



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2023 003748

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	VNP
Date of birth:	1981
Date of death:	10 July 2023
Cause of death:	1(a) Injuries sustained in a fall from a height
Place of death:	Dandenong Square Shopping Centre, McCrae Street, Dandenong, Victoria
Key words:	Fall from height, suicide, police negotiations

INTRODUCTION

1. On 10 July 2023, VNP was 41 years old when she took her own life in the presence of emergency services personnel. At the time, VNP had no fixed address.
2. VNP was the only child of QUD and NDT, who separated several months after VNP's birth. QUD was an Aboriginal woman who subsequently passed away in 2011 from natural causes. NDT had two children from a later relationship. At the time of her death, VNP was estranged from her father and half-siblings.
3. In about 2000, VNP met HSE, and they went on to commence a relationship in about 2005. According to HSE, it was at about this time that he noticed that VNP was experiencing mental health issues and was trying to see a psychiatrist. He also learned that VNP suffered from significant pain from endometriosis since her teenage years and had been prescribed strong pain medication. This ongoing pain affected VNP's mental health.
4. VNP was employed in a variety of jobs. However, from about 2010, she ceased paid employment due ongoing medical and mental health issues. At the time of her death, she was in receipt of Centrelink benefits.
5. In 2013, the couple welcomed a son. Following his birth, VNP experience post-natal depression.

THE CORONIAL INVESTIGATION

6. VNP'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.
7. 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.
8. 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.

9. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of VNP's death. The Coronial 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.
10. This finding draws on the totality of the coronial investigation into VNP'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

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

Identity of the deceased

11. On 13 July 2023, Coroner Paul Lawrie made a formal determination identifying the deceased as VNP, born 1981, based on fingerprint comparison.
12. Identity is not in dispute and requires no further investigation.

Medical cause of death

13. Forensic Pathologist, Dr Victoria Francis, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 11 July 2023 and provided a written report of her findings dated 23 August 2023.
14. The post-mortem external examination revealed multiple superficial injuries. There were some superficial incised injuries over the right side of her neck.
15. The post-mortem CT (computed tomography) scan showed pelvic and sacral fractures, a distal tibial fracture, subcutaneous emphysema. There was a left haemopneumothorax and a right pneumothorax with pneumomediastinum and prominent subcutaneous emphysema, particularly on the left posterior chest wall. There was a right clavicle fracture and bilateral rib fractures, which were most severe on the left posterior chest wall.

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.

16. Routine toxicological analysis of post-mortem samples detected ethanol² (alcohol, 0.12 g/100mL), methylamphetamine and amphetamine,³ phentermine,⁴ and meloxicam.⁵
17. Dr Francis provided an opinion that the medical cause of death was “*1(a) Injuries sustained in a fall from a height*”.
18. I accept Dr Francis’ opinion.

Circumstances in which the death occurred

VNP’s mental health history

19. VNP saw Dr Nicola Wheatley-Price at Your Doctor Medical Centre from 2013 to 2021. Dr Wheatley-Price stated that VNP had been diagnosed with Bipolar Affective Disorder (**BPAD**) Type 1 and also had a history of depression and anxiety in the context of substance use related to pain management for oligomenorrhea (irregular and inconsistent menstrual flow), dysmenorrhea (painful menstruation), and endometriosis. During this period, VNP received assistance from Dr Adaobi Udechuku, post-natal psychiatrist, and Dr Chui Chong, pain medicine specialist.
20. In about mid-2014, Dr Udechuku reported that VNP’s mental health declined on the background of ongoing pain and she was referred to Dr John Monagle for pain management.
21. According to Dr Wheatley-Price, VNP was “*caught in a difficult place in our mental health system*”. She had consulted a private psychiatrist in late 2014 but was then declined further treatment on the basis that she needed more regular visits and would have to go to a community (public) psychiatrist to accommodate her needs. VNP then sought assistance from

² In Australia, it is illegal for full license holders to drive with a blood alcohol concentration of more than 0.05 g/100 mL. A blood alcohol concentration in excess of ~ 0.30% can cause death in the absence of other contributing factors. Aspiration of gastric contents is a significant risk factor in such cases. Other drugs capable of depressing the central nervous system will increase the effects of alcohol when co-consumed.

³ Methylamphetamine is supplied in powder or pill form (speed), as crystal methylamphetamine (crystal meth or ice), and a sticky paste (base). Methylamphetamine may be ingested orally, snorted, injected or smoked. The desired effects sought by methylamphetamine users include an increased alertness, reduced fatigue, weight loss, and intense euphoria. The onset of effects is rapid after intravenous injection or smoking, and slower after oral ingestion. The effects typically last four to eight hours but residual effects may persist for up to 12 hours. Adverse effects of methylamphetamine use include dizziness, headache, restlessness and tremor. Overdose may cause anxiety, cardiac arrhythmias, circulatory collapse, coma, confusion, convulsions, hallucinations, hypertension and hyperthermia. Users of methylamphetamine may develop psychosis, particularly a paranoid psychosis that is oftentimes indistinguishable from schizophrenia. This can often lead to irrational or violent behaviour and is a frequent factor in serious assault implicating methylamphetamine use. Chronic methylamphetamine users have an increased risk of cardiovascular and cerebrovascular disease, especially cardiac arrhythmias, myocardial infarction, and haemorrhagic stroke.

⁴ Phentermine is prescribed for weight reduction but also has temulent properties related to amphetamines.

⁵ Meloxicam is an anti-inflammatory.

a consultant psychiatrist at the Victoria Rehabilitation Clinic, but struggled to engage consistently and could not afford private psychiatric care.

22. In October 2015, she was referred to the Monash Health for community care and home review and monitoring. Dr Wheatley-Price stated that the Cranbourne Integrated Care Team wrote to her in early 2016 to advise that they could not continue with her care as VNP could not attend appointments and that short-term mood stabilisation was not likely to be of overall benefit to her. They recommended that she needed to establish a long-term therapeutic relationship with a psychologist and/or a private psychiatrist. However, Dr Wheatley-Price noted that throughout 2016, VNP continued to miss appointments with the psychiatry services to which she was referred.
23. In about 2016, VNP's relationship with HSE broke down and they separated. The couple continued to reside in the same house for about six months until VNP moved to Caroline Springs. Their son continued to reside with HSE, with VNP having regular contact. HSE noted that VNP was depressed at this time but did not exhibit the paranoia that later plagued her.
24. Following several moves, VNP settled in Cranbourne. According to HSE, it was about this time that he observed her exhibiting paranoia, believing that neighbours were listening to her conversations and that she was being followed. This led to outbursts of verbal abuse at strangers in the street. At about this time, VNP underwent a hysterectomy which relieved some of her pain.
25. In mid-2018, Dr Monagle informed Dr Wheatley-Price that VNP was unsettled in her mental health due to complexities with housing issues and not being able to afford a psychiatrist. She had indicated suicidal ideation but was adamant that she would not act on the thoughts after losing her own mother and having a dependent son.
26. Later that year, VNP became involved with the Police and Clinician Emergency Response (**PACER**) team after expressing suicidal ideation. When assessed, VNP reported chronic suicidal thoughts and an increased experience of pain due to her physical medical conditions. She reported that her increased pain was having a negative effect on her mental health and had a negative view of her support services. PACER recommended she be followed up by community mental health services, but she declined further help at that time.
27. Toward the end of 2018, Dr Monagle commenced VNP on Suboxone (buprenorphine and naloxone) for better pain relief.

28. At the beginning of February 2021, VNP's mental health deteriorated further which culminated in her making a false allegation against a teacher at her son's school. This led to the teacher obtaining an intervention order against VNP who then began withholding her son from school. This in turn led to Child Protection Services involvement with VNP and her son. Eventually, HSE was granted sole custody of their son with VNP only allowed supervised access visits. Later still, HSE obtained an intervention order against VNP after outbursts and threats from her.
29. Dr Wheatley-Price's last contact with VNP was via phone in September 2021 and she was last seen in person at the clinic in October 2021.
30. Toward the end of December 2021, Victoria Police members transported VNP to Maroondah Hospital for mental health assessment after she was found barefoot walking in bushland in Kinglake with a suicide note addressed to her son. She was admitted to the psychiatric unit as a voluntary patient where her mental stated settled and she was discharged after a ten-day admission for follow-up by her general practitioner and the Cranbourne Crisis Assessment and Treatment Team (CATT). However, VNP engaged poorly with community follow-up.
31. In mid-January 2022, VNP had a further inpatient admission at Maroondah Hospital where she was assessed as being in situational crisis. During the two-day admission, VNP settled and was discharged to the care of her general practitioner.
32. In January 2022, VNP had found a new general practitioner in Pakenham. In mid-2022, VNP was removed from the Your Doctor Medical Centre and the Suboxone permit was cancelled with her file transferred to the new medical clinic in Pakenham. According to Dr Wheatley-Price:

[VNP] moved around residences quite regularly and this made it challenging for her to both get the ongoing prescriptions for her medications and also to have them filled by pharmacies. She lived in many different suburbs all over Melbourne and was also homeless at times.

Due to the nature of her illness and her constant residential changes, [VNP] was a difficult patient for the clinic to manage. She would often fail to keep scheduled appointments or would contact the clinic to try and alter her prescription arrangements.

[VNP]'s mental health problems were ongoing. There are many instances within her records where we were notified by the Mental Health Nurse that [VNP] had failed to keep appointments and they would be concerned about her current mental state. We were asked on occasions to put an alert on her file so that, if she turned up, a mental health assessment could be completed, or an ambulance called.

During her visits and phone consultations, I would frequently inquire about her state of mental health and try to get her to see a psychiatrist. Throughout 2020, I was constantly trying to get her to see a psychiatrist, but she stated she did not see any benefit from doing so. I would give her referrals that she did not follow through on.

33. On 12 April 2022, VNP attended the Pakenham Medical Clinic requesting Valium (diazepam). She indicated that she had ceased all her previous medication. On 28 April 2022, VNP indicated she did not want to restart Suboxone and was advised that she would need to be referred to a psychologist and psychiatrist for Valium to be regularly prescribed.
34. On 6 May 2022, a Mental Health Care Plan was created. Later that month, on 13 May 2022, VNP returned to Pakenham Medical Clinic requesting additional Valium. She was advised again that she would need to see a psychiatrist for an ongoing prescription and was referred to Dr Pasan Manawadu, psychiatrist. It appears VNP did not pursue this referral.
35. At about this time, VNP began attending Dr Zev Barr at Carrum Clinic. The reason recorded for her first visit was “*Weight*”, which was measured at 85.2kg. She gave a history of taking Duromine (phentermine). In October 2022, VNP presented to Carrum Clinic with complaints of insomnia and requested Valium. The request for Valium was declined but she was prescribed Duromine and Circadin (melatonin) instead.
36. On 8 May 2023, VNP referred to “*childhood flashbacks*” in a consultation with Dr Barr during which she indicated she was living in Sunbury. A Mental Health Care Plan was prepared and prescriptions for Duromine, Mobic (meloxicam), and Valium were provided. On 10 May 2023, VNP had a telehealth consultation with Dr Barr at which time she requested a medical certificate as she had missed a hearing at the Magistrates’ Court due to a panic attack. Dr Barr declined to issue the certificate and advised VNP to speak to her solicitor.

The weeks leading to VNP's death

37. From about April 2023 onwards, it appears that VNP was homeless. Over the following weeks, she sought assistance from the Salvation Army Crisis Accommodation Centre with temporary accommodation arranged for her at various times.
38. VNP last saw her son on 18 June 2023 when she attended a supervised visit at HSE's parents' home. According to police, during the visit, VNP took items from the property, including a debit card which she used later that day to withdraw \$1,380 from an automatic teller machine in Cranbourne.
39. On 23 June 2023, VNP had a verbal altercation with Dr Barr when she attended Carrum Clinic requesting repeat scripts. Dr Barr declined to provide her medical care and left the clinic, at which time VNP shouted abuse at him in the street.
40. On 29 June 2023, VNP self-presented to Dandenong Hospital Emergency Department with symptoms of a panic attack. She denied acute current medical or mental health concerns. VNP was assessed and referred to the ENGAGE⁶ Program for 28 days of follow-up and psychosocial supports in the community. ENGAGE followed up with VNP on 5 and 6 July 2023 at which time she engaged well with no safety concerns noted by their staff.
41. In the early hours of 8 July 2023, the Salvation Army Crisis Centre arranged for VNP to stay at the Comfort Inn Dandenong for three nights and she checked in at 2.26am that morning. Plans were made for VNP to contact WAYSS⁷ the following Monday.
42. Over the following days, VNP received one visitor and otherwise only left the motel to go shopping.

Day of VNP's death

43. At about 6.28am on the morning of 10 July 2023, VNP left the motel and walked toward the Dandenong Central Business District. Her movements following this time are unknown until 10.00am.

⁶ ENGAGE provide 28 days follow-up for psychosocial supports (for example, advocating to Child Protection Services, support with temporary housing, making linkages with local general practitioners and other appropriate services as needed).

⁷ WAYSS is a support service for homelessness and or family violence in Greater Dandenong, Casey, and Cardinia.

44. At about 10.00am, VNP was at the rooftop carpark of Dandenong Shopping Centre when she told a passerby to remove their children from the area because she intended to jump from the carpark.
45. According to Detective Acting Sergeant (**DASS**) Leigh Smyth, Coronial Investigator, the carpark at Dandenong Shopping Centre is a three-storey carpark with the rooftop being an open area. The rooftop carpark is bordered by a concrete wall approximately 1.2 metres in height. The southwestern edge of the carpark borders McCrae Street, Dandenong. On the southwestern edge are two main structures: to the northern-most section is a three-storey stairwell adjoining the building, with the sloping roof of this stairwell creating a ramp like structure leading to a small platform ledge approximately 1.2 by 3 metres in size abutting the edge of the carpark. From this platform were two horizontal light poles: one perpendicular to the carpark wall; and the other running adjacent to the wall.
46. Further southeast of the stairwell is a series of rooftop-mounted air-conditioning units which are protected by a rectangular area of cyclone fence. The 1.2-metre concrete carpark wall has a 2-metre cyclone fence capped with barbed wire, which runs from the edge of the carpark around the rear of the stairwell and to the furthest southern end of the air-conditioning unit structure. Further to the south there is no cyclone fence, so the 1.2-metre concrete wall is climbable.
47. Mounted on the southwestern wall of the carpark, directly below the air-conditioning units, is a large 'Reading Cinema' sign. Both the upper surface of the concrete wall and the signage are each approximately 20 centimetres wide.
48. At an unknown time, a person at the nearby Holiday Inn Hotel noticed VNP on the edge of the carpark roof and contacted security at the Shopping Centre.
49. At approximately 10.09am, the Security Manager from the Shopping Centre made his way to the carpark roof where he observed VNP holding a bottle and standing on the other side of the carpark barrier. He immediately contacted emergency services to requested police attendance in relation to a suicidal female who was standing on a ledge of the rooftop carpark.
50. At 10.16am, police attended the carpark at ground level and observed a female on the outside of a barrier fence, standing on a narrow ledge. A second police unit arrived on the rooftop carpark at 10.18am. Fire Rescue Victoria, Ambulance Victoria, and additional police members also arrived at the scene a short time later.

51. Once the police unit had arrived at the rooftop carpark, Sergeant Chris Michael approached VNP from the carpark side of the cyclone fence and engaged in dialogue with her. At that time, VNP was standing on top of the 'Reading Cinema' sign so that she was slightly below the level of the carpark wall. Sergeant Michael was blocked from getting closer to VNP by both the exterior barbed wire cyclone fence and the air-conditioning enclosure. Senior Constable Alexander King remained on the opposite side of the enclosure and maintained police communications.
52. VNP expressed a desire to jump but said she was having trouble finding the courage to do so. Sergeant Michael continued engaging with her, asking questions about her life, while awaiting the arrival of Police Negotiators from the Critical Incident Response Team (CIRT). While Sergeant Michael was engaging with VNP, she remained on the opposite side of the cyclone fencing and continued moving about near the edge of the carpark roof and atop a ledge created by 'Reading Cinema' signage attached to the carpark structure.
53. During this time, VNP was drinking from a bottle of Baileys Liqueur for a period before smashing the bottle and using some of the broken glass to self-inflict incisions to the right side of her jaw and neck. Sergeant Michael maintained engagement with VNP until shortly after 11.30am, when police negotiators, arrived on scene.
54. One of the negotiators took on the primary role of engaging with VNP, during which time she frequently held on to the cyclone fencing while hanging out over the edge. At one point, she sat one of the horizontal light poles that stretched out from the carpark structure and over the pavement below.
55. Despite attempts to engage with VNP and have her return to a safe position on the inside of the cyclone fence, she never fully engaged with negotiators.
56. At 12.08pm, VNP lay out along the length of a horizontal light pole and then rotated herself to be in an upside-down position on the light pole with her feet on the edge of the building. She then released her feet so that she was hanging only by her hands from this light pole. Within 15 seconds, VNP lost her grip and fell a distance of 11.12 metres to the pavement on McCrae Street.
57. She was immediately attended to by Ambulance Victoria paramedics and Fire Rescue Victoria members who had been on standby at the scene. Despite their best efforts at resuscitation, VNP went into cardiac arrest and could not be revived. Resuscitation efforts were ceased, and VNP was verified deceased at 12.28pm that day.

FURTHER INVESTIGATION

Coroners Prevention Unit

58. As part of my investigation, I obtained advice from the Coroners Prevention Unit⁸ (CPU) about the mental health care VNP received from Monash Health proximate to her death, noting that VNP had contact with Dandenong Hospital Emergency Department and a community-based Monash Health program in the days before her death.

Background

59. The CPU noted that VNP had a long history of contacts with mental health, Alcohol and Other Drug (AOD) and social services in the context of her long-term mental health issues (bipolar affective disorder, anxiety, depression), chronic pelvic pain, and sporadic periods of methamphetamine use.
60. From 2015 until the time of her death, VNP struggled to sustain stability in her life. Post relationship breakdown, VNP's life appeared to be one of a transient nature having lived in many different suburbs over Melbourne and was also homeless at times, often failing to keep scheduled appointments. Although VNP connected with multiple support services, she found it difficult to sustain the engagement required by services and agencies reported challenges in maintaining follow-up.
61. One constant in her life appeared to be her general practitioner, Dr Nicola Wheatley-Price, who cared for VNP from 2013 to 2021. The CPU considered that Dr Wheatley-Price was an accessible, present, and empathetic professional who made appropriate referrals for the multitude of issues that VNP faced over eight years.

Monash Health contact proximate to death

62. On 29 June 2023, VNP self-presented to Dandenong Hospital Emergency Department seeking social support. She reported that Victoria Police had not been responsive to her complaints and cited numerous other psychosocial stressors, namely financial stress and housing instability, which was leading to her experiencing panic attacks.

⁸ 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.

63. She was subsequently referred to the Emergency Psychiatric Service where a mental health clinician conducted a compressive risk and psychiatric assessment. VNP was found to be in the midst of a situational crisis. She denied thoughts, ideation, plan, or intent of self-harm or suicide and was assessed as not meeting the criteria to be managed compulsorily under the *Mental Health Act 2014 (Vic)*.
64. She was therefore referred to the ENGAGE Program. VNP expressed her gratitude for the referral to ENGAGE and was discharged home. After a failed phone contact by ENGAGE on 30 June 2023, VNP returned the call on 5 July 2023, where she engaged well and was help-seeking. She was seen face-to-face in a pre-booked review at Casey Hospital on 6 July 2023 by two senior social workers.
65. The CPU considered that this appeared to be a thorough review, where no safety concerns were noted or raised. The ENGAGE Team arranged ongoing contact with VNP and planned to support her to engage with Child Protection Services and Victoria Police.

Conclusion regarding mental health care

66. The CPU noted VNP had several factors known to increase suicide risk including her mental health history, chronic pain, limited access to her son, financial stress, housing instability, and substance misuse. She did have protective factors by way of clear future focus on getting more access to her son and putting plans in place for more stable housing.
67. Proximate to her death, she was engaging with mental health professionals, and there was no documented suicidal ideation, plan, or intent during the reviews with the mental health clinician and social workers.
68. However, post-mortem toxicology indicated VNP was alcohol and drug affected at the time of the fatal incident. The CPU noted that the Victorian Suicide Register data held by the Coroners Court of Victoria shows that alcohol is consistently detected during post-mortem examination between 25 percent and 35 percent of Victorian suicides each year (discussed further below). While the mechanisms underlying the association between alcohol and suicide remain somewhat unclear, it is likely that VNP's intoxication led to impaired judgement which could have been a significant contributing factor in her death.
69. The CPU also highlighted that it is difficult to assess which people with identified suicide risk factors may suicide, and if they may do so in the short term. The risk assessments completed in the days and weeks prior to the fatal incident were comprehensive and gave no indication

of acute risk at that point in time VNP appeared to be actively help-seeking but her actions on the day of her death appear to have been greatly influenced by being intoxicated with alcohol and methylamphetamine.

70. The CPU did not identify any opportunities for prevention.

71. I accept and agree with the CPU's advice.

Police contact

72. As part of my investigation, I also reviewed the conduct of police who attended the scene on 10 July 2023 and engaged in negotiations with VNP immediately preceding her fall.

73. At the outset, I consider that none of the police members who engaged with VNP while she was on the rooftop of the Dandenong Shopping Centre carpark were attempting to take her into custody. I therefore consider that VNP did not meet the definition of a 'person placed in custody or care' under section 3(1) of the Act and that section 52(2) which mandates a mandatory inquest, is not enlivened.

74. However, I am of the opinion that VNP's death constitutes a police contact death as described in part 2.2.2 of Practice Direction 3 of 2021, *Police Contact Deaths*, that is, 'circumstances where a Police Officer's conduct immediately preceding the death requires further investigation by the coroner under the Act (as determined by the investigating coroner)'.

75. To assist my investigation, I received a submission from Matthew Haslem, Managing Principal Lawyer, Civil Litigation Unit, on behalf of the Chief Commissioner of Police.

Assessment of the conduct of Victoria Police members and negotiators on 10 July 2023

76. At 10.09am on Monday 10 July 2023, the Dandenong Plaza Security contacted emergency services and informed the call-taker that *"we have a lady here, she's on the tallest building, carpark level 5, I believe she's suicidal at the edge of the gates she looks like she's going to jump I can see her but I didn't speak to her, she's at the edge of the carpark, the top level, behind the fence she looks alcohol affected angry, screaming, screaming like angry wearing black jacket, blue pants, long black hair, Caucasian, mid 30s"*.

77. Following this a Police event was created and coded a 597-P EME-THR ATTEMPT OR THREAT SUICIDE, assigned a priority 1. The following notes were made on the Police Computer-Aided Dispatch (CAD) system:

**** POL S.C.T. USED ****

F ON TOP OF ROOF

COMP BELIVES SHE IS GOING TO JUMP OFF

COMP CAN SEE F

F IS ON THE EDGE OF CAR PARK ON TOP LEVEL

<ATTEMPT TO DISPATCH>

NIL INJ

LOOKS A/D AFFCTED

NIL W SIGHTED

F LOOKS VERY ANGRY AND IS ANGRY SCREAMING

SDG251 AWARE

F NK TO COMP

F DESC: CAUC, APPROX 30YO, LONG DARK HAIR, BLA JACKET, BLU PANTS

...

78. Following a review of the audio of the emergency services call made by the Security Manager, I am satisfied the above CAD notations were accurate.
79. Further, the selection of event type 597-P EME-THR ATTEMPT OR THREAT SUICIDE was appropriate. The event being assigned an event 'Priority 1' was also appropriate (person in danger or a life-threatening situation).⁹
80. The first Victoria Police unit arrived on scene within seven minutes of the call to emergency services, the second Victoria Police unit arriving two minutes later. Thus, there were two Victoria Police units on the scene in under 10 minutes and negotiations with VNP commenced. This was a timely response in the circumstances.

⁹ Victoria Police Guidelines, VPMG – Patrol responsibilities and communications in respect of Victoria Police, Event Priority, stated that a Priority 1 indicate the need for an urgent response by police due to: persons are seriously injured, in danger or trapped, life threatening situations, or offenders held and violent.

81. Both Sergeant Michael and the CIRT Negotiator had their body worn cameras (**BWC**) activated for the entirety of their negotiations with VNP, and this footage has been available for review.
82. Sergeant Michael negotiated with VNP for 67 minutes prior to the CIRT Negotiator taking over. He made a timely request for the assistance of CIRT negotiators, Fire Rescue Victoria, Ambulance Victoria, Highway Patrol units for street closures/traffic control, and Victoria Police Search and Rescue.
83. With respect to negotiating with VNP, Sergeant Michael gave the following evidence within his statement:

FC [First Constable] KING and I approached her and she stayed where she was, she was still seated and very quiet and calm, not erratic at all. I begun to speak with the female, my goal was to build rapport with her, get her name and find out what she was doing.

Every detail I got from her, I was updating the information to the D24 operator so they could find out who she might have been. She was pretty stubborn and didn't open up much at all.

She really didn't want to talk at all really, it took ages just to get her name. I eventually got her name which was [VNP], no surname or anything, and that was towards the end.

I grabbed her purse out of the bag whilst I was talking to her, so that she wouldn't notice and gave it to my offsider to look through. Again, that was towards the end of when the 'negs' came but I had already got her name.

She repeatedly told me that there was 10% in her head that was stopping from her jumping, she would hit her head whilst she would say it. I sort of kept going that the 10% was good and that's what I needed her to focus on, it doesn't need to end like this, you're a good person, think of your son, I've got kids. I can't remember exactly when I said these things, just over the course of the conversation.

Over my time speaking with [VNP], a consistent thing she would say is that 10% in her head, she just wanted to overcome that, and she would do it. She also offered for

someone to come and push her. She also said a few times that if she saw parents with children walking around the area for them to get out of here.

At no time did she become erratic, and if she didn't want to talk, she said that she didn't want to talk. There is something that stands out to me, when she pulled out a fifty (50) dollar note and puffed it on the road. This sparked me asking her if she wanted anything, if she was hungry, when she had eaten and if she wanted a drink. She refused all of my offers.

84. The CIRT Negotiator provided the following evidence in attempting to ascertain VNP's background and circumstances prior his arrival on scene at 11.26am:

Before we roll out to such a job, we normally start doing name checks and checking up backgrounds of the person involved for any things like warning flags. These are assisted with by our Tactical Intelligence Officers to see if there is any previous CIRT involvement with this person.

For this particular job at Dandenong, we did not have any details on who the female was so had none of this background material. We did not actually establish who she was until about 3 minutes before arriving at the job.

Just before we arrived, I was provided with the details of the female that was put in the job. Her name was [VNP] (1981). I did a couple of quick LEAP checks via the Iris device to look at her dossier or any warning flags or antecedents. There was nothing there of value.

There were no warning flags and there was minimal contact with police. She had some recent family violence incidents with charges pending in relation to her breaching family violence orders. I cannot get into the individual screens, but I was made aware that it had something to do with an ex-partner and her son [name redacted] who she had lost custody of. This was onwards from 2022, I think.

85. The Victoria Police LEAP¹⁰ Person History Report supports the above evidence that VNP did not have any warnings listed on LEAP. With respect to involvements, she had recent family violence incidents with charges pending in relation to her breaching family violence orders, but ultimately nothing of significant interest.

¹⁰ Law Enforcement Assistance Program database.

86. The CIRT Negotiator gave the following evidence within his statement:

After asking Sergeant MICHAEL to leave the matter with us, is when I have moved forward and commenced speaking with her. She continued to pace back and forth and was talking to herself. She was saying things like I have to get the courage up. I'm 90% there and its only 10% holding me back. I was concerned because I could see that she was in a state and having a mental health episode.

I was basically talking to her, and she was talking to herself. She was giving minimal responses to me other than telling me to shut up and she didn't want to hear it. I was trying to engage her to talk about her son and referencing how he shouldn't grow up without a mother and try to bring her mind back online.

I believed her to be alcohol and possibly drug effected and not thinking clearly. I was offering her cigarettes and water which worked for a moment, and she sort of paused and talked to me normally. She took the offer of a cigarette, but she was not given one. This is offered to her on the promise and pretence of her coming back onto the safe side of the fence. Part of it is trying to connect with her and getting her back to safety.

It felt like we were going around in circles and one moment of clarity would lead to others of delusion. At times during this engagement, she was laying down flat with her legs on the ledge and her body overlooking the ground below.

I said to Senior Constable [redacted] that since we had her details, we should ring Northwest Mental Health triage to get any further information that we could. Again, normally we would do this on the way to the job, but we did not have her details until our arrival. Senior Constable [redacted] went and made that call and came back to me with some notes in his phone about her.

This information was that she had had multiple contacts with Casey and Dandenong Psych Services. She was in a current engagement program that was open and active. She had suicidal ideation, and she had a personality disorder.

I had a bad feeling about [VNP] and how she was continuing to act. I thought she was either going to fall off by misadventure or get the courage finally to jump off. I conveyed this feeling to [redacted] as well.

This maybe lasted for 30 odd seconds, and I was still talking with her and pleading with her to try and pull herself back up. At that point her feet let go of their grip and she was just hanging there with both hands from the light pole and her whole weight being supported by her grip. She was not saying a word to me and showed no signs of regret.

My feeling it that the death was intentional on her part but because she couldn't find the 10%, she needed to do it (in her words) she put herself in a position where it was going to be a natural consequence.

87. I have not identified anything within the attempted negotiations of both Sergeant Michael and the CIRT Negotiator that would attract adverse comment or criticism. Both police members engaged with core suicidal negotiation strategies including being clear and concise, constantly assessing VNP's demeanour, being neutral and empathetic, showing genuine concern for VNP, and showing an understanding of her challenges.
88. There is no precise or explicit 'playbook' or script for attempting to talk down a person threatening suicide, there are only general principles with which both Sergeant Michael and the CIRT Negotiator comprehensively engaged. Within the early exchanges with Sergeant Michael, VNP expressed a clear and unequivocal intent, "*you're not getting me down, that's how it is ... there's no I'm going to climb down and come with you, that's just, I just need to be pushed ... coming back, coming down, that's not happening ... I'm done, I just need a push, you won't find me on things like this unless I'm about to go*".
89. Ultimately Sergeant Michael and the CIRT Negotiator engaged with VNP in a calm, compassionate, and empathetic manner. They were demonstrably invested in securing her safety and demonstrated significant professionalism and humanity in the way they sought to assist VNP and dissuade her from taking her life.
90. I am satisfied that these police members acted reasonably and appropriately and in accordance with Victoria Police policies, procedures, and their training.

Preventative measures

Environmental Design

91. Following a review of photographs the rooftop level of the Dandenong Shopping Centre carpark, it is apparent there was no fencing or similar structure preventing a person with intent

jumping from the top level and falling 11.2 metres to the ground below. There was a substantial concrete barrier, however it was only waist-stomach high, so it prevented accidental but not intentional conduct.

92. VNP accessed both the concrete ledge and concrete slab by climbing up onto the ledge, supported by the wire fencing enclosing the air conditioning units and other infrastructure. Whether the installation of structures would prevent the conduct that VNP engaged in is debatable.
93. By comparison, I note that suicides from the West Gate Bridge dropped by 85 percent in the two years after barriers were installed without any apparent concomitant shift to other Victorian locations. Given there have not been any other suicides at this location, it does not appear to be a 'landmark suicide location' such as the West Gate Bridge was previously.¹¹ Frequency therefore needs to be balanced against the practicality and cost of mitigating against that risk.

Police Rescue

94. I note within the police statements that Victoria Police Search and Rescue were initially called to the scene in the event VNP was unable to return to the correct side of the roof and needing assistance to do so. However, it was ultimately determined that they would not be required as it would be too dangerous and pointless to harness any members in close proximity to her. Acting Sergeant Daniel Trajanovski, attached to the CIRT, stated "*We do not attempt to grab suicidal people at heights due to the obvious risks involved to Police members.*"
95. Ultimately, Victoria Police Search and Rescue were of limited assistance in the circumstances given VNP's erratic behaviour and non-compliance. Further I note VNP's repeated requests to be either pushed or chased from the concrete ledge, the clear inference being had an attempt been made to secure a Victoria Police member onto the platform, she may have used that as the basis to suicide.
96. The submission on behalf of the Chief Commissioner of Police confirmed that it is rare that a rescue would occur if a subject was refusing to voluntarily return to safety due to the danger of losing control of the subject and the risk of the subject or member performing the rescue falling to the ground as a result of Search and Rescue's actions. A non-compliant subject

¹¹ The Coroners Prevention Unit reviewed the Victorian Suicide Register, which indicated there had been six jump from height suicides, none of which occurred at Dandenong Shopping Centre.

increases the danger of falling from height when trying to rescue a person against their will. Acting Sergeant Trajanovski correctly assessed, consistent with Victoria Police procedures, that in the specific circumstances of this case a rescue would only have occurred if VNP was unable to voluntarily return to a position of safety and/or was compliant with police instructions.

Fire Rescue Victoria

97. The police statements also indicated that Fire Rescue Victoria was requested to attend the scene with possible assistance from a Ladder Platform appliance (otherwise known as a ‘Cherry Picker’) if required. However, shortly after requesting the asset, VNP changed position to hanging off the light pole after which she quickly fell.
98. I am not satisfied the evidence suggests that the Ladder Platform would have prevented VNP’s death as assistance from Fire Rescue Victoria and Victoria Police Search and Rescue would have required VNP’s compliance. The evidence is clear that negotiators never had compliance from VNP. At all times she was able to leave the concrete ledge/concrete platform and return to the correct side of the wire fencing without assistance. Her behaviour whilst on the concrete ledge/platform was described as erratic and unpredictable. In these circumstances, there was a credible risk to any personnel deployed to assist VNP.
99. I also note that VNP had multiple potential points of departure from the rooftop. At 12:04:51, she sat down at the edge of a ledge where a light pole was overhanging and then at 12:05:43, she moved back onto the concrete ledge before sitting down at a different light pole where she eventually fell from at 12:06:01.
100. It appears that both the vehicle and ladder could not have moved sufficiently fast enough to prevent VNP’s fall. At 12:07:07, VNP had moved sufficiently far forward onto the light pole and was starting to twist around. It was only 75 seconds later that she fell to her death.
101. Deputy Commissioner Costa Katsikis provided a statement on behalf of Fire Rescue Victoria to assist my investigation. He confirmed that as a general proposition, it is correct that the assistance of the High Angle Rescue Techniques (**HART**) team would only have occurred in circumstances where VNP was unable to voluntarily return to a position of safety, and where she was compliant with the instructions of Victoria Police (noting Victoria Police was the incident control agency and as such, had the control and knowledge of the state of negotiations with VNP, and was in the best position to judge if, and when the HART team’s expertise could be best deployed to support a safe and effective rescue).

102. Deputy Commissioner Katsikis also explained that the time to set up a Ladder Platform can vary and the operator will take into account a number of considerations before deciding on a plan to set up the Ladder Platform; however, in emergency scenarios, if all conditions are favourable (that is, flat ground and no obstructions), the shortest time for a Ladder Platform to set up and manoeuvre the ladder into position would be approximately five minutes. If conditions were not favourable, the entire process of setting up the Ladder Platform may take up to 20 minutes.
103. The extremely short timeframe between VNP moving from the concrete platform to a light pole and then releasing herself from height means that it would not have been possible in these circumstances for the Fire Rescue Victoria Ladder Platform to have been used to prevent the fall.

Anti-suicide air mattress

104. I asked the Chief Commissioner of Police whether Victoria Police use anti-suicide air mattresses, which are inflatable mats designed to cushion the fall of a person either attempting suicide jumping from a height or jumping from a burning building.
105. The Chief Commissioner confirmed that Search and Rescue does not possess or utilise equipment of this nature. Victoria Police have previously considered anti-suicide air mattresses however when assessing this equipment against locations previously attended, it was rare that these mats could be set up in ideal positions. This was due to obstacles on the ground, unsuitable terrain, the subject moving positions, transport limitations and a fall height restriction of two storeys.
106. Victoria Police is not aware of any other police force in Australia which utilises this capability.
107. Fire Rescue Victoria was also asked to comment on this issue. Deputy Commissioner Katsikis advised that Fire Rescue Victoria does not have this equipment or capability. The former Metropolitan Fire Brigade held this capability many years ago, however the use of such technology was discontinued as it did not prevent death or serious injury and in fact presented a serious risk to crew members attempting to position the device. There are safety risks to firefighters associated with this type of equipment including being situated immediately beneath the person at risk of falling from height. These risks were exacerbated if those persons were intentionally seeking to avoid landing on the device or were otherwise not assisting attempts to rescue them.

108. Fire Rescue Victoria does not have records of any formal evaluation of apparatus of this nature but considers that the effective use of such inflatable safety devices poses several limitations and risks for use in an operational emergency.

Victoria Police Operational Safety Critical Incident Review

109. The Chief Commissioner of Police provided the Operational Safety Critical Incident Review (**OS CIR**) to assist my investigation.

110. The scope of the review into the incident considered the adequacy of the relevant Victoria Police policies procedures guidelines and training, compliance with the relevant Victoria Police policies procedures guidelines and training, the appropriateness of the actions behaviours and decision making by police employees, and the appropriateness of police practises.

111. The Review Team determined that VNP appeared intent on taking her own life, as demonstrated by the preparatory acts she took leading up to her death at Dandenong on 10 July 2023, and by repeatedly verbalising her intentions to police as captured on BWC recordings. The Review Team considered that police members responding to the incident discharged their duties both professionally and in accordance with organisational and community expectations.

FINDINGS AND CONCLUSION

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

- (a) the identity of the deceased was VNP, born 1981;
- (b) the death occurred on 10 July 2023 at Dandenong Square Shopping Centre, McCrae Street, Dandenong, Victoria;
- (c) the cause of VNP's death was injuries sustained in a fall from a height; and
- (d) the death occurred in the circumstances described above.

113. The available evidence, including VNP's historic and recent mental health history, ongoing stressors, and her behaviour on the rooftop carpark, supports a finding that VNP intentionally took her own life and that, to an extent that I am unable to determine, the alcohol and methylamphetamine she had ingested contributed to her resolve.

114. The available evidence supports a finding that the emergency services personnel who responded to the rooftop carpark followed applicable procedures and did their best to engage with VNP in the hopes of preventing harm. However, it is also evident that VNP did not fully engage with police members who were attempting to negotiate with her, and that she ultimately made the decision to take her own life.
115. Finally, I commend each of the emergency responders who attended the scene and Sergeant Michael and the CIRT Negotiator for the manner in which they approached VNP and their efforts to dissuade her.
116. I convey my sincere condolences to VNP's family and friends for their loss.

COMMENTS

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

117. 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.
118. 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 796 deaths in 2023 (777 deaths in 2024).¹²
119. 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.
120. 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

¹² Coroners Court Monthly Suicide Data report, November 2025 update. Published 17 December 2025.

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.

Acute alcohol use and suicide

121. The extant literature shows that acute alcohol use (also referred to as alcohol consumption or alcohol intoxication) is a risk factor for completed suicide and suicide attempts, with higher amounts of alcohol consumed correlating to higher suicide risk post-consumption.¹³
122. Explanations for why acute alcohol use might trigger suicidal behaviour include that it can increase aggressiveness and impulsivity; affect mood and amplify feelings of sadness and despair; weaken thresholds for engaging in self-harm; and/or have a general disinhibiting effect on behaviour. Excessive consumption of alcohol may particularly heighten suicide risk in people experiencing stressful life events (for example job loss, relationship breakdown), by inhibiting their ability to deploy constructive coping strategies.

Methamphetamine use and suicide

123. There is a substantial literature linking chronic methamphetamine use and dependence with heightened suicide risk; proposed mechanisms for the link include the negative impact of chronic stimulant use on mental health (particularly development or exacerbation of depression and psychosis), sleep-wake patterns, aggression, emotional stability and social functioning.¹⁴
124. However, the basis for proposing a link between acute methamphetamine use and suicidality appears to be less clear. Researchers have noted that acute intoxication by methamphetamine can produce panic and agitation and exacerbate anxiety, as well as psychotic symptoms and delusional thought processes,¹⁵ which may be associated with suicidality. On the other hand,

13 Norstrom T and Rossow I, “Alcohol Consumption as a Risk Factor for Suicidal Behavior: A Systematic Review of Associations at the Individual and at the Population Level”, *Archives of Suicide Research*, 20(4), 2016, pp.489-506; Borges G et al, “A meta-analysis of acute use of alcohol and the risk of suicide attempt”, *Psychological Medicine*, 47(5), 2017, pp.949-957; Amiri S and Behnezhad S, “Alcohol use and risk of suicide: a systematic review and Meta-analysis”, *Journal of Addictive Diseases*, 38(2), 2020, pp.200-213; Kolves K et al, “Alcohol Consumption and Suicidal Behavior: Current Research Evidence and Potential for Prevention”, in VB Patel and VR Reedy (eds), *Handbook of Substance Misuse and Addictions*, 2022, pp.1151-1176; Giesbrecht N et al, “Prevention of alcohol-related suicide: a rapid review”, *Drugs: Education, Prevention and Policy*, 31(1), 2024, pp.1-26.

14 See for example Marshall B and Werb D, “Health outcomes associated with methamphetamine use among young people: a systematic review”, *Addiction*, 105(6), 2010, pp.991-1002; McKetin R et al, “Mental health outcomes associated with the use of amphetamines: A systematic review and meta-analysis”, *eClinicalMedicine*, 16, 2019, pp.81-97; Adam HM et al, “Suicide and psychiatric disorders associated with amphetamine type stimulant use: a systematic review and meta-analysis”, *Frontiers in Psychiatry*, 17, 2026, article 1654091.

15 McKetin R et al, “Mental health outcomes associated with the use of amphetamines: A systematic review and meta-analysis”, *eClinicalMedicine*, 16, 2019, pp.81-97; Jayanthi S et al, “Neurotoxicity of methamphetamine: Main effects and

researchers have not explicitly linked the acute intoxication with suicidality, and in fact some researchers have proposed that the circumstances of suicides involving stimulants “argue against any impulsive effect towards self-injurious behaviour”.¹⁶

125. According to data held in the VSR, methamphetamine was detected in postmortem toxicology in approximately 7.2 percent of suicides investigated by Victorian coroners between 2009 and 2019. This is approximately consistent with the findings of a recent systematic review of studies of stimulant use in suicide internationally, which reported that methamphetamine was detected in between 3.1 to 7 percent of suicide cases.¹⁷

mechanisms”, *Experimental Neurology*, 334, 2021, article 113795; Edinoff AN et al, “Methamphetamine Use: A Narrative Review of Adverse Effects and Related Toxicities”, *Health Psychology Research*, 10(3), 2022, article 38161.

16 See Mantinieks D et al, “Stimulant use in suicides: A systematic review”, *Forensic Science International*, 338 (2022), article 111391.

17 See Mantinieks D et al, “Stimulant use in suicides: A systematic review”, *Forensic Science International*, 338 (2022), article 111391.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

NDT, senior next of kin

Chief Commissioner of Victoria Police

Monash Health

Eastern Health

Detective Acting Sergeant Leigh Smyth, Victoria Police, Coronial Investigator

Signature:



Deputy State Coroner Paresa Antoniadis Spanos

Date: 01 July 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.
