IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 0584

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner John Olle
Deceased:	Silin Wang
Date of birth:	4 April 1995
Date of death:	31 January 2021
Cause of death:	1(a) multiple injuries
Place of death:	Peter MacCallum Cancer Institute/Hospital, 305 Grattan Street, Melbourne, Victoria, 3000
Keywords:	Suicide of terminally ill woman, fall from a height in a public space

INTRODUCTION

1. On 31 January 2021, Silin Wang (**Celine**) was 25 years old when she was found deceased at the Peter MacCallum Cancer Institute in Melbourne. At the time of her death, Celine lived with her boyfriend, Guanpeng (**Riccardo**).

THE CORONIAL INVESTIGATION

2. Celine'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 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.

4. 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.

5. Victoria Police assigned Sergeant Brgoc to be the Coroner's Investigator for the investigation of Celine's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of Celine 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.[1]

[1] 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

7. In 2017, Celine and her twin sister Siqi (**Maggie**) moved from China to Melbourne to undertake postgraduate study. Celine had just completed a Master of Environmental Engineering from the University of Melbourne and was looking for a job.

8. Celine and Maggie's parents died from cancer. According to Maggie, Celine was profoundly affected by the death of their mother and was traumatised by the experience of providing end-of-life care.

Celine's cancer diagnosis

9. On 22 December 2020, Celine was admitted to the Gastroenterology Unit at the Royal Melbourne Hospital (**RMH**) after experiencing dysphagia, weight loss and iron deficiency for the previous seven weeks.

10. On 24 December 2020, Celine was transferred to the Peter MacCallum Cancer Centre (**PMCC**) in the Victorian Comprehensive Cancer Centre (**VCCC**) building and diagnosed with metastatic gastro oesophageal junction adenocarcinoma. Celine was given a life expectancy of less than two years with treatment, and less than one year if she did not undergo treatment.

11. On 29 December 2020, Celine was discharged home with referrals for outpatient oncology.

12. On 1 January 2021, Celine presented to the RMH Emergency Department (**ED**) with worsening symptoms. She was admitted and transferred to Ward 3A at PMCC under the care of the Medical Oncology Team where she remained an inpatient until 28 January 2021. During this time, she was treated for her cancer including with radiotherapy and chemotherapy.

13. On 18 January 2021, the psychiatric registrar reviewed Celine after her treating team noted low mood and passive suicidal ideation. The psychiatric registrar documented that Celine was experiencing a major depressive disorder or an adjustment disorder with depressive features. The registrar considered that Celine's suicide risk was minimal but documented that her risk was 'statistically elevated by the cancer diagnosis, palliative prognosis, social isolation, and depressive symptomatology which includes a strong component of demoralisation.'

14. On 27 January 2021, the psychiatric registrar attempted to review Celine again. However, Celine declined any further psychiatric input, and the psychiatric registrar discharged her from the Psychological Oncology team but advised Celine how she could refer herself to mental health services should she change her mind.

15. On 28 January 2021, Celine was discharged from PMCC. The medical discharge summary noted her unwillingness to engage with mental health therapy and that she was focussed on her cancer therapy.

Readmission

16. On 30 January 2021, Celine called PMCC and stated she felt very short of breath. The nurse she spoke with advised that she should present to RMH ED. Maggie accompanied Celine to the hospital. In the ED, the treating emergency medical officer ordered further imaging which showed progression of Celine's cancer including a new mass. The doctor spoke to the PMCC oncology registrar and arranged an admission to PMCC for further management.

17. Celine and Maggie requested that the doctor discuss the results of the scan with them. The emergency medical officer doctor initially expressed their discomfort to have such a discussion because they were a junior doctor with relative inexperience with cancer progress or prognosis. However, Celine and Maggie insisted, and so the doctor decided to read the imaging report verbatim and deferred explanation of the results to oncologists at PMCC.

18. Later in evening after Celine was admitted to PMCC, the oncology resident reviewed Celine with Maggie present. In a private discussion with the oncology resident, away from Celine, Maggie disclosed that Celine had been seeking information about the Voluntary Assisted Dying Programme and that she was still traumatised by her parents' deaths. The oncology resident, after discussing with the oncology registrar, referred Celine for psychiatry review as part of her admission plan.

19. Maggie stayed with Celine at PMCC until about 9pm. During this time, Celine told her that she wanted to 'go back to the Great Ocean Road and jump off somewhere pretty'. According to Maggie, she thought that Celine 'did not have any fighting spirit or the will to continue on'. Maggie was concerned about Celine's mental state and shared her concerns with hospital staff.

Events proximate to Celine's death

20. On 31 January 2021, at approximately 7.40am, Celine asked her nurse if she could go up to The Loft café for breakfast and some fresh air. The nurse allowed Celine to do so. The Loft café is located on the seventh floor of the VCCC building. Adjacent to the café is a large publicly accessible rooftop garden bordered by a glass balustrade. Beyond the balustrade is the edge of the building with a direct drop to street level. The part of the rooftop immediately outside the entrance from the café is a terrace with tables and chairs for café patrons and other visitors to the building.

21. Celine asked the café worker if they were open yet and for breakfast recommendations before ordering food and a coffee. Celine took her coffee out with her to the rooftop garden while waiting for her food to be ready for collection.

22. When her food was ready, the café worker became concerned that Celine had not returned. The worker went outside and saw Celine on the other side of the glass balustrade sitting on the outer edge of the building. The worker called out to Celine to come off the ledge. Celine did not respond verbally. When Celine stopped making eye contact and turned with her back to the ledge, the worker became concerned that she would jump and ran back inside to call for help.

23. Meanwhile, police officers on the street below had also seen Celine on the ledge. They called out to her and attempted to de-escalate the situation, but it was unclear if she could hear them.

24. A doctor who had just finished a shift at the RMH witnessed the incident from street level. They saw Celine approach the ledge a few times and the attempts from police to communicate with her. The doctor stated the police officer was 'saying the right things' and 'doing a really good job'. The last time Celine approached the ledge she approached backwards. Once on the edge, Celine lifted her arms to her side and fell backwards. The doctor ran over to assist, but tragically Celine had died.

Identity of the deceased

25. On 5 February 2021 Silin Wang, born 4 April 1995, was identified by visual recognition and circumstantial evidence.

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

Medical cause of death

27. Forensic Pathologist Dr Brian David Beer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 2 February 2021 and provided a written report of his findings dated 15 February 2021. Dr Beer also reviewed the post-mortem computed tomography (**CT**) scan and the Victoria Police Report of Death (**Form 83**)

28. The post-mortem examination showed findings in keeping with the clinical history.

29. Toxicological analysis of post-mortem samples identified the presence of diazepam, haloperidol, metoclopramide, and ondansetron. The report commented that the presence of some of these drugs should be considered as being administered by hospital staff.

30. Dr Beer provided an opinion that the medical cause of death was *1 (a) multiple injuries*.

31. I accept and adopt Dr Beer's opinion.

CPU REVIEW

32. Celine's death was referred to the Coroners Prevention Unit (**CPU**) to determine whether there were any prevention opportunities arising from the circumstances of her death.[2] The CPU reviewed the available material and, where instructed by me, conducted further inquiries on my behalf.

Review of Care

33. CPU examined the circumstances in which Celine was told about her most recent imaging results that showed cancer progression. CPU concluded that the decision to read the report result to Celine and Maggie at their request was reasonable and unlikely to have changed the outcome.

34. CPU were concerned about the lack of handover and discussion with Celine about her suicide risk after her admission on 30 January 2021. CPU noted that there was nothing to suggest any of the staff enquired with Celine if she was experiencing suicidal thoughts on the morning of her death. It is then unknown if her suicidal ideation had intensified and whether she planned

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

to jump from the rooftop or if it was an impulsive decision to scale the balustrade once she was on the rooftop.

35. CPU provided an opinion that it was reasonable to expect that part of the safety planning by medical and nursing staff would have been to assess the appropriateness of Celine being able to leave the ward unaccompanied while waiting for psychiatric review. CPU identified this inadequacy of Celine's mental health care as a prevention opportunity. CPU found that the urgency of the referral to the mental health team was appropriate and that it was reasonable to wait until the next morning rather than psychiatric request review that evening.

36. In May 2021, PMCC submitted their root cause analysis (**RCA**) to Safer Care Victoria (**SCV**). There were ten recommendations from the RCA. Overall, CPU noted that the recommendations and actions taken by PMCC to improve the knowledge and processes for providing care to a patient with suicidal ideation and/or self-harm should improve the experience and safety for patients.

37. The review adequately addressed CPU's concerns and identified prevention opportunities. As such, CPU had no additional recommendations. I accept this conclusion.

Environmental Safety

38. CPU also examined the environmental factors that allowed Celine to scale the glass balustrade on the rooftop garden. The VCCC building is owned by the State of Victoria. Plenary Health Pty Ltd (**Plenary Health**) is a private sector partner contracted by the Victorian Government to design, build, finance, and maintain the VCCC building. Plenary Health leases the retail spaces including The Loft café and is responsible for building compliance and environmental safety.

39. In March 2021, Plenary Health engaged Deloitte to assess the design and operations of the VCCC building including emergency response protocols. The review found the current design and function exceeded all building code regulations. However, the review identified vulnerabilities including movable furnishings and equipment, and that safety barriers could be scaled to access the edge of the building by using these items.

40. Since the review, all furniture and equipment on the terrace is now secured or tethered and there are planned works commencing in November 2022 to assess the feasibility of increasing the height of the glass balustrade from 1.8 to 2.2 metres.

41. In June 2021, PMCC engaged Workplace Access and Safety (**WAAS**) to complete a falls assessment of the VCCC building. WAAS made 14 recommendations which have all been implemented.

42. CPU provided an opinion that the actions taken by PMCC following these reviews to improve the safety of the rooftop area of the VCCC building should reduce the risk of further incidents. CPU noted that this is dependent on the glass balustrade height being increased to 2.2 metres.

Conclusions

43. CPU concluded that there were no additional recommendations to make after the internal review and subsequent RCA and submission to SCV or from the reviews pertaining to environmental safety.

44. I accept and adopt CPU's conclusion.

FINDINGS AND CONCLUSION

45. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Silin Wang, born 4 April 1995;

    b) the death occurred on 31 January 2021 at Peter MacCallum Cancer Institute/Hospital, 305 Grattan Street, Melbourne, Victoria, 3000, from multiple injuries; and

    c) the death occurred in the circumstances described above.

46. Having considered all of the circumstances and evidence, I find that Celine intentionally took her own life. It is unclear whether Celine had formed the plan to jump from the rooftop when she asked to go to The Loft café or whether it was an impulsive decision to scale the glass balustrade once she was on the rooftop.

COMMENTS

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

47. The question of whether the seventh floor is a suitable location for a café was not directly raised. However, I suggest that Peter MacCallum Cancer Centre revisit the appropriateness of housing a café with rooftop access unless environmental safety is assured.

RECOMMENDATIONS

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

(i) That Plenary Health increase the height of the glass balustrades on the rooftop garden on level seven of the VCCC building from 1.8 to 2.2 metres.

I convey my sincere condolences to Celine's loved ones for their loss, particularly to Celine's sister, Maggie, and acknowledge her love and support.

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:

Guanpeng (Riccardo) Liang, Senior Next of Kin

Siqi (Maggie) Wang, Senior Next of Kin

Melanie Harper, Peter MacCallum Cancer Centre

The Proper Officer, Plenary Health Pty Ltd

Laura McCauley, Royal Melbourne Hospital

Sergeant Brgoc, Coroner's Investigator

Signature:

Coroner John Olle

Date : 23 May 2023

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.