IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 001340

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Andre Alistair Hei
Date of birth:	6 April 1980
Date of death:	11 March 2025
Cause of death:	1a: Neck compression 1b: Hanging
Place of death:	Fitzroy Town Hall 201 Napier Street Fitzroy Victoria 3065

INTRODUCTION

1. On 11 March 2025, Andre Alistair Hei[1] was 44 years old when he was found deceased at the Fitzroy Town Hall in Melbourne, Victoria.

2. Andre was a Māori man of Aotearoa descent who relocated to Melbourne with his mother in 1991. He had a twin sister, one other sister and other stepsiblings.

3. Andre had an unstable romantic relationship of around thirty years with his best friend and current partner, Samantha McArthur.[2] He was a qualified pastry chef but found it difficult to sustain employment and relied on Centrelink support. He had three children, with a former partner, who all live in regional Victoria.

4. From 2020, Andre had sporadic and infrequent contact with his children given the existence of family violence intervention orders and in light of his subsequent relocation to Melbourne.

5. Andre had an extensive criminal history for offences related to family violence, breach of bail conditions, theft and burglary, property damage, assault and drug possession.

6. Andre also had a history of unemployment, homelessness, financial instability, mental health concerns and substance use disorder. He had a diagnosis of childhood trauma, depression, cluster B personality traits,[3] complex post-traumatic stress disorder, nicotine dependency, methylamphetamine use disorder, methylamphetamine-induced psychosis, chronic daily suicidal ideations, multiple suicide attempts and impulsive parasuicidal behaviour due to substance use.[4] He was considered to have a '*chronic moderate risk of suicide by misadventure exacerbated by chronic and likely ongoing ice use*'.

7. Andre was well known to Victorian mental health services and had presented to St Vincent's Hospital, Alfred Hospital, Monash Medical Centre, La Trobe Regional Health, and North-West Adult Area Mental Health Service. He typically presented to local emergency departments (**ED**) under the influence of substances and following attempts to end his life.

8. Between 30 December 2023 and 5 March 2025, Andre presented to St Vincent's Hospital ED on eight occasions. These presentations were in relation to recent methylamphetamine and

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[1] Referred to throughout this finding as 'Andre', unless more formality is required.
[2] Also known by an alternative surname.
[3] Traits characterised by being dramatic, emotional, or erratic. This cluster includes antisocial personality disorder, borderline personality disorder, histrionic personality disorder, and narcissistic personality disorder. Individuals with these traits often struggle with intense emotions, impulsive behaviours, and unstable relationships.
[4] Suicidal behaviour without the actual intention of ending life.

cannabis use and relationship conflict with his partner. Once Andre returned to his baseline mental state after the effects of substance use had dissipated, he was often remorseful, attributed his behaviour as impulsive, and did not report further immediate intention to end his life. He did not meet the criteria for compulsory treatment under the *Mental Health and Wellbeing Act 2022* (Vic) during any of these presentations.

9. Andre had been prescribed and dispensed anti-depressant medication and anti-anxiety medications but often declined to take medication. Several attempts were made by health services to provide follow up and or additional mental health support via the Hospital Outreach Post-Suicidal Engagement (**HOPE**) services, drug and alcohol interventions, residential detoxification programs and psychological assistance. Many of these support services were declined by Andre. If he did engage with a service, he was unable to sustain engagement either due to the effects of substance use or frequent changes in his accommodation status. He was often lost to follow up due to housing instability, which resulted in him moving between mental health geographical catchment areas and ongoing health care services needing to be transferred to another mental health service provider. His last stable accommodation was approximately 18 months prior to his death, when he lived in St Kilda with Samantha.

10. Shortly before his death, Andre was known to have been sleeping rough at the Carlton Gardens, Fitzroy and at the bus station of Southern Cross Railway Station.

THE CORONIAL INVESTIGATION

11. Andre'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.

12. 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.

13. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Andre'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.

14. This finding draws on the totality of the coronial investigation into the death of Andre Alistair Hei 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.[5]

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

Circumstances in which the death occurred

15. On 3 March 2025, Andre was transported to Royal Melbourne Hospital by Victoria Police after being talked down, by Police negotiators, from a 30 metre high ledge overlooking train tracks at Southern Cross Station. Andre reported that he '*wanted to jump and end it all*' in the context of chronic homelessness. He was assessed and monitored in the ED whilst he returned to baseline mental state. The event was considered an impulsive reaction to persistent relationship difficulties, financial challenges and housing instability.

16. Andre remained in the ED overnight whilst recovering from the effects of polysubstance use and was discharged the following day having returned to his baseline mental health status. Emergency accommodation was not available due to capacity issues, and he was informed to self-present to St Kilda Crisis Centre after 5pm for a bed for that night.

17. On 10 March 2025, at 10:56pm, Andre (and an associate) visited Sumner House in Fitzroy.[6] He was subject to an exclusion order and was not permitted to attend that location to visit his partner, Samantha.[7] Sumner House staff contacted Victoria Police to report the proximity breach (as per IVO conditions) and were advised that, at the time of reporting, there were no police units available to attend Sumner House. It is unclear as to Andre's movements after this time, but it is noted that Sumner House is located less than 600 metres away from the Fitzroy Town Hall.

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[5] 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.

[6] Sumner House is the location of the Better Health and Housing Program, a residential health and housing response for people experiencing homelessness, delivered in partnership by St Vincent's Hospital, Launch Housing and The Brotherhood of St Lawrence.

[7] Due to a current family violence intervention order with full conditions.

18. On 11 March 2025, at 12:05am, a passerby observed Andre to be hanging outside Fitzroy Town Hall.

19. Victoria Police were alerted and promptly attended the scene. Police repositioned Andre on the ground, observed that he was not breathing and commenced cardiopulmonary resuscitation (**CPR**) to which there was no response.

20. Ambulance Victoria Paramedics continued CPR upon their arrival and provided a verification of death certificate with the time of death recorded as 12:19am.

21. Police commenced an investigation and did not identify any suspicious circumstances nor evidence that would suggest another person was involved in Andre's death. A suicide note was not located on Andre's person or in the nearby vicinity.

Identity of the deceased

22. On 13 March 2025, Andre Alistair Hei, born 6 April 1980, was visually identified by his partner, Samantha Mcarthur.

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

Medical cause of death

24. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 12 March 2025 and provided a written report of their findings dated 22 April 2025.

25. The post-mortem examination revealed findings consistent with the history.

26. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine and its metabolite amphetamine in blood. Alcohol was not detected.

27. Dr Bouwer provided an opinion that the medical cause of death was '*1(a) Neck compression, 1(b) Hanging*'.

28. I accept Dr Bouwer's opinion.

FINDINGS AND CONCLUSION

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

a) the identity of the deceased was Andre Alistair Hei, born 6 April 1980;

b) Andre's death occurred on 11 March 2025 at Fitzroy Town Hall, 201 Napier Street, Fitzroy Victoria 3065, from 1(a) Neck compression, 1(b) Hanging; and

c) his death occurred in the circumstances described above.

30. Having considered all of the circumstances, I am satisfied that Andre intentionally took his own life in the context of persistent psychosocial stressors and polysubstance use, in what may have been an impulsive decision.

31. Whilst Andre was in frequent contact with the mental health system, he was unable to engage in or sustain recovery for his deteriorating mental health and concurrent substance use issues and faced a chronic risk of suicidal ideation and repeated presentations at Victorian emergency departments for suicidal behaviours whilst under the influence of illicit substances.

32. I am satisfied that the care provided to Andre at his last admission to the Royal Melbourne Hospital was considered, compassionate and appropriate. I note that a referral to Homeless Outreach Mental Health Support could not be actioned at this time, as the service was at capacity.

33. Andre's case highlights the impact of multiple psychosocial stressors and poorer outcomes faced by people experiencing homelessness, financial hardship and mental health distress with concurrent substance use dependence, an issue that I have commented upon in other recent findings.[8] It is clear from the circumstances that health services and housing agencies are essential in supporting this particularly vulnerable cohort of the Victorian community. I direct that a copy of this finding be provided to the Victorian Department of Health and Department of Families, Fairness and Housing to help inform policy, funding and future initiatives targeted towards people experiencing homelessness who are in need of intensive mental health supports.

I convey my sincere condolences to Andre's family and loved ones for their loss.

[8] *See for example* the Finding into the death with inquest of Simon Gaskill, COR 2022 002051, available here. Paragraph 24 on p.7 includes '*homelessness is intrinsically linked to poorer health outcomes and is as an independent risk factor for premature mortality. Research has repeatedly found that people who experience homelessness have higher rates of premature mortality than the general population and are at higher risk of non-natural deaths such as suicide, homicide and overdose, as well as deaths from natural causes such as infectious diseases, coronary artery disease and cancer*'. Responses to recommendations made in that case will be published on the Court's website.

ORDERS AND DIRECTIONS

I order that a copy of this finding be published on the Court's website in accordance with the Rules.

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

Samantha Mcarthur

Chanelle Hei

Kate Smith

St Vincent's Hospital Melbourne

The Royal Melbourne Hospital

Victorian Department of Health

Department of Families, Fairness and Housing

First Constable Abraham Booker, Victoria Police, Coronial Investigator

Signature:

Ingrid Giles

CORONER

Date: 23 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.