



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 004477

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:	AQV
Date of birth:	22 October 1991
Date of death:	4 August 2024
Cause of death:	1(a) Multiple injuries sustained in a fall from a height
Place of death:	Alfred Hospital, 55 Commercial Road, Melbourne, Victoria
Key words:	Family violence, threats to suicide, suicide

INTRODUCTION

1. On 4 August 2024, Aqv was 32 years old when he sustained fatal injuries in a fall from his apartment window. At the time, Aqv lived in South Yarra with his partner.
2. Aqv was born in England. He met HKI in 2014 whilst they were both travelling in Thailand. At the time of Aqv's death, they had been in a relationship for about 10 years.
3. HKI stated that she first observed Aqv's mental health symptoms between 2017 and 2020 when he was serving in the British Army Reserves. She noted that he had become depressed and sometimes insinuated that he had engaged or intended to engage in self-harm.
4. In February 2020, the couple moved from the United Kingdom to Australia and settled in South Yarra. HKI stated, "*His mental health seemed good when we first got here*". Aqv initially worked as a labourer before moving to carpentry.

THE CORONIAL INVESTIGATION

5. Aqv'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.
6. 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.
7. 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.
8. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Aqv'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.

9. This finding draws on the totality of the coronial investigation into AQV'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

10. On 4 August 2024, AQV, born 22 October 1991, was visually identified by his partner, HKI, who signed a formal Statement of Identification to this effect.
11. Identity is not in dispute and requires no further investigation.

Medical cause of death

12. Forensic Pathologist, Dr Sarah Parsons, from the Victorian Institute of Forensic Medicine (VIFM), conducted an inspection on 6 August 2024 and provided a written report of her findings dated 8 August 2024.
13. The post-mortem examination was consistent with the reported circumstances.
14. Routine toxicological analysis of ante-mortem samples collected at 5.37am on 4 August 2024 detected ethanol² (0.20 g/100mL), acetone,³ diazepam and nordiazepam,⁴ zopiclone,⁵ citalopram,⁶ metoprolol,⁷ and acamprosate.⁸ Midazolam⁹ and rocuronium¹⁰ were also detected in post-mortem samples.

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 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 Low levels of acetone in the blood are likely attributable to ketosis secondary to diabetes or a fasted-stat.

⁴ Diazepam is indicated for anxiety, muscle relaxation and seizures. Nordiazepam, temazepam, and oxazepam are metabolites. Adverse effects of diazepam include confusion, incoordination, physical dependence, sedation, and seizures in withdrawal. Overdose can cause ataxia, drowsiness, and muscular weakness.

⁵ Zopiclone is used in the short-term treatment of insomnia.

⁶ Citalopram is indicated for major depression and panic disorders.

⁷ Metoprolol tartrate is an anti-hypertensive drug.

⁸ Acamprosate is clinically indicated for alcohol dependence.

⁹ Midazolam is used as a preoperative medication, antiepileptic, sedative-hypnotic, and anaesthetic induction agent.

¹⁰ Rocuronium is indicated for skeletal muscle relaxation in anaesthesia and intensive care.

15. Dr Parsons provided an opinion that the medical cause of death was “*1(a) Multiple injuries sustained in a fall from a height*”.
16. I accept Dr Parsons’ opinion.

Circumstances in which the death occurred

Background

17. HKI recalled that AQV found COVID-19 lockdowns and mandates challenging, especially being in a new city. By 2023, AQV’s behaviour had become concerning; HKI noted that her partner would have “*rage fits*” and break things in the apartment. His behaviour grew increasingly aggressive, and his alcohol use also increased.
18. Toward the end of 2023, AQV reported to his then general practitioner, Dr David Bornstein at Toorak Village Medical Centre, that he was experiencing depressed mood, episodes of rage, poor motivation, and sleep disturbance. Dr Bornstein prescribed escitalopram and temazepam and provided some counselling. When he returned to Dr Bornstein in January 2024, AQV indicated he felt better.

Months leading to AQV’s death

19. According to HKI, from early 2024, AQV began perpetrating violence towards her.
20. In March 2024, AQV attempted self-harm by wrapping a vacuum cord around his neck, which HKI was able to pull off him. Following, this event, she went on holiday for several weeks.
21. In April 2024, AQV was admitted to hospital for tachycardia. It appears that it was at this time that the extent of his alcohol use came to light as he experienced symptoms of withdrawal.
22. In June 2024, AQV sexually assaulted HKI on two separate occasions.
23. Later that month, he travelled to New South Wales for work. During his trip, AQV was found unresponsive in his motel room and was taken to hospital where he was treated for alcohol intoxication with suicidal ideation. HKI stated she thereafter made her way to New South Wales, subsequently finding an empty bottle of alcohol in the fridge and one in his bag. In hospital, AQV was treated subject to a compulsory treatment order and discharged about a week later. HKI noted that it was at this time that she first learned that AQV had disclosed being sexually abused as a child.

24. Despite his assurance to HKI that he would not drink again, Aqv returned home from New South Wales smelling of alcohol. HKI later found a bottle of whiskey in the bathroom.
25. Aqv returned to see Dr Bornstein in June 2024 accompanied by HKI. They agreed Aqv would try Campral to reduce his alcohol cravings.
26. From this point on, Aqv no longer hid his drinking from HKI. She stated that he could drink a whole bottle of whiskey in 30 minutes. Whilst intoxicated, Aqv made comments to HKI about wanting to die, that he had ‘Warrior’s Syndrome’, and believed “*he was meant to be in the military and soldiers were meant to die*”. Aqv’s excessive alcohol use also led to multiple hospital presentations over the following weeks during which he threatened attending paramedics.
27. On 27 June 2024, Aqv attended a new general practitioner, Dr Timothy Lucas at South Yarra Medical, at which time he disclosed low mood and suicidal ideation, and reported having taken citalopram for about eight months at an increased dose following his hospital admission. He also disclosed drinking up to two bottles of whiskey per day, noting he was waiting to see an alcohol counsellor through Star Health. Dr Lucas provided contact details for Alfred Emergency Psychiatry, prescribed naltrexone and diazepam, and created a Mental Health Care Plan with a referral to Dr Francis Puccio, clinical psychologist.
28. Aqv attended Dr Puccio on 28 June 2024 for an initial assessment. According to Dr Puccio, Aqv indicated he had commenced naltrexone the previous day to help manage his alcohol consumption, and that he experienced nausea throughout the meeting as the result. He explained he was consuming alcohol during the meeting to help settle his distress, and Dr Puccio formed the opinion he was likely intoxicated. Given his presentation, Dr Puccio determined that Aqv was not in a mentally or physically fit state to participate in a clinical assessment and so he was unable to conduct a comprehensive clinical assessment of Aqv’s mental health. However, during their discussion, Aqv referred to aspects of his current distress and issues relating to depression and anxiety, also noting that he had difficulty with managing anger and experienced fits of rage.
29. Dr Puccio conducted a suicide risk assessment, which indicated that Aqv experienced current suicidal ideation, but he did not have any plan or desire to take his own life. They nevertheless devised a safety plan.
30. HKI later informed Dr Puccio of Aqv’s plan to enter a detox facility, which would have precluded sessions for the foreseeable future. Dr Puccio advised that Aqv could re-engage

once he had completed the programme. However, AQV did not ultimately return to Dr Puccio's care.

31. On 29 June 2024, AQV presented to the Victorian Virtual Emergency Department (**VVED**) at Northern Hospital Epping with alcohol withdrawal symptoms, and depression with suicidal ideation. He indicated he had reduced his alcohol intake from two bottles of whiskey per day to one bottle. It was recommended that AQV attend the emergency department in person, but he ultimately declined. HKI was advised to contact emergency services if AQV's condition deteriorated.
32. Over the next few days, AQV presented to Alfred Hospital on two occasions with alcohol intoxication. He declined hospital admission and was advised to continue with community Alcohol and Other Drug (**AOD**) services. During the presentation on 4 July 2024, AQV struck HKI whilst in the emergency department. Records noted that this was the first physical assault of HKI but his aggressive behaviour toward her had been increasing. He reported feeling overwhelmed as HKI was unemployed while completing her masters, which required him to work 12 hours per day as well as undertaking household tasks such as cooking and cleaning. HKI was offered social work support for family violence, which she declined.
33. According to HKI, by July 2024, the couple had run out of money as AQV had spent what savings they had on alcohol purchases.
34. On 8 July 2024, AQV had a telehealth consultation with Dr Lucas and requested a referral for an alcohol withdrawal and detox program.
35. From 9 to 16 July 2024, AQV was admitted to Delmont Private Hospital where he was diagnosed with Alcohol Use Disorder and Obsessive-Compulsive Disorder (**OCD**). According to Dr Vinit Mathur, consultant psychiatrist, AQV reported three to four months of escalating alcohol use, consuming up to one to two bottles of whiskey daily with interval withdrawal symptoms on waking each morning in the form of sweats, significant tremor, and nausea. He reported drinking to loss of consciousness daily. This was on the background of a two-year history of daily alcohol use in the context of multiple stressors. He reported to use alcohol to manage anxiety symptoms. AQV also reported seven to eight months of depressive and anxiety symptoms, but denied any suicidal thoughts, plan or intent on admission.
36. During his admission, AQV experienced moderately significant withdrawal symptoms in form of headache, tremor, sweats, anxiety, and agitation and was prescribed diazepam to assist. The diazepam was gradually weaned off during admission and AQV was commenced

on acamprosate to manage alcohol cravings. He was continued on escitalopram antidepressant and commenced on zopiclone for sleep.

37. A QV had regularly psychiatric reviews and attended the in-patient group therapy program to help with his alcohol use and psychological symptoms. Dr Mathur noted that A QV's mental state readily settled post alcohol withdrawal with no significant depressive or anxiety symptoms. A QV consistently denied any self-harm or suicidal ideation or risk to self throughout admission. His OCD symptoms were longstanding without any significant distress. It was noted A QV was at low acute risk at time of discharge and was referred for the Delmont Day Program.
38. According to records from South Yarra Medical, A QV consulted Dr Lucas again on 19 July 2024 at which time he indicated he had completed a 10-day detox program, was feeling much better with minimal cravings, and had massively reduced his alcohol intake.
39. However, once discharged, A QV immediately began consuming alcohol again. When contacted on 25 July 2025, A QV declined to attend the day program and indicated his alcohol intake had reduced by 80 percent.

Weeks leading to A QV's death

40. From about 19 July 2024, HKI did not reside at their apartment after A QV threatened to assault her, and fears of further violence. However, she regularly checked on him due to concerns he would die of alcohol poisoning or accidental injury whilst intoxicated.
41. On the evening of 25 July 2025, HKI was at their apartment when A QV asked her for the tea she had just made. She offered to make him one, but A QV demanded the one she had made and threatened to strangle their cat which was sitting on HKI's lap. HKI walked away from A QV, intending to leave, at which time A QV physically assaulted her by pushing her against a wall, punching her ribs and neck, as well as head butting her. HKI was able to push A QV away in his intoxicated state and attempted to leave before A QV again assaulted her. Fortunately, HKI was able to flee, with A QV chasing her down the stairs.
42. HKI returned to the apartment the following morning, 26 July 2024, to collect some belongings. Once she had gathered some belongings, HKI sat in her car making a phone call. At this point, A QV exited the apartment building and attempted to assault HKI again. Fortunately, she was able to drive away without significant injury.

43. At about midday, AQV sent a text message to HKI threatening to take his own life. She contacted emergency services to request a welfare check.
44. Later that day, Victoria Police members requested HKI's assistance to gain access to their apartment in South Yarra. According to Constable Pierson Kenney-Seach, Coronial Investigator, police members subsequently found AQV in a highly intoxicated state, dishevelled, unsteady on his feet, with very dilated pupils. He was given a direction to accompany police to issue a safety notice. Police transported AQV to Prahran Police station where a Family Violence Safety Notice (FVSN) was issued,¹¹ and he was interviewed in relation to common law assault.
45. HKI also attended the police station to make a statement about the family violence incidents. At this time, she also informed police of previous strangulation and the two incidents of sexual assault occurring in June 2024 but declined to make a formal statement in relation to those incidents.
46. At about 4.00am on 4 August 2024, Victoria Police members and an Ambulance Victoria paramedic were dispatched to South Yarra, to conduct a welfare check on a male who was reportedly experiencing a numb arm and chest pain whilst withdrawing from alcohol. They arrived at the apartment a short time later and walked down the north side of the apartment building. At the door, they attempted to contact their patient via the apartment's intercom. Following a static sound on the intercom, Senior Constable Zachary Niwa stated, "*Hello this is Ambulance and Police. Are you okay? Can you let us in*". The static sound disappeared but there was no response. Further attempts to ring the intercom were unsuccessful.
47. At about this time, the police members heard an electric drill being used but were unsure of the location of the sound. A resident in the building also heard the electric drill, followed by tree branches breaking. She then observed something fall in front of her bedroom window. Once she realised a person had fallen, she contacted emergency services.
48. Senior Constable Niwa walked around to the back of the apartment building but did not see or hear anything further. Constable Alan So also searched the back garden, directing his touch up to Level 2 to see if any lights were on but he did not see anything.
49. Senior Constable Niwa conducted a check of the Law Enforcement Assistance Program (LEAP) database, which indicated that AQV resided at Unit 8. They noted that a FVSN had

¹¹ The FVSN was a full exclusion order.

been issued and that he should not be at the apartment. Using the contact details provided on LEAP, the police members then attempted to contact AQV via his mobile phone, but all calls rang out unanswered. Ambulance Victoria also attempted to contact AQV without success.

50. Having made multiple unsuccessful attempts to contact AQV over a period of about 30 minutes, they decided to leave the scene. As they headed out, Constable So decided to walk down the driveway on the south side to see if there was another entry. At this point, Constable So observed a male, later identified to be AQV, on the ground with a head wound. Further emergency personnel were requested to attend the scene. Paramedics subsequently transported AQV to Alfred Hospital, where he arrived at 5.21am.
51. In hospital, AQV was found to have sustained a significant intracranial injury and haemorrhagic shock from severe bilateral chest injuries. He continued to clinically deteriorate. At approximately 7.45am, a consensus decision was reached between Emergency, Trauma, Intensive Care, Neurosurgery and Anaesthetic Consultants that AQV's injuries were unsurvivable. Given this determination, active resuscitation measures were ceased. AQV was verified deceased at 8.07am.
52. Following his transport to hospital, police members forced entry into the apartment and conducted a search of the apartment, finding an unscrewed window hinge in the bedroom. A power drill was found on the bed.

FINDINGS AND CONCLUSION

53. Pursuant to section 67(1) of the Act I make the following findings:
 - (a) the identity of the deceased was AQV, born 22 October 1991;
 - (b) the death occurred on 4 August 2024 at Alfred Hospital, 55 Commercial Road, Melbourne, Victoria;
 - (c) the cause of AQV's death was multiple injuries sustained in a fall from a height; and
 - (d) the death occurred in the circumstances described above.
54. Having considered all of the evidence, including AQV's worsening mental health and alcohol use disorder and lethality of means, I am satisfied that AQV intentionally took his own life.
55. I convey my sincere condolences to AQV'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.

56. 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.
57. 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 (778 deaths in 2024 and 788 in 2025).¹²
58. 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.
59. 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.

Alcohol use and suicide

60. There is an increased rate of suicidal behaviour as well as completed suicide among individuals with an alcohol use disorder.¹³
61. VSR data shows that alcohol is consistently detected during post-mortem examination in between 25 percent and 35 percent of Victorian suicides each year. Substance misuse generally predisposes an individual to suicide by disinhibiting or providing ‘courage’ to

¹² Coroners Court Monthly Suicide Data Report, April 2026 update. Published 18 May 2026.

¹³ American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, fifth edition, 2013, p.493.

overcome resistance in carrying through the act, clouding one's ability to see alternatives, and worsening of mood disorders.

62. However, it should be noted that the nature of the association between alcohol consumption and self-harm/suicide is not entirely clear. Consumption of alcohol might influence self-harm/suicide due to the depressant influence of the substance itself; likewise, acute alcohol intoxication might contribute to disinhibited or impulsive behaviours.

Mental illness and suicide

63. The proportion of suicides by history of diagnosed or suspected mental ill health between 2009 and 2016 was 55.7 percent (for those diagnosed) and 19.8 percent (for those suspected but not diagnosed).

Family violence and suicide

64. Between 2009 and 2016, there were 4790 Victorian suicides recorded in the VSR. Of these, there was evidence in 1172 suicides (24.5 percent) that the deceased had experienced family violence.
65. Among the 1172 suicides where there was evidence the deceased had experienced family violence, the deceased were divided into three mutually exclusive groups based on their relationship to the family violence: the 'perpetrator only' group (for those who had only ever perpetrated family violence but had not been a victim of family violence), the 'victim only' group, and the 'both victim and perpetrator' group. The statistics for these groups are as follows:
 - (a) Perpetrator only – 597 persons, representing 50.9 percent;
 - (b) Victim only – 370 persons, representing 31.6 percent;
 - (c) Both victim and perpetrator – 205 persons, representing 17.5 percent.
66. In just over half of cases (50.9 percent) the deceased had only ever been a perpetrator of family violence. There was a substantial difference in proportion by sex: 65.1 percent of the males were in the perpetrator only group, compared to 16.0 percent of females.
67. Whilst academic exploration into the suicidality of men who perpetrate family violence is in its infancy, the association between the perpetration of family violence, suicide, and threats

of suicide is recognised by family violence practitioners and researchers.¹⁴ These understandings have informed risk assessment tools such as the Multi Agency Risk Assessment and Management Framework (**MARAM**)¹⁵ in Victoria and the National Risk Assessment Principles.¹⁶ The MARAM recognises threats to suicide in a family violence context can be an extreme extension of controlling behaviours.¹⁷

68. I note there is a current Federal Parliamentary Inquiry into Domestic Family and Sexual Violence and Suicide¹⁸ underway, with a specific term of reference to consider the use of suicide and threats of suicide as a tactic of coercive control by perpetrators of domestic, family, and sexual violence (**DFSV**), and how legal and justice systems, DFSV specialist services, health, mental health, and other services recognise and respond to suicide in the context of DFSV.

¹⁴ Australia's National Research Organisation for Women's Safety Limited, 'Inquiry into the relationship between domestic, family and sexual violence and suicide' (Submission 17, January 2026), 14, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Social_Policy_and_Legal_Affairs/DFSVSuicidedata/Submissions.

¹⁵ Family Safety Victoria. (2021). MARAM Practice Guides: Foundation knowledge guide. State of Victoria, Australia.

¹⁶ Toivonen, C., & Backhouse, C. (2018). National Risk Assessment Principles for domestic and family violence (ANROWS Insights 07/2018). Sydney, NSW: ANROWS. https://anrows-2019.s3.ap-southeast-2.amazonaws.com/wp-content/uploads/2018/07/19030421/ANROWS_NRAP_National-Risk-Assessment-Principles.1.pdf.

¹⁷ Family Safety Victoria. (2018). Family Violence Multi-Agency Risk Assessment and Management Framework, 28.

¹⁸ Parliament of Australia, Inquiry into the relationship between domestic, family and sexual violence and suicide, https://www.aph.gov.au/Parliamentary_Business/Committees/House/Social_Policy_and_Legal_Affairs/DFSVSuicidedata.

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 deidentified form in accordance with the rules.

DISTRIBUTION OF FINDING

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

HKI, senior next of kin

Bayside Alfred Care Group (Alfred Health)

Somerset Coroner's Service, England

Constable Pierson Kenney-Seach, Victoria Police, Coronial Investigator

Signature:



Deputy State Coroner Paresa Antoniadis Spanos

Date: 02 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.
