it out.*[77]

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[73] T236.

[74] T237. Dr White read out the passage *The person reporting the bullying should be respectfully listened to and their report treated as credible and reliable, unless conclusively proven otherwise.*

[75] T239.

[76] T239.

[77] T240.

12. *Can the analysis or interrogation of a person's assertion that they have been subjected to bullying negatively psychologically impact that person?*

    Response: Yes, it might be perceived as the manager disbelieving the worker. Dr Large's view was that most managers *actually do an okay job*. These complaints happen often, and it is usually dealt with fairly sensitively. Dr White noted that the key word in the question was 'can' and said yes, *particularly if the analysis or interrogation is aggressive or disrespectful or the manager is expressing doubt or frustration.*[78]

    a. *If so, how is an employer to meaningfully investigate allegations of workplace bullying without risking a negative impact to that person?*

       Response: This is very difficult to do without risking exacerbating the situation. A formal investigation *raises the stakes*.[79] Dr Large said *very carefully, cautiously* is how you might investigate while minimising the risk of negative impact. Dr White reiterated a passage from the Safe Work Australia Guide for Preventing and Responding to Workplace Bullying 2016: *The person reporting the bullying should be respectfully listened to and their report treated as credible and reliable, unless conclusively proven otherwise.*[80]

13. *Can a matter causing a person psychological distress set that person on a path of ill mental health which persists even after the factor which caused the distress has abated?*

    Response: Yes, *clearly people don't forget things.*[81]

14. *If a person's sense of purpose or identity is linked to their employment, can an inability to engage in that employment negatively psychologically impact them such that it causes ill mental health?*

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[78] T241.

[79] T241.

[80] T242.

[81] T242.

Response: Yes. This is supported by the literature – there is some consensus that the period of becoming unemployed is associated with a range of adverse outcomes. The process of becoming unemployed is worse than being unemployed.[82]

15. *Is there sufficient evidence to support the assertion that Natasha's work injury and work environment were precipitating factors to*

    a. *her ill mental health and/or*

    b. *her eventual suicide?*

<u>Response:</u> The experts agreed that there was something about her work that was associated with her ill health.[83]

Dr Large said that there may have been an element of precipitation, and her ill health may have caused some of her workplace issues. He said there was sufficient evidence to support the assertion that Natasha's work injury and work environment were precipitant factors, *but it's a bit more complicated than that.* Dr White opined that there was a clear link between her physical injury and its impacts to say that her work injury and her subsequent perceptions of the work environment were significant precipitating factors with regard to her depression *and therefore her eventual suicide.*[84]

The experts diverged on the issue of suicide.

Dr Large said *suicide's a complicated, mysterious phenomenon. No single factor is strongly associated with suicide.* Natasha enacted something *dramatic and unexpected* years after the events started, so 'precipitant' is not a word I would use. In many coroners matters, there are lots of witness statements explaining the contemporaneous events, which is lacking in Natasha's case. He said *I don't think there is a compelling causal chain between the events that occurred … two and a half years previously and her suicide* and *as a suicide researcher, I just actually don't buy it … I don't accept*

[82] T243.

[83] T243.

[84] T244.

that the word 'precipitant' is how I would characterise the role of causation in her workplace to her suicide.[85] He pointed to the events in the months prior to her suicide – she had become withdrawn, had sold the family home, had moved in with her mother – and said *I don't see how that all hangs together using the word 'precipitant'.* He said that in the mental health field, *if you were going to use the word 'precipitant', more proximal events would be more appropriate.*[86]

Dr White said that in medico-legal psychiatry, *we usually talk about precipitating as being the original important event that changed a person's life.* He agreed with Dr Large (*he's the expert*) that suicide is complex but said *I'm not so persuaded that suicide's a mystery*. He hypothesised that Natasha developed chronic pain following her injury which would have been demoralising for her, and that she would have been further demoralised by her perceptions that she was being bullied and not adequately supported, and *its unfortunately a pretty good recipe to leading to significant depression, and significant depression, in my opinion, can sometimes lead to suicide.*[87]

16. *Can the experts identify any other matters that may have been precipitating or contributing factors to Natasha's ill mental health and/or eventual suicide?*

<u>Response:</u> Dr Large said there were a number of factors occurring in Natasha's personal life that he was happier to attribute to "precipitating" events. He said: *there was the issue of her having sold the house she inherited from her father, possibly a process not driven as much by her as by her husband, and I think her husband's friend who's a developer of some sort, and she ended up in her mother's house and had some loss of role associated with that. And her brother said that she wasn't right* after that happened. *And that coincides with her probably developing a major depression. So that's another*

[85] T245-246.

[86] T247.

[87] T248-249.

factor.[88] Dr Large said all of these things *can definitely be considered to be both precipitating and contributing factors*.[89]

Dr White agreed that the loss of the house would have been a factor, but he said it would have been an *exacerbating factor because I think it's clear that by the time that happened she had already developed depression. She had already perceived herself to be bullied and to be suffering chronic pain*. Dr White also pointed out that there was no evidence that Natasha had *any ongoing major previous psychiatric history, or family psychiatric history, or alcohol or drug problems, or personality disorder, other unresolved medical issues, other major social issues* and he was struck that she had been employed by the Good Guys for 9 years prior to the relevant events and he was not aware of there being any prior issues related to her employment either from her or her employer's perspective.[90]

17. *Noting that neither drug was found to be present in her blood at the time of her death, is Natasha's prescription of:*

    a. *Baclofen; or*

    b. *Lexapro;*

    likely to have had any impact on the decline of her mental health and/or decision to commit suicide?

Response: Dr Large responded that they thought it possible but unlikely. Dr White said it was highly unlikely stating: *I've seen thousands of patients on SSRI antidepressants, and quite a few on Baclofen, and I think the sorts of acute side effects or acute withdrawal - devastating withdrawal side effects are unusual and unlikely*.[91]

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88 T249.

89 T250.

90 T250 – 251.

91 T253.

18. *There is a breadth of materials and resources for employers instructive in dealing with employees' complaints of bullying in the workplace (e.g. from WorkSafe, Fair Work) – is there anything additional that an employer such as The Good Guys could have done in response to Natasha's complaints?*

    Response: Dr Large said this was tricky territory but he could not identify much more that could have been done. Dr White said it was a difficult question but said: *maybe her bullying complaint could have been taken more seriously earlier* which, when asked to elaborate on said that it goes back to the meeting on 23 September 2019 *when she was advised to go away and meet with the purported bullies and sort it all out*.[92]

19. *Was the support provided to Natasha by The Good Guys with respect to her mental health reasonable and appropriate in light of her presentation and complaints?*

    Response: Dr Large responded that this was again tricky – he reflected that he had been head of a mental health service, and although this had not been for a decade he said it was tricky because in Natasha's situation it *definitely proved to be a very complex and lethal psychiatric disorder that would be difficult for a mental health department to manage* and here we are looking at a retailer not a mental health department.[93]

    Dr White he was not sure this was about what the Good Guys should have done in response to Natasha's mental health as opposed to what they should have done in response in light of her presentation and her complaints. He reflected that he had *been part of the process of the evolution of society's understanding about bullying complaints for a long time* and said *there had been an evolution ... with regard to definitions about bullying, and there's lots of information*. He believed it was incumbent upon employers and managers to have a solid understanding about how to deal with a bullying complaint.[94]

[92] T254.

[93] T255.

[94] T255 – 256.

Dr White said it was not obvious to him that the support provided to Natasha by The Good Guys was reasonable and appropriate. He noted the "eggshell skull" principle and said: *it's not obvious that there was an apparent awareness of the fact that employees bring a background history ... which the employer doesn't know.* He also said *referral to employment assistance program and moving office does not fix an employee's perception that the bullying was not taken seriously.*[95]

134. At the time Natasha raised her bullying complaint, The Good Guys had in place an 'Equal Opportunity and Workplace Behaviour Policy' which outlined what constituted inappropriate workplace behaviour – for example, bullying, harassment and vilification – and provided brief procedures for raising a complaint. It said*: In the first instance, you are encouraged to raise your concerns directly with the person involved to ensure they are fully aware that the conduct is unwelcome and inappropriate.*[96]

135. The experts were asked about the appropriateness of that approach in a situation where there were four alleged bullies and one complainant. Dr White thought it was *dreadful.* He said that it was likely a complainant would have done that if they had the capability to do so, but *they've come for help.*[97] Dr Large said that *the fact there was four of them does complicate matters* but noted that in his experience, often these things are based on a misunderstanding and an apology from those involved can go a long way and resolve things. He said that the person accused is *usually horrified that their actions have been perceived as bullying and are very keen to ... apologise.* It does however make it a bit more complicated when there are four people.[98]

Additional questions to the panel by Mr O'Neill:

136. Mr O'Neill directed the experts to the text message exchange between Mr SEM and Natasha, two days after their inaugural meeting about Natasha's complaints of bullying towards her. In the first instance Mr O'Neill referred to the part of the text message

[95] T257.

[96] The Good Guys, Equal Opportunity and Workplace Behaviour Policy, December 2019, CB Tab 144-11.

[97] T258.

[98] T259.

where Natasha said: *'Thanks [Mr SEM], I really appreciate it. I'm confident we'll get through this together',* and that she then went onto express "appreciation for another team member". Mr O'Neill asked the experts whether in light of *the informal and friendly tone of the exchange, does that affect your opinions as to the reasonableness of Mr SEM feeling that Natasha was genuinely consenting and open to an approach where these issues were resolved among the team?*[99]

Dr White responded that he was more struck by the subsequent text message from Mr SEM commencing "Tash it doesn't need to be like this….". Dr White gave a somewhat genteel exclamation of "gee-whiz" after reading the whole text message and then responded to Mr O'Neill's question by saying: *I'm not persuaded that that's really an appropriate text message to send an employee who's complained about bullying. So that just leads me on to read the rest of it and think, yeah, okay, she's being nice. She's being hopeful. She's trying. She's possibly being subservient. The horse has bolted.*[100]

137. Mr O'Neill persisted about the tone of the communications reflecting a friendly and open relationship/ "a degree of trust between them" referring to Natasha's use of the word "shit" within their communications.[101] Dr White however responded: *I'm not sure about the relationship between using expletives and trust.*[102] Ultimately, Dr White, in part, agreed with Mr O'Neill that the text reflected a genuineness on Natasha's part to participate in the informal process proposed by Mr SEM but he somewhat clarified his position by saying: *At that very point in time, there might have been. Yes.*[103] Dr White again emphasised that the text message to Natasha from Mr SEM where, as Mr O'Neill stated, was "deflecting things back onto Natasha", was inappropriate but that the

[99] T261.

[100] T261 – 262.

[101] Ms HBP had similarly referred to the use of the expletive by Natasha, also suggesting that an employee would not use this or like words unless they had a very close working relationship with their manger – T189.

[102] T262.

[103] T263.

approach taken by Mr SEM in the first instance, was an attempt to resolve the issues raised by Natasha about her team members.[104]

138. The focus of Mr O'Neill's additional questions was on Dr White and despite Dr White again referencing his broad clinical experience, Mr O'Neill put to Dr White that he had a "bias"[105] – *that there is a degree of bias in the selection group that you see*. Dr White disagreed and said that his reference to WorkCover was because it was specific (to Natasha's circumstances) and it is the area in which he has developed a degree of expertise - *from thinking about bullying, and the literature, and the expectations.*[106]

139. Mr O'Neill changed the topic and asked Dr White about his use of the terms "precipitating" and "exacerbating" and whether an exacerbating matter might be more significant to the eventual result than the original precipitating matter to which Dr White said *it can be*. Dr White agreed that there was not sufficient information to say which matters were the most significant to Natasha's eventual suicide.[107]

140. Mr O'Neill turned to Natasha's attendance at the NHED on 7 March 2021 and asked if there were missed opportunities to address her condition. Dr White opined that the treatment/ advice – pathology testing, advice to continue escitalopram and attend her GP for titration and follow up with a psychologist – was a *fairly standard treatment for an emergency department* but added that *Dr Large would have more experience with regard to that*.[108]

141. Dr Large effectively said that her attendance was a missed opportunity, saying *it's very hard to say that it wasn't.* He said the NHED's assessment was narrow, focussed on the medical factors underlaying her depression rather than *an assessment of her actual psychiatric treatment needs.* He explained at some length what a psychiatric assessment

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[104] T266.

[105] Mr O'Neill resiled from the use of the word bias which he said was a *poorly chosen word* and confirmed that he was not suggesting Dr White was biased in his approach to these issues. T268.

[106] T267.

[107] T268 – 269.

[108] T269 – 270.

entails and its importance as *one of the few things you can do that's actually a bit protective*, concluding *all of that aside, this is not a psychiatric assessment. This is a very narrow medical assessment, not a psychiatric assessment.* Mr O'Neill asked if the lack of such documentation was a limitation in seeking to understand Natasha's condition and what might have led to her suicide, to which he responded in the affirmative.[109]

142. Mr O'Neill asked Dr White if he agreed with Dr Large. Dr White *applaud[ed] Dr Large for his standards of care* but drew on his personal experiencing running a private practice in the Northern Hospital's catchment area where he exclaimed that *gosh, the difficulty in getting my patients assessed quickly and efficiently was lacking at times.* He said that in *an ideal world* there would be a full developmental history and a couple of hours spent with the patient, but emergency departments sometimes just don't have the time. He was *not totally convinced that you could have spent three hours with her on that day and taken all the history in the world, whether the end result* (her management plan) *would have been particularly different.*[110]

143. Mr O'Neill queried with Dr White whether a lack of detailed history/assessment affected his ability to assess the development of Natasha's condition and eventual suicide. He said that *he could be more sure … with more detailed information* but pointed to the information that was available and noted *she had seen so many people over a number of years that I would expect that likely somewhere in the notes there'd be some information that there were those other problem areas, and there doesn't seem to be.*[111] At this time, I added that even with a lack of information about Natasha's last few months, she still spoke about work at her ED attendance in March 2021. Dr White agreed: *it was still important to her.*[112]

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[109] T270 – 274.

[110] T274 – 276.

[111] T276.

[112] T277.

144. Mr O'Neill's last question to the experts was whether there was any capability to disentangle the WAV incident and injury, Natasha's resulting physical symptoms, and her experiences of isolation and potential bulling with regards to causation of her mental health condition. Dr White was succinct, saying *hard to unscramble the egg*. Dr Large agreed that *its very tricky. It's very, very difficult to disentangle those things.*[113]

145. At this juncture I took the opportunity to explore with the experts whether the decision to not commence a formal investigation was a missed opportunity, and did they think it was reasonable for The Good Guys to not commence a formal investigation given its potential accusing nature?[114]

146. Dr Large said that only a small proportion of interpersonal conflict, even bullying complaints, result in a formal process. He said there was usually some delay between the manager becoming aware and engaging HR, and as a manager *you've got to have some skills in this area*. Once it reaches HR, he said *it's not rare* that the person effectively does not want to pursue the complaint. He said that while *it might've been a missed opportunity*, HR has a threshold for initiating a formal process and they have to consider the interests of others. And, *accusing someone of bullying is a big deal.*[115]

147. Dr White responded that Natasha *was an employee who was clearly distressed* and *she was fairly eloquent about what she perceived to be bullying.* He struggled to imagine why someone could not obtain sufficient information in 45 minutes – this quandary *bemused* him. He again referred to the Safe Work Australia Guide for Preventing and Responding to Workplace Bullying 2016 *which talks about acting promptly, treating all reports seriously, ensuring procedural fairness including to the colleagues.*[116]

148. Mr O'Neill posed one question arising from Dr White's answer – what step could have been taken to communicate to Natasha that The Good Guys were taking the situation seriously, in circumstances where Ms HBP did not have the particulars of what had

[113] T279.

[114] T280.

[115] T280 – 281.

[116] T282.

been said by the perpetrators, and she had planned to speak again with Natasha the following day though ultimately Natasha chose not to participate. Dr White again exclaimed *gee whiz.* He expressed the *cynical little thought* of *why would you tell an employee they need to meet again the next day to further discuss it* and that interviews for employees were stressful. He likened not being able to find examples of what Natasha was reporting in a 45-minute conversation to him doing a psychiatric assessment and not finding out if that person was depressed.[117]

149. Dr White suggested that perhaps Ms HBP was not asking the right questions. To that, Mr O'Neill asked *having not done so* (asking the right questions)*, what could she have done to investigate those claims?* Dr White responded: *I don't know, it's all gone a bit pear shaped. I talked about the horse having bolted before, it just sounds to me like the horse has bolted again. I don't know there is a lot one can do after missed opportunities.*[118]

150. In closing the evidence, I asked the experts if there was anything else they'd like to say about opportunities that were lost or could have been expanded upon and indeed, whether Natasha's passing could have been prevented, which I qualified was *a big call* for me to make as well. Dr White said that forming an opinion about unreasonable management actions was *more of a legal question than a medical question* but, had I formed that view and informed the experts of such, he would *highlight the importance of that with regard to Natasha's mental state suicide. So I would say yes … it seems there was a missed opportunity.*[119]

151. Dr Large returned to the issue of Natasha's attendance at the NHED and said that emergency departments *are not adequately resourced for mental health assessments … not a very good place for a mental health assessment.*[120] At this point I interrupted Dr Large to ask whether his focus was the missed opportunity at NH and clarified that I

[117] T283.

[118] T283 – 284.

[119] T284.

[120] T285.

was *trying to look at the bigger picture in relation to her work injury … her allegations and perception of bullying and the decline in her mental health.* To this, Dr Large said that Natasha's *complicated problem was well beyond what could have easily been sorted out by a white goods retailer. But it wasn't beyond what could be sorted out by a well-resourced professional mental health unit and she did pass through that unit.* He said that he had seen change in his career, but *its still got quite a long way to go* and that Natasha's situation was *maybe not all that atypical of what happens in emergency departments, unfortunately.*[121]

152. At the conclusion of the *viva voce* evidence on 27 November 2025, I informed the Interested Parties that I had relisted the matter for closing Submissions for 11 December 2025 and that in the interim, I expected them to prepare, file and serve an outline of their respective submissions.

153. The Inquest resumed on 11 December 2025 for closing submissions. I did not have an opportunity to read the outlines from The Good Guys as they were not provided to me until the morning of 11 December 2025. Similarly, I received an outline of submissions from Mr Almond on behalf of Mr SEM who simultaneously sought leave to appear on his behalf. Mr Almond informed me that he had been acting for Mr SEM throughout the Inquest but had not sought to represent him at the Bar table. He had agreed to Mr O'Neill leading Mr SEM's examination and had not intervened when Counsel Assisting posed questions to his client but was now seeking leave on the grounds that he took some issue with the outline of submissions prepared by Counsel Assisting. I informed Mr Almond that I had assumed Mr SEM was represented by the legal representatives from The Good Guys as I had not been informed to the contrary. I further informed Mr Almond that the application in the final stages of my investigation was somewhat unusual however, leave to appear was granted.

154. I do not propose to repeat the final submissions from The Good Guys, Allianz, Mr SEM's legal representative and Counsel Assisting. I do not propose to indicate which submissions I have accepted in part, in full or not at all as this will be apparent by my

[121] T286.

Comments and formal Findings. As indicated previously[122], the absence to any reference to any particular piece of evidence does not infer that I have not considered it.

COMMENTS

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

1. Allegations of bullying in a workplace is a serious matter for any employer. They run the risk of destabilising the cultural integrity of a workplace if not dealt with efficiently and in a timely manner and in accordance with the policies and procedures of that particular organisation. Perception of bullying cannot be dismissed at the outset – the perceived victim is entitled to believe that their employer will investigate the allegations. In a 1:1 situation I accept that, following enquiries/an investigation by the employer, asking the parties to meet and talk through the issues and why the perception has arisen, may be appropriate. If it has the potential to resolve the issues between the perceived victim and the alleged perpetrator, then it is appropriate and worthwhile. It is an approach that could well be managed and resolved at the "departmental" level.

2. When the employer learns from an employee that the alleged bullying is being perpetrated by a group or team against that one employee then the situation immediately warrants escalation to the HR and away from a "departmental" approach to ensure impartiality and fairness afforded to all. Although this "departmental" approach was instigated by Mr SEM with the intention to support Natasha, address inappropriate behaviours amongst people he was managing and resolve the issues as quickly as possible, the outcome likely worsened the situation for all. The task for Natasha was to speak to each individual she had named in her team and even though there was no facilitation of these discussions Mr SEM believed that Natasha and most of the team were receptive to this approach. But Mr SEM – the manager of them all – very early on in his informal investigation had already accepted that the named team members had some legitimate frustrations with Natasha that she needed to work on. He was not impartial.

[122] See paragraphs 50 & 60 of this Finding.

He gave more weight to the team members' complaints about Natasha's performance as a team member and less weight to her complaints of bullying. He conflated her performance with her complaints of bullying. Natasha felt that he was blaming her.[123] Mr SEM had also become frustrated with Natasha – not providing him[124] with information about her injuries from her GP, that she referenced having scoliosis which he believed not to be a work related injury, that the nature of the injuries seemed to change and he started to wonder what other intent might be behind Natasha's behaviour.[125] When Natasha sought a copy of the Incident Report from HR, Mr SEM, in an email exchange with HR questioned why she was seeking the Incident Report when she had told him her back issue was due to "stress" and he communicated his views with HR that "something doesn't smell right."[126] He agreed with Counsel Assisting, that with the benefit of hindsight, a likely interpretation of the text he sent to Natasha gave the appearance that he had already taken one side – the side of the other team members named by Natasha as collectively bullying her.[127]

3. According to Mr SEM, Ms HBP was aware of the situation with Natasha's complaints *from quite early on.*[128] Ms HBP's evidence on the other hand, is difficult to reconcile with Mr SEM's – she purported to have no knowledge of his direct conversations with Natasha in which she provided specific details of her allegations against her team members and of which Mr SEM said he took immediate and direct action about.

4. HR was better placed to investigate Natasha's complaints of bullying from an impartial or at the least, from an "arms-length" position, and it was acknowledged by Ms HBP that

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[123] See Counsel Assisting's reference to Natasha's diary entry @ T350 - 'I wrote this while I was off on leave, however I held off until I got to sit with you face to face, Monday 23 September 2019, and after today's conversation, this left me feeling like you were putting the blame on me and you're expecting me to go out of my way to fix the situation, and I do not believe this is fair as I had reported this numerous times to management and nothing has been done about it, and it's escalated to this point. I would like to send this to you on file.'

[124] Mr SEM also used "evading" giving him information from the GP and not being "forthcoming" with the information – T74 – 75.

[125] T49.

[126] Tab 103 CB.

[127] T124.

[128] T46.

formal investigations into bullying were the domain of HR rather than the manager.[129] But this never occurred and according to Ms HBP this was because Natasha failed to co-operate with the process.[130] A 45 minute telephone conversation between Ms HBP and Natasha in which it was noted by Ms HBP that Natasha was crying and upset in discussing what had been occurring and informing Ms HBP that Mr SEM had acknowledged the bullying did not, according to Ms HBP, provide her with sufficient details to commence her own investigation such as speaking to the Store Manager, Mr SEM who had first-hand knowledge of Natasha's complaints.

5. Ms HBP repeatedly referred to the need for "details" and relied on the lack of those details as justification for not commencing a formal investigation, but it remains unclear what exactly she required. She said she *didn't know what I was going to present to [the alleged bullies] as allegations*. I find this difficult to parse in a situation where, as put by Counsel Assisting to Ms HBP, *you already know the identity of the alleged perpetrators of the bullying ... you've got Natasha saying she's upset with the bullying, you've got Natasha's request for a formal investigation, you've got information about a group chat, you've got two manager's names that have been identified.*[131] Ms HBP's justification for HR's inaction equates to a form of filibustering.

6. Ms HBP consistently avoided providing an example of when HR should commence a formal investigation but eventually conceded, in part, when Counsel Assisting put to her that if she was provided with some details like the "who, what and why" even if more details were required – she was asked: *Is that a circumstance that ought to involve HR at that point in time?* And she responded: *Ideally, yes, unless there's other factors, but yes*[132]. She also agreed that if she was provided with sufficient details of any sort of bullying it ought to involve HR.[133]

[129] T169.

[130] Exhibit 4, T155.

[131] T174-175.

[132] T184.

[133] T185,195.

7. I accept that The Good Guys implemented the investigation of complaints of bullying through policies and procedures, including providing training on the application of these to staff, and in particular, to managerial staff. But the shortcomings identified in the implementation of those policies and procedures by the managerial staff at The Good Guys, falls to The Good Guys themselves. They are the employer of all those involved in the circumstances related to Natasha and they – The Good Guys – let everyone down. Significantly, they let Natasha down. She felt let down by her employer of 9 years.

8. Natasha was let down by the Store Manager who commenced his investigation into Natasha's complaints with the best of intentions – to resolve the issue as quickly as possible. But he was not able to conceptualise a need to escalate her complaints to HR as soon as he started to doubt her and was instead favouring the accounts of her team that this was all about her performance. That change in his attitude happened proximate to Natasha approaching him, but he persevered, contacting Natasha while getting more frustrated with her – as depicted in his text messages to her. The Equal Opportunity and Workplace Behaviour Policy in place at the time of Natasha's initial complaint did not include instructions to managers or those receiving a complaint – this was added in the September 2020 iteration, which specifically stated that managers should *1. Listen to the complaint seriously; 2. Treat the complaint confidentially; and 3. Contact HR.*[134] In this regard, The Good Guys let Mr SEM down because at the time of Natasha's complaint, he was operating on a belief he could, or perhaps should, solve every problem that came to him in his role as Store Manager – The Good Guys are responsible for the actions and inactions of their Managers.

9. The Good Guys also let their Human Resources Business Partner, Ms HBP, down because despite her important position and level of responsibility to take seriously matters of significance to employees such as perceived bullying, she did not or did not know how to, support Natasha – the complainant and aggrieved employee. She could have communicated to Natasha that she was the person who would take charge of an investigation into Natasha's complaints but instead, she merely told Natasha at the

[134] CB Tab 144-23. Emphasis mine.

conclusion of 45 minutes of discussion that she would need to speak to her again the next day.

10. The circumstances surrounding the handling of Natasha's allegations of bullying causes me great disquiet and reflects that The Good Guys' training to its managerial staff on their obligations to employees around allegations of bullying was wanting and emblematic of poor leadership created by The Good Guys. Consequentially a number of opportunities were lost by The Good Guys to respond to and take seriously the complaints of their employee of 9 years who they knew had been physically injured at work, who was distressed and openly upset about behaviours she claimed were directed at her and about her by colleagues. Natasha changed from a long serving employee with no "black marks" on her employment record to a distressed and vulnerable employee.

11. I was assisted by the concurrent evidence of Dr Large and Dr White, both experts in psychiatry but from entirely different approaches such that I have had to attach weight to one over the other on certain issues. Dr Large's expertise in suicide research equated to an "academic perspective". Dr White on the other hand has a broader experience/expertise due to nearly 50 years in clinical practice which also involved assessing hundreds of individuals making WorkCover claims. The nexus between Natasha's employment – her physical injury and the behaviour she alleged to have been subject to – and her mental ill health was more readily accepted by Dr White and his views were not dissimilar to Natasha's treating GP, treating psychologist and of the psychologist who examined Natasha on behalf of Allianz, and unlike Drs Large and White, had the benefit of examining Natasha before her passing. In this regard, I attached more weight to the opinion(s) of Dr White.

12. The conduct of The Good Guys during the course of my investigation into the death of Natasha Stojkoski was disappointing – I often felt that they were attempting to hamper my investigation rather than assist me to reach a position where I could comfortably discharge my statutory obligations. Documents were not forthcoming – including the very relevant incident report. Witness availability was compromised by not informing the Court of a witness' very limited availability; discussions and documents were provided to their own expert despite my express directions to the contrary. I am not

intending to be critical of lawyers acting in the interests of their clients however, the role of lawyers in an inquisitorial, as opposed to adversarial, jurisdiction should be tempered to fit in with the Court's principles and objectives.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

1. With the aim of promoting health and safety within the workplace and preventing like scenarios as Natasha Stojkoski's, I recommend that The Good Guys develop detailed policies and procedures which address circumstances germane to Natasha Stokoski's where there is an allegation of group bullying or where there are complaints from both the accuser and the accused, and that such policies and procedures outline consistent and unambiguous steps to be taken by management when a bullying complaint is raised by an employee.

2. With the aim of promoting health and safety within the workplace and preventing like scenarios as Natasha Stojkoski's, I recommend that The Good Guys incorporate into newly developed policies and procedures as recommended above, additional guidance to the reference to "at an early stage" in the form of examples and/or scenarios to its managers as to what circumstances that Human Resources ought to be involved/informed about allegations of bullying.

FINDINGS

1. I find that Natasha Stojkoski, born 4 May 1982, tragically died on 2 May 2021 on the rail track, approximately 400 metres from the Thomastown Railway Station.

2. I accept and adopt the cause of death as ascribed by Forensic Pathologist, Dr Sarah Parsons and I find that Natasha Stojkoski died from multiple injuries sustained when she was struck by a train in circumstances where I find, that she intended to take her own life.

3. AND I find that there is clear and cogent evidence of a causal connection between the injuries sustained by Natasha Stojkoski in her workplace, her perception of bullying by

her work colleagues and her perception of her employer's lack of response to her complaints, and the deterioration in her mental health leading up to death.

4. AND I accept the submissions of Counsel Assisting that the opinions of both Dr White and Dr Large involved an acceptance that Natasha Stojkoski experienced pain after her workplace accident, that her psychological response was disproportionate to this, either by way of somatoform disorder or adjustment disorder, and that she ultimately developed severe major depression which was operative at the time of her death. Accordingly, I accept the post mortem mental ill health diagnosis of Drs White and Large and I find that Natasha Stojkoski was suffering from severe major depression at the time of her death.

5. AND although it is not necessary for me to make a definitive finding on whether the behaviour, approach towards and exclusion from discussions within and by her Team did constitute bullying, I do find that there is clear and cogent evidence that Natasha Stojkoski believed, and persistently articulated, that she indeed perceived this to be occurring in her workplace.

6. AND further, I find that Natasha Stojkoski's employer, The Good Guys, failed to respond appropriately to her complaints of bullying when there was clear and consistent articulation by Natasha Stojkoski of the emotional impact her work environment and relationship with her team members was having on her. The Good Guys did not instigate a fair and impartial investigation into Natasha Stjkoski's complaints of bullying but instead favoured the team's collective reasoning for their behaviour towards her. They confabulated her complaints of bullying with other's perception of her performance, effectively contributing to Natasha Stjkoski's feelings of isolation and despair.

7. AND although the evidence indicates that there were other personal emotional destabilising issues occurring in Natasha Stojkoski's life, there is no evidence that they played anything but an insignificant contribution to what might be deemed precipitating factors to Natasha Stjkoski's decision to take her own life. On the other hand, there is clear and cogent evidence to support a finding that her mental deterioration and thus, the significant precipitating factor contributing to her decision to take her own life, was her perception of bullying, perpetrated on her in her workplace and significantly, her employer's failure to investigate her complaints of the same.

8. However, having regard to all of the evidence of the known circumstances surrounding Natasha Stojkoski's death including the other personal emotional destabilising issues and the passage of time from the WAV related physical injuries, her first, and repeated complaints of bullying, and her ultimate decision to take her own life, I cannot make a finding to the requisite standard, on the balance of probabilities, that Natasha Stojkoski's death was preventable.

I convey my sincere condolences to Natasha's family for their loss.

To enable compliance with section 73(1) of the Coroners Act 2008 (Vic), I direct that the Findings will be published on the internet.

I direct that a copy of this Finding be provided to the following:

The Injury Law Group on behalf of George Stojkoski

Seyfarth Shaw LLP on behalf of The Good Guys Discount Warehouse

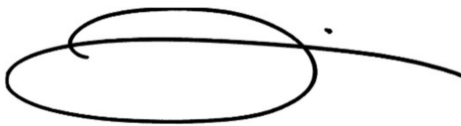
WorkSafe Victoria

HWL Ebsworth on behalf of Mr SEM

Wisewould Mahoney Lawyers on behalf of Allianz Australia

Leading Senior Constable Theo Tsichrintzis

Signature:



AUDREY JAMIESON
CORONER
Date: 22 April 2026