



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

**COR 2020 004062**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Anuruddha Bandara Abeysinghe
Date of birth:	20 November 1968
Date of death:	28 July 2020
Cause of death:	1(a) Asphyxiation due to diffusion of exhaust fumes into a car
Place of death:	1 Fairview Avenue, Narre Warren, Victoria, 3805

## INTRODUCTION

1. On 28 July 2020, Anuruddha Bandara Abeysinghe (**Mr Abeysinghe**) was 51 years old when he was found deceased in his car at home. At the time of his death, Mr Abeysinghe lived with his wife, Thilani Abeysinghe (**Ms Abeysinghe**) and two daughters.
2. According to Ms Abeysinghe, Mr Abeysinghe had been an alcoholic since she met him, but his alcoholism had become worse over the years and had caused particular strain on their relationship in the last three years. They slept in separate bedrooms and Ms Abeysinghe had not spoken to Mr Abeysinghe in two months. They were also in discussions about getting lawyers to finalise a divorce. Mr Abeysinghe did not have a history of mental health issues nor suicidal ideation.<sup>1</sup>
3. Mr Abeysinghe worked for Oceania Glass Pty Ltd (**Oceania Glass**); the company had undergone many ownership and name changes over the years, most recently in February 2019. Mr Abeysinghe had worked for the company for approximately 17 years and was employed as an assistant team leader at the ‘hot end’<sup>2</sup> of the workplace.<sup>3</sup>
4. Mr Abeysinghe’s alcohol misuse affected his work. On one occasion, in October 2019, Mr Abeysinghe arrived at work smelling of alcohol. An offsite test returned a blood alcohol content of less than the allowable limit of 0.05g/100mL and thus he returned to work and there was no disciplinary action at that time.<sup>4</sup>
5. At the start of 2020, the senior supervisor had a meeting with Mr Abeysinghe as other colleagues had noticed that he had smelt of alcohol while at work. Mr Abeysinghe disclosed that he was drinking more due to family issues and was warned to not come to work smelling of alcohol in the future. Other staff members in the meeting did not recall him being offered formal support services.<sup>5</sup>
6. Aside from these incidents, Mr Abeysinghe was known at work as being friendly, not one to ruffle feathers, and always in a good mood. The company always regarded him as a good employee.<sup>6</sup>

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<sup>1</sup> Coronial Brief (**CB**), Statement of Thilani Abeysinghe dated 28 July 2020.

<sup>2</sup> The hot end of a glass manufacturer is the section of the operation that manufactures the glass.

<sup>3</sup> CB, Statement of Blerin “Harry” Lumanovski dated 18 August 2020.

<sup>4</sup> CB, Statement of Blerin “Harry” Lumanovski dated 18 August 2020.

<sup>5</sup> Court File (**CF**), Supplementary statement of Brian Mujedinovski dated 27 January 2021.

<sup>6</sup> CB, Statement of Brian Mujedinovski dated 19 August 2020.

## THE CORONIAL INVESTIGATION

7. Mr Abeysinghe'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.
8. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.
9. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
10. State Coroner Judge Cain initially held carriage of this investigation. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Abeysinghe's death. The Coroner's Investigator conducted inquiries on State Coroner Judge Cain's behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. I took carriage of this matter in October 2022 for the purposes of finalising the investigation and making findings.
11. This finding draws on the totality of the coronial investigation into the death of Anuruddha Bandara Abeysinghe including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.<sup>7</sup>

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<sup>7</sup> Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

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

### Circumstances in which the death occurred

#### Background Circumstances

12. On 17 July 2020, at about 6.30pm, the HR manager, Skye Hennessy (**Ms Hennessy**), called the Australian Workers' Union (**AWU**) site delegate, Harry Lumanovski (**Mr Lumanovski**), to attend the workplace as Mr Abeysinghe reportedly 'looked off his head'. When Mr Lumanovski arrived, he noticed that Mr Abeysinghe appeared to be disoriented and referred him for an onsite breathalyser test.<sup>8</sup>
13. However, the onsite breathalyser was not working, and no offsite testing was available at the time. Ms Hennessy allegedly called the police to perform a breathalyser test, but they did not attend the workplace.<sup>9</sup> Mr Abeysinghe disclosed to Ms Hennessy that he had consumed wine over lunch. Mr Abeysinghe was stood down while the company investigated possible intoxication at work. Several colleagues were reportedly interviewed, who confirmed that Mr Abeysinghe had a drinking problem.<sup>10</sup>
14. On 22 July 2020, Mr Abeysinghe returned to work to attend a meeting about the incident. The other attendees were Ms Hennessy and Mr Lumanovski, as well as the plant manager, Paul Hutchinson (**Mr Hutchinson**), and Mr Abeysinghe's team leader, Brian Mujedinovski (**Mr Mujedinovski**) as a support person.
15. In the meeting, Mr Abeysinghe acknowledged that he had 'a couple' of glasses of wine but was unsure if he would have been over the 0.05g/100mL limit.<sup>11</sup> He was very apologetic and embarrassed and did not deny that he was possibly intoxicated. Mr Mujedinovski thought that he 'became a total wreck' once the reality started to set in that he could lose his job.<sup>12</sup>
16. Mr Abeysinghe remained stood down to prepare a more detailed response and for the company to consider the appropriate next steps. After the meeting, Mr Abeysinghe disclosed to Mr Lumanovski that he was worried about losing his job and to not tell his wife if that occurred. He used words to the effect that if he did lose his job, he 'would end it' and kill himself. Mr

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<sup>8</sup> CB, Statement of Blerim "Harry" Lumanovski dated 18 August 2020.

<sup>9</sup> CF, Supplementary statement of Blerim "Harry" Lumanovski dated 21 January 2021.

<sup>10</sup> CB, Statement of Blerim "Harry" Lumanovski dated 18 August 2020.

<sup>11</sup> CB, Statement of Blerim "Harry" Lumanovski dated 18 August 2020.

<sup>12</sup> CB, Statement of Brian Mujedinovski dated 19 August 2020.

Lumanovski immediately reported this to Mr Hutchinson and stated that the company should reconsider the way they were approaching this matter.<sup>13</sup>

17. On 27 July 2020, a second meeting was held. Mr Abeysinghe read from a prepared response apologising for attended work alcohol affected and acknowledging that he had an issue with alcohol dependency. He outlined the steps he had taken already, including seeing his General Practitioner (**GP**) for medication and referral for counselling, as well as offering to submit to regular and/or random breathalyser checks before the commencement of each shift.<sup>14</sup>
18. Mr Lumanovski recalled Ms Hennessy expressing concern that Mr Abeysinghe could have killed someone and that the company could be liable under industrial manslaughter laws. The meeting closed and Mr Abeysinghe again disclosed to Mr Lumanovski that he was ‘going to end it’. Mr Lumanovski then returned to see Mr Hutchinson to tell him of the conversation and to urge the company to rethink how they were approaching the matter.<sup>15</sup>
19. Within an hour, Mr Lumanovski was called back into a meeting with Ms Hennessy and Mr Hutchinson where they told him they would be terminating Mr Abeysinghe’s employment. Again, Mr Lumanovski urged them to reconsider and was shocked at the approach. A request to speak with the Chief Executive Officer (**CEO**) about the decision was denied, as the CEO was reportedly aware of the situation and had agreed with the decision.<sup>16</sup>
20. Mr Lumanovski contacted the assistant state secretary of the AWU, Jimmy Mastrandonakis (**Mr Mastrandonakis**), to express his concerns. Mr Mastrandonakis then contacted Ms Hennessy to discuss the case and urged her to give Mr Abeysinghe another chance particularly as he thought the drug and alcohol guideline contained in the company’s Enterprise Agreement (**EA**) had not been followed, in addition to the context of Mr Abeysinghe’s threats of self-harm. Mr Hennessy reportedly replied that the company had made their decision and would not be changing their view.<sup>17</sup>
21. At around midday, Mr Abeysinghe was called back into the meeting and told that his employment would be terminated. On the way out of the meeting he disclosed again to Mr

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<sup>13</sup> CB, Statement of Blerim “Harry” Lumanovski dated 18 August 2020.

<sup>14</sup> CB, Statement of Brian Mujedinovski dated 19 August 2020; statement of Blerim “Harry” Lumanovski dated 18 August 2020; Exhibit 4; Statement of Dr Alex Mogilevski dated 14 October 2020.

<sup>15</sup> CB, Statement of Blerim “Harry” Lumanovski dated 18 August 2020.

<sup>16</sup> CB, Statement of Blerim “Harry” Lumanovski dated 18 August 2020.

<sup>17</sup> CB, Statement of Jimmy Mastrandonakis dated 19 August 2020.

Lumanovski that he would take his own life.<sup>18</sup> Mr Mujedinovski was also worried about Mr Abeysinghe's welfare and sent a message to Mr Lumanovski to express his concern.<sup>19</sup>

22. Later in the evening, after hearing about further threats of self-harm from Mr Lumanovski, Mr Mastrandonakis sent an email to Ms Hennessy and the CEO outlining his concern about Mr Abeysinghe's mental health and urged that the company follow up with him and ensure that he was offered help as well as to notify the relevant authorities about Mr Abeysinghe's threats of self-harm.<sup>20</sup>

### Proximate Circumstances

23. At about 10pm on 27 July 2020, Ms Abeysinghe last saw Mr Abeysinghe downstairs watching TV in the loungeroom. She was apparently not aware that Mr Abeysinghe's employment had been terminated nor that he had been previously stood down.<sup>21</sup>
24. The next morning, at 6am, Ms Abeysinghe woke up and noticed that the laundry light was on. She thought this was odd, as this suggested to her that Mr Abeysinghe was going to work despite thinking he was not going in that day. While getting ready, she noticed a file on top of her folders in the lounge room which she assumed was related to Mr Abeysinghe finding a lawyer for their divorce and decided to follow up on it after work.<sup>22</sup>
25. However, at 7.10am, Ms Abeysinghe changed her mind and looked in the folder. She found a typed and printed suicide note outlining financial plans and an apology. Ms Abeysinghe became distressed at reading this and woke her eldest daughter who called Triple Zero. The family checked Mr Abeysinghe's bedroom but not the garage.<sup>23</sup>
26. Officers from Victoria Police attended and opened the garage at Ms Abeysinghe's request. They found Mr Abeysinghe in his car with the engine running and a hose connecting the exhaust to the interior of the car. Officers turned the engine off and requested for Ambulance Victoria to attend.<sup>24</sup>

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<sup>18</sup> CB, Statement of Blerim "Harry" Lumanovski dated 18 August 2020.

<sup>19</sup> CB, Statement of Brian Mujedinovski dated 19 August 2020.

<sup>20</sup> CB, Statement of Jimmy Mastrandonakis dated 19 August 2020; CF, bundle of emails to WorkSafe, email from Jimmy Mastrandonakis dated 27 July 2020.

<sup>21</sup> CB, Statement of Thilani Abeysinghe dated 28 July 2020.

<sup>22</sup> CB, Statement of Thilani Abeysinghe dated 28 July 2020.

<sup>23</sup> CB, Statement of Thilani Abeysinghe dated 28 July 2020.

<sup>24</sup> CB, Statement of Constable Leisa Evans dated 20 August 2020; Statement of Constable Brayden Ford dated 28 July 2020.

27. Paramedics from Ambulance Victoria attended soon after but unfortunately Mr Abeysinghe was deceased and could not be revived.<sup>25</sup>
28. After examination of the available evidence at the scene, officers formed the belief that there were no suspicious circumstances.<sup>26</sup>

### **Identity of the deceased**

29. On 28 July 2020, Anuruddha Bandara Abeysinghe, born 20 November 1968, was visually identified by his wife, Thilani Abeysinghe, who completed a Statement of Identification.
30. Identity is not in dispute and requires no further investigation.

### **Medical cause of death**

31. Forensic Pathologist Dr Joanne Ho (**Dr Ho**) from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 3 August 2020 and provided a written report of the findings. Dr Ho also reviewed the Victoria Police Report of Death (Form 83), a post-mortem computed tomography (**CT**) scan, VIFM preliminary examination form, and three scene photographs.
32. Dr Ho commented that the described circumstances indicate asphyxiation from exhaust fumes. This increases carbon dioxide concentration and decreases oxygen concentration which causes unconsciousness and death. As such, there are no specific findings on autopsy. Blood analysis is similarly non-diagnostic as carbon dioxide rapidly accumulates after death regardless of any perimortem accumulation.
33. The autopsy showed no evidence of any injuries which may have caused or contributed to death. The autopsy showed prostate cancer. Given Mr Abeysinghe's young age, Dr Ho referred the case to the family genetic health service at VIFM.
34. Toxicological analysis of post-mortem samples identified the presence of ethanol at a concentration of 0.11g/100mL.
35. Dr Ho provided an opinion that the medical cause of death was 1(a) asphyxiation due to diffusion of exhaust fumes into a car.

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<sup>25</sup> CB, Statement of Aimee Stevens dated 7 September 2020.

<sup>26</sup> CB, Statement of Constable Brayden Ford dated 28 July 2020.

## WORKSAFE INVESTIGATION

36. On 13 August 2020, WorkSafe commenced an investigation of the incident to explore possible breaches of *Occupational Health and Safety Act 2004*. The coronial investigation was suspended during this investigation and resumed when WorkSafe wrote to the Court on 6 January 2022 advising that they did not commence a prosecution against any party in relation to this matter due to insufficient evidence. WorkSafe enclosed a copy of their Investigation Brief to aid in the coronial investigation.
37. The WorkSafe Investigation Brief contained the Enterprise Agreement (EA) that applied at the time of the incident which outlined both the disciplinary procedures and drug and alcohol procedures.<sup>27</sup>
38. The EA states that ‘the primary purpose of the disciplinary procedure is to modify behaviour, re-educate Employees and prevent recurrence. It is not intended to be primarily used for terminating the services of Employees.’<sup>28</sup>
39. The EA outlines circumstances which warrant summary dismissal which includes serious breaches of safety regulations.<sup>29</sup> Although Mr Abeysinghe’s conduct on the 17 July 2020 could possibly be classified as such as breach, the drug and alcohol policy states that a positive blood alcohol result is defined as misconduct and to be dealt with pursuant to clause 2.4 (disciplinary procedure) which should include consideration of the purposes described above.<sup>30</sup>
40. Appendix A sets out the drug and alcohol policy as part of fitness for duty procedure. The underlying principles of which are to minimise risks associated with impairment, including from alcohol, with a non-moralistic focus and aim to help people deal with issues that are causing impairment.<sup>31</sup>
41. The allowable limit of alcohol is a blood alcohol concentration of 0.05g/100mL.<sup>32</sup> This appears to have come as a surprise to many in the business who wrongly assumed that there was no acceptable limit of blood alcohol concentration (that is, 0.00g/100mL).<sup>33</sup> The procedure outlines that if an employee returns a positive result, they may be required to

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<sup>27</sup> CSR Viridian Dandenong and AWU Enterprise Agreement 2016-2020, at cl 2.4 and Appendix A respectively. NB: the company became known as Oceania Glass after the EA was implemented. Any reference to Viridian Glass or CSR Viridian Dandenong is a reference to Oceania Glass and Oceania Glass Dandenong.

<sup>28</sup> CSR Viridian Dandenong and AWU Enterprise Agreement 2016-2020, cl 2.4.1.

<sup>29</sup> CSR Viridian Dandenong and AWU Enterprise Agreement 2016-2020, cl 2.4.4(ix)

<sup>30</sup> CSR Viridian Dandenong and AWU Enterprise Agreement 2016-2020, Appendix A, cl 11.

<sup>31</sup> CSR Viridian Dandenong and AWU Enterprise Agreement 2016-2020, Appendix A, cl 1.

<sup>32</sup> CSR Viridian Dandenong and AWU Enterprise Agreement 2016-2020, Appendix A, cl 2.

<sup>33</sup> CF, bundle of emails to WorkSafe.



undergo ongoing alcohol and/or other drug testing as case management.<sup>34</sup> A referral program for assistance with drug and alcohol problems is also to be offered to employees who return a positive alcohol result,<sup>35</sup> and alcohol is not permitted to be stored or consumed on site outside of approved functions.<sup>36</sup>

42. Finally, the site manager and HR manager are responsible for ensuring the effective implementation of this procedure and to provide access to the Employee Assistance Program.<sup>37</sup>
43. Emails contained in the WorkSafe Investigation Brief also explain why the breathalyser was not operational at any of the attempts to test Mr Abeysinghe. This model of breathalyser is designed to lock out after six months until it is recalibrated to ensure compliance with the relevant Australian Standards requirements. This is only in the models sold in Australia, and this information is not in the user manual but only in the Australian product brochure.<sup>38</sup>

## COMMENTS

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

1. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.<sup>39</sup>
2. With respect to adverse comments or findings, the effect of the authorities is that they should not be made unless the evidence provides a comfortable level of satisfaction that an individual (or institution) caused or contributed to the death, and in the case of individuals acting in a professional capacity, that they departed materially from the standards of their profession.
3. I reiterate that a coronial investigation is a fact-finding exercise rather than a vehicle for the apportionment of blame. Further, a finding that a person is, or may be, guilty of an offence is specifically prohibited by s 69(1) of the Act. However, that is not to say that individuals or other entities will not be criticised in a coronial finding. It is sometimes necessary to identify

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<sup>34</sup> CSR Viridian Dandenong and AWU Enterprise Agreement 2016-2020, Appendix A, cl 5.

<sup>35</sup> CSR Viridian Dandenong and AWU Enterprise Agreement 2016-2020, Appendix A, cl 7.

<sup>36</sup> CSR Viridian Dandenong and AWU Enterprise Agreement 2016-2020, Appendix A, cl 9.

<sup>37</sup> CSR Viridian Dandenong and AWU Enterprise Agreement 2016-2020, Appendix A, cl 3.

<sup>38</sup> AS 3547:2019, cl 2.7 and 4.1; CF, email from Ben Ridley to WorkSafe dated 25 January 2021.

<sup>39</sup> *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences...'

fault to devise a means of correction through a coronial recommendation, or fault may be implied in the description of the circumstances in which the death occurred.

4. As such, it is inappropriate to comment on any potential breach of the *Occupational Health and Safety Act 2004*. This is for Work Safe Victoria to investigate and bring about prosecution if it is appropriate to do so. Instead, my comments, findings, and recommendations are to be read in the context of the Court's function of promoting public health and safety and preventing similar deaths from occurring in the future.
5. There is no doubt that intoxication in this workplace poses a significant risk to the health and safety of other workers and the intoxicated person. However, the response apparently led by Ms Hennessy appears to be disproportionate, and the alternatives that would have mitigated these risks but also maintained Mr Abeysinghe's employment and helped him with his health problem, were not seriously considered. This includes but is not limited to Mr Abeysinghe's own suggestion of regular or random breathalyser testing before the commencement of each shift. As such, the termination also appears to be inconsistent with EA which emphasises a rehabilitative and health-based approach to alcohol misuse.
6. I accept the submissions of Ms Hennessy's legal representation<sup>40</sup> and find that it was reasonable in the circumstances for Ms Hennessy to decline to provide a statement to protect against self-incrimination.
7. Nonetheless, the lack of a statement remains disappointing as this precludes an opportunity for Ms Hennessy and/or Oceania Glass to provide any information about any internal reviews and/or recommendations made to ensure the relevant procedures in the EA are adhered to or other changes made by the company to prevent similar deaths from occurring in the future. As such, I have made recommendations to this effect. These remain relevant despite the expiry of the EA in effect at the time of the incident as the relevant sections remain unchanged in the current EA.<sup>41</sup>

## RECOMMENDATIONS

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

- (i) With the aim of preventing like deaths and promoting public health and safety, I recommend that Oceania Glass Pty Ltd review the incident and explore ways to ensure

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<sup>40</sup> CF, Letter from Johnson Winter & Slattery dated 8 April 2021.

<sup>41</sup> Oceania Glass Dandenong and AWU Enterprise Agreement 2020-2024. Available on the Fair Work Commission website <[www.fwc.gov.au](http://www.fwc.gov.au)>

that all relevant managerial staff are familiar with the Enterprise Agreement, particularly to ensure adherence to the disciplinary procedures and drug and alcohol guidelines.

## **FINDINGS AND CONCLUSION**

1. Pursuant to section 67(1) of the Act I make the following findings:
  - a) the identity of the deceased was Anuruddha Bandara Abeysinghe, born 20 November 1968;
  - b) the death occurred on 28 July 2020 at 1 Fairview Avenue, Narre Warren, Victoria, 3805; and,
  - c) I accept and adopt the medical cause of death ascribed by Dr Ho and I find that Anuruddha Bandara Abeysinghe died from asphyxiation due to diffusion of exhaust fumes into a car.
2. Having considered all the evidence, I find that Anuruddha Bandara Abeysinghe deliberately took his own life. A clear precipitating factor was the termination of his long-standing employment with Oceania Glass. I also find that the termination was contrary to the Enterprise Agreement and that had the alternatives to termination as set out in the Enterprise Agreement been followed, the death would very likely have been prevented.

I convey my sincere condolences to Anuruddha'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:

Gino Andrieri, Maurice Blackburn Lawyers on behalf of Thilani Abeysinghe

Greta Madsen, Wisewould Mahony

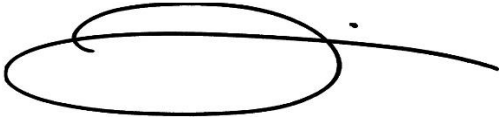
Louise Russel, Johnson Winter & Slattery

Seyfarth Shaw Lawyers, Legal Representative for Oceania Glass Pty Ltd

WorkSafe Victoria

Senior Constable Leisa Evans, Coroner's Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 14 August 2023



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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.

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