IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 002762

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Jacqueline Courtenay Hunter Pringle
Date of birth:	2 August 1994
Date of death:	10 June 2018
Cause of death:	1(a) Injuries sustained in a fall from a height
Place of death:	Maintenance yard of Translink Operations Pty Ltd, 49 Balston Street, Southbank, Victoria, 3006

INTRODUCTION

1. On 10 June 2018, Jacqueline Courtenay Hunter Pringle was 23 years old when she descended from the sixtieth floor of an apartment on Balston Street, Southbank.

THE CORONIAL INVESTIGATION

2. Jacqueline's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

3. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial. The purpose of the coronial investigation is to independently investigate reportable deaths to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

4. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

5. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

6. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the prevention role. Coroners are empowered to advance their prevention role by –

    a. reporting to the Attorney-General on a death;

    b. commenting on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    c. making recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.

7. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited

from including a finding or comment or any statement that a person is, or may be, guilty of an offence. It is therefore not the role of the coroner to lay or apportion blame, but rather to establish the facts.

8. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.

9. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

10. Victoria Police assigned Detective Senior Constable Nicole Walker to be the Coroner's Investigator. The Coroner's Investigator conducted inquiries on my behalf including taking statements from witnesses, family, the forensic pathologist, treating clinicians and investigating officers and submitted a coronial brief of evidence.

11. This finding draws on the totality of the coronial investigation into the death of Jacqueline including evidence contained in the coronial brief as well as the large number of allegations and concerns submitted by Jacqueline's family.

12. I have reviewed all the material however refer to it only in such detail that appears relevant to my findings or necessary for narrative clarity. It should not be inferred from the absence of reference to any aspect of the evidence that it has not been considered.

BACKGROUND

13. Jacqueline was born on 2 August 1994 in South Australia to Ms Edith Pringle and Mr Warren Hunter. Jacqueline grew up with her mother and step-father, Mr Scott Oliver, with whom she

shared a fatherly-like bond. Jacqueline did not have a relationship with her biological father, Mr Hunter.

14. Jacqueline was the youngest of six half-siblings, Louise, Storm, Thoran, Crystal, Sean and Jesse.

15. In 2006, the family relocated to Victoria where Jacqueline attended Williamstown Primary School and then Williamstown High School.

16. In 2009, Jacqueline completed the remainder of her schooling at Maribyrnong High School. Jacqueline regrettably struggled at school, particularly as a teenager due to learning difficulties as well as being bullied by other students. Jacqueline's mother believed that this contributed to the instability in Jacqueline's mental health which Jacqueline masked with risk-taking behaviours such as substance abuse and self-harm. Jacqueline's mother also considered that the conduct of the South Australian Police, when investigating an allegation made by Jacqueline that she was sexually assaulted as a child, had a significant impact on her mental health and sense of self.

17. Jacqueline began taking various kinds of illicit substances in or around 2009. According to her best friend,[1] Jacqueline used substances frequently but would often minimise how much she was using to friends and family. The same friend also stated Jacqueline would often befriend unknown males whilst they were out 'partying' and return to their accommodation so that she could obtain access to more illicit substances.[2]

18. On 13 June 2016, Jacqueline was referred to the Youth Access Team at Orygen Youth Health after overdosing on gamma-hydroxybutyrate (**GHB**) with suicidal intent.[3] Jacqueline had a period of hospitalisation at the inpatient unit at Orygen Youth Health immediately following the referral.[4]

19. After six months of treatment, Jacqueline was discharged on 24 December 2016 as an outpatient to the Youth Mood Clinic.[5] During treatment at the Youth Mood Clinic, Jacqueline was diagnosed with Major Depressive Disorder, Generalised Anxiety Disorder, Substance Abuse and Attention-Deficit/Hyperactivity Disorder.[6] Her clinicians also suspected that

[1] Statement of Suwatchani Nonthathi, Coronial Brief, pp.38-39.
[2] Ibid, p. 40.
[3] Statement of Dr Mark Phelan, Coronial Brief, p. 259.
[4] Ibid.
[5] Ibid.
[6] Statement of Lisa Bloom, Coronial Brief, p. 266.

Jacquline was suffering from Post Traumatic Stress Disorder symptoms given her extensive trauma history of physical and sexual abuse.[7]

20. On 13 June 2017, Jacqueline was discharged from Youth Mood Clinic after her treating clinicians had observed notable improvements and stability in her mood.[8] Jacqueline was also engaged in tertiary studies at the time.

21. Approximately three weeks after being discharged from Youth Mood Clinic, Jacqueline reportedly began using intravenous heroin.[9]

22. On 13 September 2017, Jacqueline presented to the Emergency Department at Footscray Hospital after an alleged sexual assault. Staff had to delay their initial assessment due to Jacqueline being intoxicated. During the assessment, Jacqueline displayed emotional dysregulation and affective instability. Jacqueline was therefore re-referred to Youth Mood Clinic for ongoing outpatient services. [10]

23. While receiving treatment at the Youth Mood Clinic, Jacqueline made the following disclosures to her trying psychiatrist, Dr Mark Phelan –

    a. *That she felt anxious in social situations;*

    b. *That she often experienced nightmares and flashbacks due to having been assaulted a number of times;*

    c. *That she was different to other people because she attracted unwanted sexual advances;*

    d. *That she wished, at times, that she did not exist; and*

    e. *That she felt that she was better off dead.*[11]

24. On 20 March 2018, Jacqueline's case was presented to an internal multi-disciplinary review panel by Dr Phelan and Clinician Psychologist, Ms Lisa Bloom at the Youth Mood Clinic. The purpose of this meeting was to provide a forum for Youth Mood Clinic Clinicians to

[7] Ibid.
[8] Statement of Dr Mark Phelan, Coronial Brief, p. 260.
[9] Ibid.
[10] Statement of Lisa Bloom, Coronial Brief, p. 263.
[11] Statement of Dr Mark Phelan, Coronial Brief, p. 260.

discuss clients who are presenting with treatment resistant depression, or complexity in relation to poor engagement, poor functioning and/or high risk.[12]

25. Ms Bloom reported that Jacqueline was referred for discussion because she was identified as being at high risk of misadventure due to her ongoing substance misuse as well as her tendency to trust other people, particularly men who sexually assaulted her. Ms Bloom was also concerned about Jacqueline's safety and vulnerability in the community, in the context of Jacquline reporting that she episodically engaging in sex work which she arranged through "sugar daddy" websites.[13]

26. The recommendations from the panel included involving family in Jacqueline's treatment through engaging a family therapist, to consider a referral to the Centre Against Sexual Assault, to allocate a senior outreach clinician and a psychiatrist with experience in drug and alcohol, and to assist Jacqueline with developing self-care around sexual health and sexual rights as well as techniques to minimise harm from substance use.[14]

27. On 1 May 2018, Jacqueline was referred to the Centre Against Sexual Assault by family therapist, Ms Sandy Jackson after Jacqueline had disclosed details of a sexual assault that had recently occurred.[15]

28. On 22 May 2018, Jacqueline completed an intake with the Centre Against Sexual Assault.[16]

29. On 24 May 2018, Jacqueline did not engage in her scheduled outreach appointment with Ms Bloom as she was not home.[17]

30. On 28 May 2018, Ms Bloom arranged for Jacqueline to attend the Youth Mood Clinic on 31 May 2028 for a medical review.[18]

31. On 31 May 2018, Jacquline attended her medical review with Dr Phelan and Ms Bloom. During the review, Jacqueline did not disclose experiencing any recent suicidal ideation. She did however disclose experiencing Post Traumatic Stress Disorder symptoms due to a recent sexual assault. Ms Bloom observed Jacqueline's affect in the review to be "mildly fatuous".[19]

[12] Statement of Lisa Bloom, Coronial Brief, p. 264.
[13] Ibid.
[14] Ibid.
[15] Ibid, p. 256.
[16] Ibid.
[17] Ibid.
[18] Ibid.
[19] Statement of Lisa Bloom, Coronial Brief, p. 265.

Ms Bloom therefore suspected that Jacqueline was substance affected. Dr Phelan did not however appear to have any concerns about Jacqueline's presentation. He discussed the option of re-commencing fluoxetine, an antidepressant. While Jacqueline was ambivalent, he re-prescribed Jacqueline with 20mg of fluoxetine to fill if she chose to recommence the medication. He also prescribed her 5mg diazepam.[20]

32. On 7 June 2018 Jacqueline engaged with Ms Bloom during an outreach visit. Jacqueline denied any suicidal ideation but had decided not to start with the fluoxetine as she reported wanting to manage her mental health independently. This was Jacqueline's last interaction with treating clinicians at the Youth Mood Clinic.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred[21]

33. On 9 June 2018, Jacqueline attended an event at the Crown Casino complex on 8 Whiteman Street, Southbank with three friends. The group consumed an unknown quantity of alcoholic drinks while at the event.[22]

34. At some time between 4:30am and 5:00am on 10 June 2018, the group exited the Crown Casino complex to purchase methylenedioxymethamphetamine (**MDMA**) pills from a dealer known to the group. It is not known how may pills Jacqueline purchased. The group then re-entered Crown Casino a short time later to use the bathrooms in the Food Court area. At that time, an unrelated pair of young men walked past Jacqueline in the Food Court area. Jacqueline had a brief verbal exchange with them and proceeded to go to an apartment in Docklands that the males were staying at with a group of friends. Jacqueline went alone, leaving her friends at the Crown Casino complex.[23]

35. Jacqueline arrived at the apartment on 42-48 Balston Street, Docklands at approximately 5:30am.[24]

36. Shortly after arriving at the apartment, the two males who Jacqueline had befriended fell asleep in one of the bedrooms. Jacqueline however continued interacting with the other males

[20] Statement of Dr Mark Phelan, Coronial Brief, p. 261.
[21] The 'Circumstances in which the death occurred' refers only to those events necessary for narrative clarity.
[22] Statement of Chantelle Gontier, Coronial Brief, p. 43.
[23] Statement of Suwatchani Nonthathi, Coronial Brief, p. 41.
[24] Statement of Witness 6, Coronial Brief, p. 125.

in the apartment who remained awake for approximately an hour before they asked her to leave. Jacqueline was asked multiple times but refused to do so.

37. According to the accounts of several witnesses, Jacqueline was asked to leave after she began offering to have "sex for money or drugs".[25] The witnesses also described a notable change in Jacqueline's presentation and behaviour which made them feel uncomfortable.[26] One witness in particular, described Jacqueline's behaviour as "really odd" as "she started cleaning up" and then began "pulling things out of the cupboards".[27] The witnesses became concerned that she may have been trying to steal from them.[28]

38. At approximately 7:50am, one of the males booked an Uber home as he did not want to remain in the apartment with Jacqueline.[29] He waited downstairs in the lobby with three other males[30] while the remaining two males that were awake collected their belongings from various locations inside the apartment.[31]

39. At the same time, Jacqueline walked out onto the balcony which was located on the south side of the apartment which could only be accessed via a sliding glass door from the lounge. The balcony was surrounded by glass panelling and a metal handrail which was approximately 1280mm high. There was also an air conditioning unit against the west end wall of the balcony.

40. While collecting his belongings, the male in the bedroom adjacent to the balcony, described seeing Jacqueline "climb onto a heater/cooler unit on the balcony" and "sit on the edge of the railing" before "fall[ing] forwards over the balcony".[32] The other male, who was in the bedroom further away, describes Jacqueline's movements slightly differently. He did not observe Jacqueline on the balcony until hearing his friend yell "Oi" at which point he saw Jacqueline on the "other side of the balcony railing" before she "lent forward and let go of the railing with both hands".[33]

41. Neither was able to reach Jacqueline before she fell.

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[25] Witnesses 4, 5 and 8.
[26] Witnesses 4, 5, 8, 9 and 11.
[27] Statement of Witness 8, Coronial Brief, p. 166.
[28] Jacqueline was found with an iPhone in her bra that belonged to Witness 5.
[29] Statement of Witness 7, Coronial Brief, p. 155.
[30] Witnesses 8,9 and 11.
[31] Witnesses 4 and 5.
[32] Statement of Witness 5, Coronial Brief, pp. 87-88.
[33] Statement of Witness 4, Coronial Brief, p. 54.

42. At approximately 7:55am, one of the males rang Triple Zero and requested police attendance, telling the phone operator that "a girl just jump-[ed] off our balcony".[34]

43. At approximately 8:00am, four police units attended the Marco Hotel. Senior Constable Paul Sedgewick and Senior Constable Jarrod Campbell observed Jacqueline's body face down in the maintenance yard of Translink Operations Pty Ltd. After gaining access to the yard, Senior Constable Paul Sedgewick and Senior Constable Jarrod Campbell established a crime scene while Ambulance Victoria members assessed the injuries to Jacqueline's body. Jacqueline injuries were observed as incompatible with life, and she was declared deceased at the scene.[35]

Identity of the deceased

44. On 14 June 2018, the identity of the deceased was confirmed to be Jacqueline Courtenay Hunter Pringle born on 2 August 1994 on the basis of materials including a Statement of Identification and Fingerprint report.

45. Identity is not in dispute and requires no further investigation.

Medical cause of death

46. On 11 June 2018 Forensic Pathologist Dr Joanna Moira Glengarry of the Victorian Institute of Forensic Medicine (**VIFM**) conducted post-mortem examination and provided a written report of her findings dated 10 August 2018.

47. The post-mortem examination revealed severe, non-survival injuries to the head, neck, chest, abdomen, pelvis and limbs. Dr Glengarry noted that the injuries observed were consistent with those sustained in a fall[36] from a height and were consistent with a rapid death upon impact with the ground.

48. Dr Glengarry did not observe injuries suggestive of either physical or sexual assault. Further, there were no injuries to specifically suggest attempts at self-harm.[37]

49. Toxicological analysis of post-mortem samples identified the demonstrated a blood alcohol of 0.08 g/100mL, methylamphetamine (and metabolite of amphetamine),

[34] Exhibit 5, Transcription of Triple Zero, Coronial Brief.
[35] Ambulance Victoria, Patient Care Record.
[36] Dr Glengarry noted that use of the word 'fall' in the case of death formulation was not intended to imply any conclusion about the circumstances leading up to or surrounding Jacqueline's fall from the apartment.
[37] Victorian Institute of Forensic Medicine Report prepared by Dr Joanna Moira Glengarry, Coronial Brief, p.408.

methylenedioxyamphetamine (**MDMA**), diazepam, paracetamol, 7-aminoclonazepam and cannabis.[38]

50. Dr Glengarry provided an opinion that the medical cause of death was, '1(a) *Injuries sustained in a fall from a height*.'[39]

51. I accept Dr Glengarry's opinion as to medical cause of death.

POLICE INVESTIGATION

10 June 2018

52. At approximately 8:00am, Sergeant Matthew Vernon arrived at the Marco Hotel and began performing supervisory duties.[40]

53. At approximately 8.13am, Detective Senior Constable Nicole Walker of the Melbourne Crimes Investigation Unit arrived and was briefed by Sergeant Vernon.[41] Witnesses were identified, separated and statements were taken.

54. Based on the initial witness information and scene analysis, Detective Senior Constable Walker formed a preliminary view that the injuries on Jacqueline that were visible were consistent with the accounts obtained as a result of enquiries, observations and information shared by witnesses, suggesting Jacqueline had deliberately gone out to, and then jumped or fallen from, the balcony. Detective Senior Constable Walker did not consider Jacqueline's death to be suspicious however still sought advice from the Homicide Squad given the nature of the dynamics at the scene.[42]

55. At approximately 9:20am, Detective Senior Constable Walker provided a briefing to Detective Senior Sergeant Mark Colbert of the Homicide Squad on the following matters –

    a. the male witnesses had been separated immediately upon police arriving on scene, they were cooperative, and appeared to be genuine in their engagement and were providing witness statements;

[38] Victorian Institute of Forensic Medicine Toxicology Report, Coronial Brief, pp. 423-424.
[39] Victorian Institute of Forensic Medicine Report prepared by Dr Joanna Moira Glengarry, Coronial Brief, p.407.
[40] Statement of Sergeant Matthew Veron, Coronial Brief, pp. 206-208.
[41] Statement of Detective Senior Constable Nicole Walker, Coronial Brief, p. 267.
[42] Ibid, p. 268.

b. that arrangements had been made for the Major Crime Scene Unit to attend and forensically examine and document the scene; and

c. that enquiries were being made to canvas for and collect, any CCTV that covered the area.[43]

56. Detective Senior Sergeant Colbert was satisfied that all appropriate processes were in hand however encouraged Detective Senior Constable Walker to contact the Homicide Squad again if any new information came to light.[44]

57. At approximately 10:30am, the Major Crime Scene Unit attended the Marco Hotel to process the scene.

11 June 2018

58. At approximately 8:10am, Detective Senior Constable Walker received a phone call from Senior Constable Matthew James, a member of the major crime scene unit.[45] Senior Constable James queried the circumstances of Jacqueline's death noting –

a. the absence of scruff marks on the air conditioning unit or leg marks on the top of the balcony rail; and

b. the positioning of some of the fingerprint markings on the balcony rail.[46]

59. After consideration of Senior Constable James' concerns, Detective Senior Constable Walker sought advice from the Homicide Squad.[47]

60. At approximately 8:35am, Detective Senior Sergeant Colbert spoke to Senior Constable James about the concerns he had raised with Detective Senior Constable Walker. Detective Senior Sergeant Colbert considered, in the circumstances, that it would be appropriate for the Homicide Squad to review the crime scene as well as request an autopsy.[48]

61. Detective Senior Sergeant Colbert also sent emails to potential witnesses who had stayed in rooms of the eastern side of Marco Hotel on 9 June 2018. No responding witnesses reported

[43] Statement of Detective Senior Constable Nicole Walker, Coronial Brief, pp. 268-269. Statement of Detective Senior Sergeant Mark Colbert, Coronial Brief, pp. 243-244.
[44] Statement of Detective Senior Sergeant Mark Colbert, Coronial Brief, p. 244
[45] Statement of Detective Senior Constable Nicole Walker, Coronial Brief, p. 270
[46] Statement of Detective Senior Sergeant Mark Colbert, Coronial Brief, p. 244.
[47] Statement of Detective Senior Constable Nicole Walker, Coronial Brief, p.270.
[48] Statement of Detective Senior Sergeant Mark Colbert, Coronial Brief, p. 244.

having seen or heard anything untoward in connection with Jacqueline's death. Detective Senior Sergeant Colbert therefore did not find any evidence of a criminal offence in the lead up to, or at the time of, the fatal incident.[49]

62. I am satisfied that it was reasonable for Detective Senior Sergeant Colbert to conclude on behalf of the Homicide Squad that Jacqueline's death did not involve a third party. In addition to the brief of evidence I also directed Victoria Police to obtain statements from Dr Phelan and Ms Bloom of Orygen Youth Health.

FAMILY CONCERNS

63. Throughout the coronial investigation, Jacqueline's family have expressed concerns regarding the investigation into Jacqueline's death.

64. In particular Jacqueline's family was concerned about the inconsistencies in the evidence of the witnesses that last saw Jacqueline on the balcony as well as the adequacy of the investigations by Victoria Police.

Inconsistencies in the evidence

65. I acknowledge, based on the available evidence, that the male witnesses who were present, immediately before Jacqueline's death, did not provide comprehensive statements about the circumstances surrounding her fall.

66. There were inconsistencies in the timeline and accounts of the events leading to Jacqueline's death. These inconsistencies do not provide evidence of any wrongdoing, however it is unfortunate that there are gaps in crucial information as to whether Jacqueline was climbing the railing[50] before she fell or whether she was sitting on the railing[51] before she fell.

67. After careful consideration of the evidence available to me, the inconsistencies do not suggest a deliberate attempt by the male witnesses to collude or fabricate their evidence. I also do not consider the inconsistencies support an alternative narrative that a third party caused or contributed to Jacqueline's death.

68. Rather, I am satisfied that the witnesses have made a genuine attempt to recall events that occurred within matter of seconds, were viewed from distance and were traumatic to observe.

[49] Ibid, p. 245-247.
[50] Statement of Witness 4, Coronial Brief, p. 54.
[51] Statement of Witness 5, Coronial Brief, p. 88.

I therefore consider the inconsistencies to reflect the witness's trauma and likely a product of them tapering off illicit substances and alcohol as well as a lack of sleep. In the circumstances, I am not satisfied that further investigation will materially change the state of the evidence. Tragically, despite the best efforts of investigators, some questions surrounding Jacqueline's fall may never be able to be answered.

Adequacy of the investigation by Victoria Police

69. I note that Jacqueline's family has been critical of the investigation by Victoria Police and seek further interrogation of –

    a. Mr Ben Duddy who was the last person to text Jacqueline before she fell and an ex-boyfriend who may have been acquainted with the males staying in the apartment;

    b. Jacqueline's state of mind immediately prior to her death; and

    c. the location of Jacqueline's fingerprints on the balcony.

70. I have discussed each concern below.

71. In relation to obtaining a statement from Mr Duddy, I note that Victoria Police formed the view that despite interacting with Jacqueline on the night of her death, it was unlikely that further investigation of Mr Duddy would materially change the state of the evidence. I agree with Victoria Police that further investigation in this respect is not warranted given that I already have sufficient information from the witnesses who were at the Marco Hotel to make findings as required under the Act.

72. In relation to Jacqueline's state of mind prior to her fall, I am satisfied that that I have sufficient information to conclude that Jacqueline's demeanour deteriorated shortly after arriving at the Marco Hotel for reasons unknown. While I do not consider the evidence enables me to be comfortably satisfied that Jacqueline experienced suicidal ideation, I do not consider the use of further judicial forensic processes will materially change the state of the evidence. Tragically, despite medical intervention, Jacqueline had significant mental health and personality issues at the time of her death and had often relied upon alcohol and illicit substances to self-medicate. Questions regarding Jacqueline's state of mind will remain unanswered.

73. In relation to the analysis of the positioning of Jacqueline's fingerprints on the balcony, I am satisfied that Victoria Police acted appropriately when examining the evidence from the scene.

I note that the Homicide Squad returned to the scene to conduct their own analysis independently of the Crimes Investigation Unit. Detective Senior Sergeant Colbert did not consider this evidence altered the veracity of the evidence provided by the witnesses. In reaching his opinion, Detective Senior Sergeant Colbert provided the following rationale in his statement –

> *'There was no sign of a struggle having taken place and there was no evidence of witnesses coming forward to report an argument, fight or disturbance. The proximity of the neighbours and the compact size of the apartment 1608 indicated to me that had there been any foul play involved in the death then it would be highly likely that others would have heard or seen such activity. The height of the balcony railing was such that an accidental fall was highly unlikely unless the person was already position on the balcony railing. It was also unlikely that one person could lift and throw another person over the railing without that person being able to resist or at least cause a significant disturbance'.*[52]

74. I agree with the analysis of Detective Senior Sergeant Colbert. I am not satisfied that any further investigation will materially change the current state of evidence.

Findings and conclusion

75. Pursuant to section 67(1) of the Act, I make the following findings –

    a. the identity of the deceased was Jacqueline Courtenay Hunter Pringle, born 2 August 1994;

    b. the death occurred on 10 June 2018 at maintenance yard of TransLink Operations Pty Ltd, 49 Balston Street, Southbank, Victoria, 3006, from injuries sustained in a fall from a height; and

    c. the death occurred in the circumstances described above.

76. Having considered all of the circumstances, I am satisfied that Jacqueline's death occurred as the result of a fall from a height, and that there is insufficient evidence to support the involvement of a third party in the circumstances of death.

[52] Statement of Detective Senior Sergeant Mark Colbert, Coronial Brief, p. 245.

77. Based on the evidence and on the balance of probabilities, I am not comfortably satisfied that Jacqueline intended to end her own life. It is possible, in the context of her use of drugs that night, that she positioned herself on the railing without further thought of the consequences should she lose her balance.

78. While I recognise this uncertainty will cause further distress for Jacqueline's family, I am satisfied that all reasonable lines of investigation have now been exhausted and that it is appropriate to finalise the matter in these circumstances.

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

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Ms Edith Pringle and Mr Scott Oliver, Senior Next of Kin

NorthWestern Mental Health

Office of the Chief Psychiatrist

Detective Senior Constable Nicole Walker, Coroner's Investigator

Signature:

Coroner Leveasque Peterson

Date : 03 February 2026

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day

on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.