IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006493

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	DHI
Date of birth:	1987
Date of death:	7 November 2024
Cause of death:	1a : MULTIPLE INJURIES SUSTAINED IN A TRAIN INCIDENT
Place of death:	Middle Footscray Station Footscray Victoria 3011
Keywords:	Mental health; Train incident; Homelessness; Aboriginal

Aboriginal and Torres Strait Islander readers are advised that this content refers to a deceased Aboriginal person. Readers are warned that there are words and descriptions that may be culturally distressing.

INTRODUCTION

1. On 7 November 2024, DHI was 37 years old when he passed away from injuries sustained in a train incident. At the time of his passing, DHI lived transiently without a fixed address.

2. DHI was born in South Australia and raised by his mother, GKI. DHI lived mainly in South Australia and Queensland. In 2004, DHI relocated to Victoria, where he met his former partner, SVE. The couple had three children together but the relationship involved significant family violence and they eventually separated around 2018.[1]

3. DHI worked as a landscaper and manager on a diary farm until December 2014 when he was involved in a workplace quad bike accident. DHI was placed on work cover following the accident and developed a dependence on painkiller medications. DHI continued to live transiently across Victoria and Queensland living with various family members and associates but unable to find permanent accommodation due to his behaviour arising from substance abuse.[2]

THE CORONIAL INVESTIGATION

4. DHI's passing 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.

5. 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.

6. 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.

7. Victoria Police assigned Sergeant Leesha Laurens to be the Coronial Investigator for the investigation of DHI's death. The Coronial Investigator conducted inquiries on my behalf,

[1] *Coronial Brief,* Police memo prepared by Acting Sergeant Leesha Laurens.
[2] Ibid.

including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of DHI 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.[3]

9. In considering the issues associated with this finding, I have been mindful of DHI's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

10. On 5 November 2024, DHI was found by a member of the public slumped on a wall in the Melbourne CBD.[4] Ambulance paramedics attended to DHI and he was transported to the Royal Melbourne Hospital Emergency Department.

11. DHI arrived at the Royal Melbourne Hospital Emergency Department around 5:48 pm and was admitted to the Mental Health, Alcohol and other Drugs Hub. DHI admitted to taking Gamma-hydroxybutyrate, Olanzapine and Heroin but requested assistance to address his alcohol and drug use.[5]

12. On 6 November 2024 around 11:14 pm, DHI is observed on CCTV footage disembarking from a train with an unknown male at Middle Footscray railway station. DHI is further observed to inject a substance in his left arm and lies down to fall asleep on a chair in the middle of the train platform at 11:44 pm.[6] The other unknown male is observed to board a train and depart the station.

13. The following day on 7 November 2024 at 4:35 am, DHI is observed on CCTV footage to wake up and appears unsteady on his feet, staggering and falling backwards off the platform

[3] 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.

[4] Royal Melbourne Hospital – Clinical Incident Review Report dated July 2025.

[5] Ibid.

[6] *Coronial Brief*, Exhibit 1 – CCTV footage from Middle Footscray Railway Station.

onto the train tracks below.[7] DHI appears to attempt to stand up and hold himself up against the edge of the platform but appears disorientated. At 4:45 am, an inbound train heading towards the city enters the train station and impacts DHI.[8]

14. Train and station staff are alerted to the incident and contact emergency services. Police members, Ambulance paramedics and Fire Rescue Victoria members attend around 5:00 am to assist DHI but he was pronounced deceased at 6:34 am.[9]

Identity of the deceased

15. On 11 November 2024, DHI, born 1987, was identified via fingerprint identification.

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

Medical cause of death

17. Forensic Pathologist Dr Chong Zhou from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 8 November 2024 and provided a written report of her findings dated 23 December 2024.

18. The post-mortem examination revealed evidence of significant injuries to the head, chest, abdomen, pelvis and extremities consistent with being sustained in the circumstances reported.

19. Toxicological analysis of post-mortem blood samples identified the presence of Methylamphetamine (~0.3 mg/L), Amphetamine (~0.04 mg/L), Clonazepam (~0.04 mg/L), 7-Aminoclonzazepam (~0.2 mg/L), Pregabalin (~3.3 mg/L) and Olanzapine (~0.04 mg/L).

20. Dr Zhou provided an opinion that the medical cause of death was 1(a) MULTIPLE INJURIES SUSTAINED IN A TRAIN INCIDENT and I accept her opinion.

FURTHER INVESTIGATIONS – ROYAL MELBOURNE HOSPITAL

19. To assist with my investigation into DHI's death, I requested further information and records from the Royal Melbourne Hospital. In July 2025, a clinical incident review was undertaken by Melbourne Health and recommendations were made regarding:[10]

[7] Ibid.
[8] Ibid.
[9] *Coronial Brief*, Statement of Ambulance paramedic Lauren McNabb.
[10] Royal Melbourne Hospital – Clinical Incident Review Report dated July 2025.

a. Improvements to the documentation of patients with multiple presentations (DHI had 28 prior presentations to the Royal Melbourne Hospital alone);

b. Increasing the number of referrals to community-based Alcohol and Other Drug (**AOD**) providers from ED presentations; and

c. Exploring strategies to increase AOD treatment engagement for rehabilitation services.

20. The clinical incident review confirmed that DHI had presented to the Royal Melbourne Hospital on 28 occasions (between November 2023 and November 2024) prior to his last presentation during 5-6 November 2024.[11] On seven prior occasions, DHI chose to leave without being seen by a medical officer. On nine prior occasions, he did not engage with mental health/rehabilitation services as arranged nor did he attend medical outpatient appointments that had been booked for him.[12]

21. Furthermore, during his last presentation on 5-6 November 2024, DHI was seen by an AOD clinician who was also a qualified mental health nurse (all AOD clinicians at the Royal Melbourne Hospital have mental health qualifications).[13] The clinician was familiar with DHI and his pattern of presentations. Although they did not explicitly document a lack of suicidality, the clinician noted that DHI was not expressing suicidality during their interaction. In the view of the treating clinician and the review panel, DHI did not meet the criteria for an involuntary assessment order under the *Mental Health and Wellbeing Act 2022.*[14] DHI was referred to a crisis accommodation provider as he was living transiently but left before he was able to be connected to the provider to follow through with accommodation.

22. I find that the clinical treatment provided to DHI was reasonable and appropriate in the circumstances; the criteria for a mental health assessment order was not met, there were no clear expressed risks of self-harm reported and he was referred to appropriate support services.

[11] Ibid.
[12] Ibid.
[13] Ibid.
[14] Ibid.

FURTHER INVESTIGATIONS – METRO TRAINS MELBOURNE

23. To assist with my investigation into DHI's death, I requested further information from Metro Trains Melbourne. A statement was received from Robert Duvel, Executive Director of Safety and People (Metro Trains Melbourne), in which Mr Duvel noted that:[15]

    a. The incident occurred on 7 November 2024 at "Middle Footscray Station" which is unstaffed, there are three broad categories of stations amongst the 222 stations in Metro Trains network, ranging from premium with multiple services onsite and staff to host stations to unstaffed stations. The Middle Footscray Station being unstaffed meant that no in-person checks are undertaken at any time and there are over 14,000 CCTV surveillance cameras across their network. Station Control Rooms monitor CCTV surveillance and are not resourced to review all cameras at all times.

    b. Station Control Rooms do monitor unstaffed train stations during train operating hours and staff members are trained to call Emergency Services if they are alerted to a person at risk by Authorised Officers, PSOs or a red customer help point. In this case, no one reported DHI's behaviour or appearance despite his substance affected appearance.

    c. At CBD locations, there is a dedicated Victoria Police unit working with Melbourne City Council (**MCC**) which provides support to assist with rough sleepers, and they visit Flinders Street Station three times a week for this purpose. At Flinders Street Station, Metro Trains has partnerships with the Salvation Army and MCC to support people to move on if they are sleeping rough. At Frankston and Dandenong Stations, Metro Trains works in partnership with Frankston Council and South East Community Links in their Community Connectors Program. The program has trained community workers supporting those needing help at those locations. The Community Connectors are trained in a variety of social support skills, providing on-the-spot assistance, offering advice, and coordinating referrals to local services related to alcohol issues, mental health, homelessness, and family violence.

HOMELESSNESS IN VICTORIA AND THE COSTS OF LATE INTERVENTION

24. In my previous investigation into the death of *Sacha Lefebvre*,[16] Sebastian Salay of the Council to Homeless Persons advised me that the number of people experiencing

[15] Statement of Robert Paul Duvel dated 24 October 2025.
[16] COR 2024 007013. See also Findings of Coroner Ingrid Giles following the *Inquest into the death of Simon Christopher Gaskill* (COR 2022 002051).

homelessness in Victoria is steadily increasing, with 105,125 people seeking help from the specialist homelessness sector during 2024-25.[17] Homelessness is complex and multifactorial, so we must bear in mind that this number does not capture those unable or unwilling to seek such help, and so in reality there is actually a significantly higher number of people experiencing homelessness.

25. Victoria has the lowest proportion of social housing by jurisdiction in Australia.[18] The nexus between homelessness and the coronial jurisdiction comes via common health issues which, if left untreated, become life threatening. The life expectancy of people experiencing homelessness is reduced by decades when compared with the national average.[19] Mr Salay also alerted me to a hyper-local longitudinal study of people presenting to a Melbourne inner-city hospital emergency department evidencing a similar gap between life-expectancy.[20] In much the same way that a reputable body of pathologists now view WHO Class III Obesity, which has multifactorial origins, as an independent cause of death, there is now sufficient data correlation to conclude that "homelessness in all its forms is an independent risk factor for premature mortality."[21]

21. Whilst the avoidable costs to society of late intervention in these public health issues might be obvious to public health researchers[22] and anyone visiting a crowded hospital emergency room, the poverty that accompanies homelessness also creates avoidable costs and delays in within the justice system.

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[17] *Coronial Brief,* Statement of Senior Policy Officer Sebastian Salay.

[18] Ibid.

[19] Whilst the National Coronial Information System 2023 *Deaths of people experiencing homelessness in Australia*. https://www.mercyfoundation.com.au/wp-content/uploads/2024/02/Deaths-of-people-experiencing-homelessness-in-Australia.cleaned.pdf put 'homeless' life expectancy at age 44, it must be noted this part of the data is skewed downward by the inclusion of accidental deaths, as well as natural cause deaths, that are reported to coroners. The proposition is more reliably established at an international level in Slockers M et al, "Unnatural death: a major but largely preventable cause-of-death among homeless people?", *The European Journal of Public Health*, 28(2), 2018, pp.248-252; Aldridge RW et al, "Causes of death among homeless people: a population-based cross-sectional study of linked hospitalisation and mortality data in England", *Wellcome Open Research*, 2019, 4:49; Nilsson SF et al, "Life-years lost in people experiencing homelessness and other high-risk groups in Denmark: a population-based, register-based, cohort study", *Lancet Public Health*, 10(1), 2025, pp.e-762-e773; Fornaro M et al, "Homelessness and health-related outcomes: an umbrella review of observational studies and randomized controlled trials", *BMC Medicine*, 2022, 20(1), p.224.

[20] Seastres, RJ, Hutton, J, Zordan, R, Moore, G, Mackelprang, J, Kiburg, K. and Sundararajan, V 2020 'Long-term effects of homelessness on mortality: a 15-year Australian cohort study' *Australian and New Zealand Journal of Public Health* vol. 44, no. 6, pp. 476-481. https://doi.org/10.1111/1753-6405.13038.

[21] Ibid; Morrison, David S. 2009, 'Homelessness as an independent risk factor for mortality: results from a retrospective cohort study' *International Journal of Epidemiology* vol 38, pp. 877-883.

[22] Davies, A and Wood, L 2018 *Homeless health care: meeting the challenges of providing primary care.* https://www.mja.com.au/system/files/issues/209_05/10.5694mja17.01264.pdf. at p.230.

22. Australia spends $15.2 billion on 'late interventions' each year,[23] and the younger the homeless person is, the more expensive this 'tail' of costs will be. For instance, in 2016, youth homelessness alone cost $626 million nationally in avoidable health and justice costs – which is more than the entire national budget of the specialist homelessness sector that same year. [24]

23. In contrast, early prevention investment providing housing and wrap-around support for young people showed that every $1 invested delivers $2.60 in benefits over 30 years. [25]

24. Prevention investment in the homelessness space reduces avoidable health care and justice costs, develops productivity and decreases mortality, [26] but as then State Coroner Judge Cain recently observed, [27] the Australian Institute of Health and Welfare reported in 2022 that Victorian specialist housing support services were unable to assist 96 clients each day, and that 70% of cases were closed without the client having accessed stable housing.[28]

25. As noted in my investigation into the death of Sacha Lefebvre, Canadian experts estimated that whilst it costs at least $20,000 CAD to keep someone hospitalised for a month, and $12,000 CAD to house a prisoner for the same period, it only costs around $2,500 CAD to provide housing and wrap around support for a homeless person across that time.[29]

26. For these reasons, I continue to recommend that the State of Victoria review the suitability of St Vincent's Better Health and Housing Program for further rollout in conjunction with other public hospitals and specialist homelessness sector providers.

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[23] Teager, Fox and Stafford, *How Australia can invest in children and return more: A new look at the $15b cost of late action*, Early Intervention Foundation, The Front Project and CoLab at the Telethon Kids Institute, Australia, 2019.

[24] Flateau, P, Thielking, M, MacKenzie, D, and Steen, A 2016 *The cost of youth homelessness in Australia: Research Briefing*. https://researchoutput.csu.edu.au/ws/portalfiles/portal/20343727/1000008507_published_report.pdf.

[25] SGS Economics and Planning 2024 *Leave No Young Australian Behind: Cost-benefit analysis report*. https://housingallaustralians.org.au/wp-content/uploads/2024/04/Give-Me-Shelter-Youth-Report_110424.pdf.

[26] *Coronial Brief,* Statement of Senior Policy Officer Sebastian Salay. See also Zordan R et al, "Premature mortality 16 years after emergency department presentation among homeless and at risk of homelessness adults: a retrospective longitudinal cohort study", *International Journal of Epidemiology*, 52(2), 20-23, p.508.

[27] *Inquest in the death of Bekkie-Rae Curren* COR 2019 006509 (Cain J., 14 October 2024).

[28] At [63].

[29] Galloway M, *Why a place to call home can be the best medicine*, CBC Canada Radio, 14 October 2024**,** https://www.cbc.ca/player/play/audio/9.6535409 , interviewing Dr Andrew Boozary of the Gattuso Centre for Social Medicine Innovation, Dunn House, at the Toronto University Health Network. At this hospital, 1% of patients were unhoused but accounted for 15% of emergency room visits and 32% of in-patient visits. See also Roumeliotis I, *Hospital invests in new treatment to save lives: housing*, CBC News, 18 April 2023. See also Garrett D, *The Business Case for Ending Homelessness: Having a home improves health reduces health care utilisation and costs*, AHDB online (American Health & Drug Benefits), Vol 5, No.1, January/February 2012.

FINDINGS AND CONCLUSION

27. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[30] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was DHI, born 1987;

    b) the death occurred on 7 November 2024 at Middle Footscray Station, Footscray, Victoria 3011, from 1(a) MULTIPLE INJURIES SUSTAINED IN A TRAIN INCIDENT; and

    c) the death occurred in the circumstances described above.

29. Having considered all of the circumstances, I am satisfied that DHI's death was the unintended consequence of misadventure whilst substance affected.

RECOMMENDATIONS

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

(i) That Melbourne Metro Trains consider expanding the existing support networks and service arrangements with the Salvation Army or similar community agencies. This expansion could consider alerts or referrals from Metro Trains in circumstances where Station Control Room staff/PSOs/members of the public at unstaffed train stations observe individuals that could benefit from support services.

(ii) That Metro Trains Melbourne consider investing in the development and deployment of AI based software to assist Station Control Room staff with identifying problematic behavioral patterns observed in CCTV surveillance footage. AI software could be

[30] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

developed to scan for patterns of concerning behaviour or people sleeping at stations for review by Metro Train staff.

I convey my sincere condolences to DHI's family for their loss.

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

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

LDE, Senior Next of Kin

Andrew Mariadason, Melbourne Health

Robert Duvel, Metro Trains Melbourne

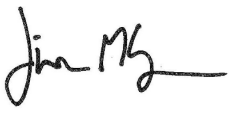
Hon. Sonya Kilkenny, Victorian Attorney-General

Peta McCammon, Secretary to the Department of Families, Fairness and Housing

Jenna Atta PSM, Secretary to the Department of Health

Sergeant Leesha Laurens, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 27 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.