IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 005550

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Sarah Gebert, Coroner
Deceased:	MNU
Date of birth:	1964
Date of death:	On or about 18 October 2021
Cause of death:	1(a) Combined drug and alcohol toxicity
Place of death:	Berwick, Victoria

INTRODUCTION

1. On 18 October 2021, MNU was 56 years old when she was found deceased at her home address in circumstances suggesting that she had taken her own life.

2. At the time of her death, MNU lived in Berwick by herself.

THE CORONIAL INVESTIGATION

3. MNU'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.

4. 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.

5. 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.

6. Victoria Police assigned Detective Senior Sergeant Catherine Mussared to be the Coroner's Investigator for the investigation of MNU'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.

7. The Court also obtained MNU's medical records from Casey Hospital, Sia Medical, and Dr Chin Tan, and records from Ambulance Victoria (**AV**) and Triple Zero Victoria (**TZV**).

8. This finding draws on the totality of the coronial investigation into MNU's death, 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]

Background

9. MNU is survived by her children EFU, YMU, and FIU from her relationship with her ex-husband, GLD. The evidence reflects some family violence incidents between with couple with MNU named as the respondent. GLD thought that MNU suffered post-natal depression with her first child, which likely was not adequately treated. She also suffered depression.

10. Following a motor vehicle accident in 2003, MNU was prescribed strong pain medication but started consuming her medication with alcohol. GLD described a change in her demeanour once she started drinking.

11. On 12 January 2018 MNU threatened suicide following which police attended and she was transferred to the Casey Hospital for a mental health assessment. She advised attending police that she was suffering depression and anxiety, and there was no point in her being there. She further stated that she had a suicide plan which she had attempted but it was ultimately not successful.

12. MNU had coeliac disease and had been diagnosed with Type 1 diabetes in 2021. She was a patient of Dr Chin Tan, Endocrinologist and Consultant Physician, and had been commenced on insulin on 19 May 2021.[2] Dr Tan said that proximate to her passing MNU struggled badly with her mental health which greatly impacted on her diabetes. He last saw her on 1 October 2021 when he counselled her to concentrate on her mental health first, to start setting goals in life including eventually returning to work.

13. On 10 September 2021, MNU was taken to the Emergency Department of Casey Hospital[3] having been found on the floor by a friend. She indicated that she did not want to wait for medical assistance and wanted to discharge against medical advice. She indicated that her partner *Chris* would be staying overnight and would monitor her Blood Sugar Level (**BSL**).

[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.
[2] MNU had been diagnosed with Type 2 diabetes since 2016.
[3] MNU had similar presentations following her diabetes diagnosis on 24 May and then on 27 July 2021 when she was admitted for three days.

She was educated about the signs and symptoms of a hypoglycaemia and to present to the Emergency Department if there were any further episodes or, to see her general practitioner.

14. MNU was a patient at Sia Medical Centre and had consulted with Dr Shabarish Kamalanathan for a number of years. MNU last consulted with her doctor on 30 September 2021 during a phone consultation when she complained of increased anxiety which she was managing with diazepam. She was counselled about the use of diazepam and the need to keep consumption to one tablet a day.

15. MNU was also supported for the management of her diabetes by Diabetes Educator Coralie Thomson, who would consult Dr Tan. Coralie monitored MNU's BLSs through the online system. Coralie advised MNU on 30 September 2021, that if at any time she was not managing, had feelings of depression or that she could not cope, she should reach out to mental health helplines (the details were provided). This was in response to a message on 28 September 2021 where MNU related that she was unsure when her blood sugars would level out and had lost her spirit. Coralie advised her,

> *We will continue to support you to manage your diabetes. I understand that this has been very difficult for you, but know that you're not alone*.

16. According to XPK, who MNU had met on a dating site called 'Plenty of Fish', she had called him on a number of occasions about hypoglycaemic events. He said that on each occasion he drove to her house to make sure she was okay. On two occasions they were able to get her blood sugars back to normal with lemonade and jellybeans. On the other two occasions she was not making sense and he called ambulance for assistance. This appears to correlate with some of the incidence described in paragraph 13.

17. MNU's daughter also said that,

> *Ever since Mum was diagnosed with type 1 diabetes she wanted me to message her every morning at 9am to make sure she was alright because everything was so up and down. Mom did say she was sick of her diabetes, she was sick of monitoring it, sick of injections and was tired of it. This was stressful for her because they would adjust her insulin and it would either be too much or not enough and she would get sick.*

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

Circumstances in which the death occurred

18. At 9.22pm on 17 October 2021, MNU's daughter EFU called 000 to request AV attendance at her mother's residence in Berwick following indications of suicidal intent from her mother.

19. EFU advised the Call Taker:

> *My mum is a diabetic and she's been in hospital quite frequently lately. She called me saying her sugar levels get very low. Sounds like she's distressed and she's saying that she's either not having her insulin or she's gonna have too much insulin, and she wants to end her life. She's very confused, vague, she can't really talk.*

20. The Call Taker made enquiries and ascertained that EFU:

    a. was not with her;

    b. did not know whether she was awake;

    c. did not know whether she was breathing;

    d. did not consider her to be completely alert; and

    e. did not know whether she had attempted suicide but thought that she had.

21. The Call Taker coded the event as a Priority 3 non-urgent response. The call to 000 was 6:44 minutes in duration and ended at 9.29pm.

22. MNU's daughter was then asked further scripted key questions by the Call Taker who was informed that MNU:

    a. had initially called her daughter saying that she loved her, was proud of her, but that she *couldn't do it anymore*;

    b. had said that someone had informed her that if she injected enough insulin she would be able to successfully end her life;

    c. had reported to her daughter that she had *done it* and injected the insulin; and

    d. had made noises before falling silent as the final phone call to her daughter ended.

23. The Call Taker obtained MNU's mobile phone number and advised EFU at 9.24pm that an attempt would be made to contact MNU directly by phone. Phone contact was attempted unsuccessfully at 9.55pm and 10.04pm.

24. Following her death, investigating police obtained a download of MNU's phone which documented the following texts (complete message not shown):

    a. 7.56.04pm from MNU to XPK – *Goodbye I have deleted you*

    b. 8.01.57pm from MNU to XPK – *Stop Insulin*

    c. 9.05.32pm from EFU to MNU – Missed Call

    d. 9.15.29pm from EFU to MNU – Missed Call

    e. 9.20.11pm from EFU to MNU – *Do u want me to come over*

    f. 9.29.28pm from EFU to MNU – *Answer the phone*

    g. 9.41.19pm from MNU to EFU – *No let me go if that's what the lord wants leave*

    h. 9.41.52pm from MNU to XPK – *I need you*

    i. 9.42.43pm from EFU to MNU – *That's not true*

    j. 9.43.25pm from MNU to XPK – *Help me or say goodbye*

    k. 9.46.03pm from MNU to EFU – *You know I love you be strong off to bed*

    l. 10.01.05pm from AV to MNU – *This is Ambulance Victoria's SMS service*

25. XPK said that in the previous two weeks their *messages had gone a bit* quiet and of the contact made by MNU on 17 October 2021, he did not see MNU's messages as he was driving back from Traralgon.

26. EFU said that during her call to 000 she asked whether they would call her back and was advised that she would have to call them back. She said that she subsequently called her mother and she said, *Sorry, EFU, I'm going to bed I'll see you in the morning.* The call records reflect that this call occurred at either 9.21.22pm (a call from EFU to her mother) or 9.23.06pm (a call from MNU to EFU).

27. The last call made by MNU was to XPK at 9.51.54pm for a duration of 25 seconds, which was likely a message left on message bank.

28. At 10.10pm, it was noted on the TZV (formally Emergency Services Telecommunication Authority (**ESTA**)) event chronology that no AV units were available nearby to be dispatched. The case was referred to the Duty Manager for a dispatch solution at 10.21pm.

29. Phone contact with MNU was again attempted and unsuccessful at 12.47am on 18 October 2021. The Triage Service Practitioner noted on the log, *Police for welfare check – suicidal – mention of insulin OD.*

30. Phone contact was again attempted by AV and was unsuccessful at 1.45am and 3.45am.

31. At 4.00am, the Duty Manager escalated the case to Victoria Police and requested that a welfare check be undertaken.

32. At 4.20am, Victoria Police advised that they would not perform a welfare check due to the time which had lapsed since the initial 000 call.

33. At 4.48am, the Duty Manager assigned the case to AV Advanced Life Support (**ALS**) Ambulance Crew but they were on meal break and therefore were only attending to Code 1 events.

34. At 6.14am, the Communications Support Paramedic (**CSP**) requested that the case be assigned to the ALS Dayshift Crew who were dispatched at 6.38am.

35. At 7.05am, the ALS Dayshift Crew arrived at MNU's house. The house was locked and curtains drawn, and no response was received to a knock on the door. The CSP attempted to call MNU but was unsuccessful.

36. The CSP contacted Victoria Police for assistance to gain entry and Victoria Police advised AV that they were permitted to force entry but gained entry with a spare key. At approximately 7.18am, the ALS Dayshift Crew gained entry and located MNU deceased in her bedroom. She was declared deceased at 7.40am.

37. Investigating police located two notes on her bedside table. Both were addressed to EFU, and said that '*XPK told me how to end my life so I did*', and the other said, '*over dose Good bye*'.

Identity of the deceased

38. On 22 October 2021, MNU, born 1964, was visually identified by her daughter, EFU.

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

Medical cause of death

40. Forensic Pathologist, Dr Heinrich Bouwer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 19 October 2021 and provided a written report of his findings dated 23 December 2021.

41. Post mortem CT scan showed, amongst other things, a hypoechoic liver, cystic liver lesions and patchy coronary artery calcifications.

42. Post mortem toxicological analysis detected an elevated blood alcohol concentration at 0.19% together with oxycodone[4] (0.04 mg/L), diazepam[5] (0.2 mg/L) and its metabolites. The concurrent use of the drugs detected, together with elevated blood alcohol may synergistically increase central nervous system depression, sedation, respiratory depression leading to coma and death.

43. The reported circumstances raised the possibility of possible intentional insulin overdose. Unfortunately, insulin could not be performed on blood as there was no suitable sample (haemolysed sample).

44. Vitreous was therefore analysed. A non-elevated level of insulin was detected and a low C-peptide. Although, there is very limited information available on vitreous insulin/C-peptide levels, a low C-peptide would be in keeping with the history of insulin dependent diabetes.

45. Dr Bouwer provided an opinion that the medical cause of death was *"1(a) Combined drug and alcohol toxicity".*

46. I accept Dr Bouwer's opinion.

[4] Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine used clinically to treat moderate to severe pain.

[5] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures. Nordiazepam, temazepam, and oxazepam are active metabolites but only nordiazepam accumulates in blood. Adverse effects of diazepam include confusion, incoordination, physical dependence, sedation, and seizures in withdrawal. Overdose can cause ataxia, drowsiness, and muscular weakness.

EMERGENCY RESPONSE

Triple Zero Victoria

47. On behalf of TZV, statements were obtained from Jessica Taylor, Quality Lead Audit, dated 31 March 2023 and 27 June 2024 and correspondence from Lander and Rogers (legal representatives) dated 26 July 2024.

48. I asked amongst other things whether the decision by the Call Taker to code MNU's daughter's call as requiring a Priority 3 response was appropriate and in accordance with policy and guidelines in the circumstances; and, whether the Call Taker should have coded the call as a suspected suicide or medical emergency in the circumstances.

49. In this case, the Call Taker asked EFU the *Protocol 25 Key Questions (Psychiatric/ Abnormal Behaviour/ Suicide Attempt)* and based on her responses, the Call Taker coded the event as *25D1 (Psych: not alert)* which is automatically assigned a Priority 3 response from referral/triage services.

50. Referral/triage services include AV's secondary triage service (Refcomm[6]) and include priority 3 events, and some priority 2 events that have been determined by AV as suitable for secondary triage. Refcomm is staffed by AV paramedics, registered nurses, and mental health triage nurses. Once an assessment has been completed by Refcomm, Refcomm may update an event priority or response. Refcomm can also provide self-care advice to the caller or refer them to alternative service providers, if after assessment, it has been identified that an event is suitable for such a response or that an emergency ambulance is not required.

51. A Priority 3 event is distinguished from other events in the AV Clinical Response Model as per the below:

Priority 0	Most critical events requiring an immediate response (lights and sirens) - i.e. cardiac arrests
Priority 1	Time critical events requiring an immediate response (lights and sirens)
Priority 2	Acute events requiring an urgent response
Priority 3	Non-urgent events, sent through to AV's Triage Services for secondary triage

[6] The AV commitment noted for 'Referral to Secondary Triage' is noted as follows, *Ambulance Victoria (AV) is committed to providing patient-centred, high quality care and ensuring appropriate levels of response to patients' needs. We aim to connect patients to the care they need in a timely manner with the suitable level of clinical care, including via referral to Secondary Triage.*

52. Ms Taylor advised that the preliminary decision by the Call Taker in MNU's case to select *Protocol 25* and event type *25D1-A Psych: Not Alert* was correct based on the initial information provided.

53. However, Ms Taylor noted that at 9.26.45pm, EFU advised the Call Taker "*On my last phone call prior to calling you, she said that she had done it……she was saying insulin*" and, that based on this information, she considered it would have been appropriate for the Call Taker to move from Protocol 25 to *Protocol 23 (Overdose/Poisoning (Ingestion)).* She stated that this would have likely reconfigured the event type from *25D1-A PSYCH: NOT ALERT to event type 23C1I – A OVERDOSE/POISONING: NOT ALERT (International)* and this reconfiguration would have altered the event priority level from a Priority 3 to a Priority 2.

54. The agency for this event would however have remained as Refcomm due to it previously being a Refcomm suitable event.

55. Due to the significant workload on the night of 17 October 2021 and the Code Orange escalation which occurred at occurred at 10.52pm, Ms Taylor was unable to say whether such a priority reconfiguration would have resulted in an ambulance attending to MNU sooner.

Ambulance Victoria

56. On behalf of AV, statements were obtained from Tegwyn Elizabeth McManamny, Acting Director Patient Safety and Experience at AV, dated 8 November 2022, 26 October 2023 and 26 July 2024.

57. The Court was advised that due to the Triage Services staff being busy on other calls, the first attempt to call MNU occurred approximately 30 minutes later at 9.55pm.

58. Ms McMananmy advised that,

> *On the night of 17 October 2021, AV's workload was significant. At 2252 hours, there had been a 'Code Orange' escalation occurred. This means that anyone needing non-emergency care should contact nurse on-call services or find alternative transport to hospital. AV had 13% of its fleet available and of the 62 cases pending, 38 were delayed. This included MNU's case. At 2359 hours, there were no available resources to move. AV's referral service was well resourced; however demand was high. Consequently, MNU's case was unable to be resourced within a reasonable timeframe.*

59. Ms McMananmy agreed with the advice provided by TZV that had this case been coded as Priority 2 instead of Priority 3, the reconfiguration would not have resulted in an ambulance attending her sooner.

60. AV performed an in-depth review of the case. The Court was advised that an issue identified included that third party callers are not called when contact with patients cannot be made. Consequently, MNU's daughter was never informed that AV did not have the resources to attend on her mother or were unable to make contact with her to inform her of this. Ms McMananmy said that had this been the case, MNU's daughter may have been afforded the opportunity to make her own attempts by arranging for another person such as a family member or friend, to attend the scene.

61. Two recommendations were proposed in the in-depth case report:

    a. *The "APINCHS" [antimicrobials, potassium and other electrolytes, insulin, narcotics and other sedatives, chemotherapeutic agents, heparin and other anticoagulants, and systems] acronym be utilised by ESTA in their call taking scripts when it is identified that patients may have taken an overdose. This is a widely used classification to assist clinicians to focus on a group of medicines known to be associated with a high potential for medication-related harm. The use of this acronym will assist in identifying and expediating treatment for patients at high risk of medication related harm. This system should also be used by AV Triage (Refcom) staff when cases are deemed appropriate for referral*; and

    b. *Communication - staff consider call backs to third party callers when contact cannot be made with the patient and when resourcing demands result in prolonged delays to attendance*.

62. The Court was advised that these recommendations were unacceptable and unfeasible but the basis upon which this conclusion was reached was not provided.

Conclusions regarding the response to the 000 Call

63. MNU's daughter EFU called 000 on 17 October 2021 requesting ambulance assistance for her mother, with information suggesting that she may suicide or had already ingested insulin for the purpose of suicide. EFU is understandably very upset and distressed that an ambulance was not dispatched that evening to assist her mother.

64. On behalf of TZV it was conceded that based on all the information provided by EFU to the Call Taker it was appropriate for the event to have been reconfigured from Priority 3 (Non-urgent events, sent through to AV's Triage Services for secondary triage) to a Priority 2 (Acute events requiring an urgent response). However the response proceeded as a Priority 3 event.

65. Following the referral to AV's Refcomm System as a Priority 3 event, on behalf of AV the Court was advised that due to their workload and the Code Orange escalation at 10.52pm, MNU's case was unable to be resourced within a reasonable timeframe.

66. Both agencies – TZV and AV – also said that had MNU's case been appropriately assigned as a Priority 2 event, the new reconfiguration would not have resulted in an ambulance attending her sooner.

67. Acknowledging the resourcing issues that evening, it remains unclear on a plain reading of the documentation from TZV [a suspected or possible suicide (by insulin)] followed by the unanswered calls to MNU, why this scenario would not have prompted a request to Victoria Police for a welfare check at an earlier stage.

68. I note that phone contact was attempted and unsuccessful at 12.47am on 18 October 2021 and the Triage Service Practitioner noted on the log, *Police for welfare check – suicidal – mention of insulin OD.*

69. No additional information was provided to Refcomm between the 000 call (and subsequent unanswered calls) and the call at 12.47am.

70. In these circumstances, there is no explanation of why the concern (*insulin OD*) was not reached and acted upon earlier by Refcomm, prompting a request for a police welfare check within a reasonable timeframe.

71. In addition, and as recognised in the AV in-depth review, EFU, as a third party caller, was not called when contact to her mother could not be made, as the relevant procedure did not provide for such a step at the time. Therefore she was never informed that AV did not have the resources to attend her mother or were unable to make contact with her to inform her of this. Had this been the case, I agree that EFU's daughter may have been afforded the opportunity to make her own by arranging for another person such as a family member or friend, to attend the scene.

72. An earlier call to Victoria Police for a welfare check, or contact with EFU may have altered the outcome in this case, although I am unable to say this with any certainty.

MPDS and AV Clinical Response Model protocols for attempted suicide by overdose

73. Neither the Medical Priority Dispatch System (**MPDS**) nor AV Clinical Response Model have protocols for response to suicide by insulin overdose.

74. I asked TZV whether, arising from a review of this case, insulin had been considered for inclusion in the list of medications in the Protocol 23 questions.

75. I was advised that it had not and, that the MPDS establishes a universal standard for emergency dispatchers and that the MPDS includes 36 protocols maintained by the International Academies of Emergency Dispatch (USA) **(IAED**). If a proposal to include insulin was made, its clinical and functional soundness, dispatch relevance, and the potential for logical implementation as part of the MPDS would be determined and if accepted, the change would be implemented in future. However, the inclusion of insulin in the list of substances in the Protocol 23 Key Questions alone, would not trigger a Priority 1 response, as AV ultimately determines the level of priority and response to each event in the context of ambulance call taking procedures and the AV's Clinical Response Model.

Proposed Recommendations

76. I wrote to AV regarding the above conclusions and proposed recommendations to improve the operation of its secondary triage service (Refcomm) and patient safety. The Court received a response dated 31 July 2025 on behalf of AV to each recommendation which is set out below.

77. In response to a proposed recommendation that, *The "APINCHS" [antimicrobials, potassium and other electrolytes, insulin, narcotics and other sedatives, chemotherapeutic agents, heparin and other anticoagulants, and systems] acronym be utilised by used by AV Triage (Refcomm) staff to assist with referrals involving patients that may have taken an overdose*, the following was received:

The proposal had already been considered by AV, and when the next clinical update for Odyssey (AV's triage tool) takes place [date not yet determined], APINCHS are to be added to the overdose question set to highlight their significance. Also, a case study is being formulated for inclusion in AV's Clinical Corner newsletter (for Triage Practitioners) in

relation to one of these drugs to further expand on APINCHS and their high risk status in overdose cases.

78. In response to a proposed recommendation that, *That AV Triage (Refcomm) staff consider call backs to third party callers when contact cannot be made with the patient and when resourcing demands result in prolonged delays to attendance, to enable for the possibility of other arrangements to be made for a patient*, the following was received:

This has also already been considered by AV and on 28 February 2025, AV published the following step to Section 5.2 of its Work Instruction – Triage Services: Performing Secondary Triage (WIN/OPS/303) … which relates to the actions to be taken in cases where a patient has not answered attempted callbacks in circumstances where the original caller was a third party:

> *'If there is still no answer after the previous actions, review additional contact information (alternate numbers in event of LOI [location of interest], triage history or contact made with original caller if not first party).'*

79. In response to a proposed recommendation that, *In circumstances of a potential suicide or self-harm event where the relevant person cannot be reached and there are insufficient AV resources to attend in a reasonable time, that amendments be considered to request an immediate Victoria Policed welfare check*, the following was received:

The ability to initiate a Victoria Police welfare check and for Victoria Police to undertake this within a reasonable time is fundamentally a resource issue. The volume and frequency with which AV receives calls from third parties where the relevant person cannot be reached is significant. For example, calls from medical alarm companies, security control rooms, train/tram control, passers-by for motor vehicle accidents or people seen lying on the ground, etc. Requests by AV for an immediate Victoria Police in each case where concerns exist for a patient's welfare but AV does not have the resources to attend could result in a significant burden for Victoria Police and, in turn, impact their ability to respond. Currently, AV does, from time to time, initiate a request for a Victoria Police welfare check when there are concerns about a patient's welfare, however, this is done on a case by case basis. For example, AV will request Victoria Police to attend to conduct a welfare check following AV's arrival at a patient's residence and there was no answer at the door, no answer on call back, and/or the case information indicates concerns for the patient's welfare. Since 21 April 2021, AV has added to its Work Instruction – Management of Response Delays (WIN/OPS/304) …,

as special note which states: 'Delayed response increased the potential for patient deterioration. Held events should be regularly reviewed and reassessed for dispatch solutions. Where concerns for patient welfare exist (such as an inability to make contact via a welfare call back), consider requesting assistance from other agencies for the purposes of a physical welfare check.'

80. Given these indications from AV, I have determined not to make formal recommendations.

FINDINGS

81. Pursuant to section 67(1) of the Act I make the following findings:

    a. the identity of the deceased was MNU, born 1964;

    b. the death occurred on or about 18 October 2021 in Berwick, Victoria, from combined drug and alcohol toxicity; and

    c. the death occurred in the circumstances described above.

82. Having considered all of the circumstances, I am satisfied that MNU intentionally took her own life. While I cannot determine the specific stressors that contributed to her decision to do so, there is evidence that she was struggling with the management of her diabetes. In addition, I note that post-mortem toxicological analysis showed that MNU had an elevated blood alcohol concentration at the time of her death and while its precise impact on her mood and judgement cannot be known, the disinhibiting effects of alcohol are well known in the broader community and well-documented in the coronial jurisdiction.

COMMENTS

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

83. The Victorian Suicide Register (**VSR**) is a database containing detailed information on suicides that have been reported to and investigated by Victorian Coroners between 1 January 2000 and the present.

84. The VSR indicates the annual frequency of suicides occurring in the state of Victoria has been steadily increasing for the past decade, from approximately 550 deaths in 2011 to a peak of 795 deaths in 2023 (777 deaths in 2024).[7]

[7] Coroners Court Monthly Suicide Data report, June 2025 update. Published 22 July 2025.

85. The primary purpose of gathering suicide data in the VSR is to assist Coroners with prevention-oriented aspects of their suicide death investigations. VSR data is often used to contextualise an individual suicide with respect to other similar suicides; this can generate insights into broader patterns and trends and themes not immediately apparent from the individual death, which in turn can lead to recommendations to reduce the risk that further such suicides will occur in the future.

86. So much is still unknown about suicide and, given that every suicide occurs in unique circumstances to a person with a unique history and life experience, possibly there is much we will never be able to quantify and understand. But through recording information about each individual suicide in the VSR, particularly information about the health and other services with whom the person had contact, and then looking at what has happened across time and across people, we hope the VSR can at least lead us to new understandings of how people who are suicidal might better be supported in our community.

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

I convey my sincere condolences to MNU's family for their loss and acknowledge the tragic circumstances in which the death occurred.

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

EFU, senior next of kin

Triple Zero Victoria (care of Lander & Rogers)

Ambulance Victoria

Detective Senior Sergeant Catherine Mussared, Victoria Police, Coroner's Investigator

Signature:

Coroner Sarah Gebert

Date: 07 August 2025

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.