IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 001057

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	TE
Date of birth:	1989
Date of death:	22 February 2024
Cause of death:	1a: 95% Total body surface area burns and inhalational injury sustained in a vehicle fire
Place of death:	The Alfred Hospital 55 Commercial Road Melbourne Victoria
Keywords:	Self-immolation, suicide

INTRODUCTION

1. On 22 February 2024, TE was 34 years old when he died at The Alfred Hospital from injuries suffered after his vehicle caught fire in circumstances suggestive of suicide. At the time of his death, TE resided with his partner, AH, and their child in Prahran, Victoria.

THE CORONIAL INVESTIGATION

2. TE'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.

3. 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.

4. The investigation into TE's death was commenced by Coroner John Olle and I assumed carriage of the matter in August 2025 upon his retirement, to conclude the investigation and make findings.

5. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of TE's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into the death of TE 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]

[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.

BACKGROUND

7. TE was born in Italy, where he grew up in a loving and supportive family environment. He was the eldest child born to his parents and had two younger siblings, BE and CE.

8. TE was an incredibly kind, caring and generous person who played a significant role in his family. He was passionate about soccer and physical fitness.[2]

9. TE originally trained as a psychologist in Italy and worked as a counsellor for survivors of domestic violence. He subsequently lived and worked in Sweden and Japan before arriving in Australia in 2018.

10. TE studied, but was yet to complete, massage therapy with the intention of becoming a qualified myotherapist. He was employed as a masseuse in South Yarra.

11. TE first met his partner, AH, in 2020 when she attended for a massage. They commenced a relationship in April 2021, moved in together and later had a child. He cherished his family and they brought him great joy.

12. TE was not known by his partner to have any mental health challenges that had been discussed with her. However, he had reported feelings of being overwhelmed, and 'drowning', in the context of occupational stress and sleep difficulties.[3] TE did not have an Australian Medicare card and there are, therefore, no Medicare claims records for attendance at medical or other healthcare services, any independent verification of his attendance on a health provider is not possible.

13. Prior to TE's death, he was interviewed on two occasions by the Bayside Sexual Offences and Child Abuse Investigation Team (**SOCIT**), in relation to two separate allegations of sexual assault, in the context of professional services he provided as a masseuse to adult female clients.[4] The first interview occurred on 18 December 2022, and the investigating officer recommended that the brief not be authorised. The reason for this decision is not known. TE was informed of the outcome in August 2023. A second interview was conducted in December 2023 after a further complaint was made to police by a second female massage client. The investigating officer provided a brief of evidence to her Detective Sergeant for determination of further action with a recommendation that the brief also not be authorised. At the time of

[2] Statement of BE, dated 2 July 2024, Coronial Brief.
[3] Statement of AH, dated 3 July 2024, Coronial Brief.
[4] Statement of Detective Leading Senior Constable Joanne Matse, dated 13 June 2024, Coronial Brief.

TE's death, no charges had been laid and he had not had any contact with the investigating officer following the second interview.

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

Circumstances in which the death occurred

14. On 22 February 2024, TE and AH spent the day together. They enjoyed lunch at the Prahran Market, talked about life and TE's plans to open his own clinic one day. The stress of work was discussed and the couple spoke of seeing a psychologist for support.

15. At 4:00pm, TE left the house to attend to an errand. They texted throughout the afternoon, with the last text being sent by TE at 4:57pm, stating '*I'll keep you posted, stay cool*'. AH texted at 7:20pm but did not receive a response.

16. At approximately 6:40 pm, witness Omer Faruk (**Mr Faruk**) was travelling on the Monash Freeway heading citybound when he observed a small white car stopped in the emergency lane just before the Toorak Road exit.[5] Mr Faruk observed TE in the driver's seat appearing to do something with his hands and whilst Mr Faruk drove past, he observed a spark and a flame, followed by a wave of fire inside the vehicle. TE exited the burning vehicle with his legs on fire and the fire quickly consuming his entire body. He took a step away from the vehicle and fell to the ground. Mr Faruk stopped and called Triple Zero.

17. Brendan Paine (**Mr Paine**) observed TE, on fire, on the ground beside the vehicle that was also fully engulfed in flames. He stopped his vehicle and ran toward the scene to assist.[6] At the same time, John Karagounis (**Mr Karagounis**) also stopped his vehicle and ran to assist.[7] Mr Paine and Mr Karagounis dragged TE away from the burning vehicle. At that time, two other road users stopped and retrieved a fire extinguisher and used it to extinguish the flames covering TE.[8]

18. Several other people in transit, including medical professionals and registered nurses also stopped and rendered assistance. Both Dr Helen Cooper (**Dr Cooper**) and Associate Professor Dr Shyaman Menon[9] provided emergency assistance within the limitations of the

[5] Statement of Omer Faruk, undated, Coronial Brief.
[6] Statement of Brendan Paine, dated 17 July 2024, Coronial Brief.
[7] Statement of John Karagounis, dated 23 February 2024, Coronial Brief.
[8] Statement of Joshua Spicer, dated 12 August 2024, Coronial Brief.
[9] Executive Director of Medical Services at Peninsula Health, Statement of Associate Professor Dr Shyaman Menon, dated 20 August 2024, Coronial Brief.

environment, including a lack of immediate access to medical equipment. The doctors confirmed that TE was alive and breathing and assisted to move him further away from the vehicle. They maintained his airway and applied wet blankets whilst waiting for Ambulance Victoria (**AV**) to arrive. Fire Rescue Victoria (**FRV**) arrived at the scene and provided the doctors with an oxygen therapy unit and Dr Cooper administered oxygen to TE.[10]

19. Dr Connor Atkinson, a burns and plastics specialist at Frankston Hospital, also stopped at the scene. He clinically assessed TE as having sustained burns to approximately 90% of his body surface area and signs of inhalation, which he considered likely to be fatal. Dr Atkinson contacted The Alfred Hospital to provide advance notice of TE's condition.[11]

20. At 6:52pm, police were dispatched and arrived at the scene within seven minutes. Shortly after their arrival, TE's vehicle exploded.

21. During the FRV firefighting efforts, the crew identified a 20-litre metal jerry can from the front seat of TE's vehicle.

22. At 7:16pm, AV paramedics and a police escort, transported TE to The Alfred Hospital. During transport, TE's breathing deteriorated and paramedics performed a cricothyrotomy to secure TE's airway.[12]

23. At 7:40pm, TE arrived at The Alfred Hospital Emergency Department in peri-cardiac arrest. The trauma team determined that his injuries were non-survivable and he passed away at 8:56pm.

Identity of the deceased

24. On 22 February 2024, TE, born 1989, was visually identified by his partner, AH.

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

Medical cause of death

26. Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 23 February 2024 and provided a written report of her findings dated 26 February 2024.

[10] Statement of Dr Helen Cooper, dated 15 August 2024, Coronial Brief.
[11] Statement of Dr Connor Atkinson, dated 15 August 2024, Coronial Brief.
[12] An emergency procedure used to establish an airway by creating a surgical opening through the front of the neck.

27. The post-mortem examination revealed features consistent with the clinical history of extensive total body surface area full thickness burns. A post-mortem computed tomography (**CT**) scan was unremarkable.

28. Toxicological analysis of post-mortem samples identified the presence of medications administered in the course of emergency medical treatment. No alcohol was detected.

29. I accept Dr Glengarry's opinion that the medical cause of death was 1(a) 95% Total body surface area burns and inhalational injury sustained in a vehicle fire.

FURTHER INVESTIGATIONS

30. The Court obtained additional information regarding TE's movements and actions prior to the events leading to his death on 22 February 2024. I note the following facts as relevant to TE's death:

    a) At 4:53pm, he purchased the metal jerry can and a gas lighter from Bunnings in Collingwood;

    b) He electronically transferred $20,000 to AH; and

    c) At 6.48pm, TE emailed AH with sentiments of love, plans for his possessions, and words of encouragement that she will '*get through this*'. He also provided his passwords in case she needed '*to have access to anything*'.

31. As part of the police investigation, a Forensic Officer, Michelle Morrison (**FO Morrison**) attended the scene to assess TE's vehicle. FO Morrison provided a report, dated 14 April 2024, that made three conclusions:

    a) the cause of the fire was the ignition of combustible materials;

    b) the pattern of fire damage to the vehicle, together with the fuel container, suggested that flammable liquid had been present in the passenger compartment at the time of the fire;[13] and

    c) the source of ignition was undetermined, however in the circumstances, the fire was probably ignited directly, by means such as a match or cigarette lighter.

[13] Although, given the level of damage and presence of foam from fire extinguishing efforts, there were no suitable samples on which further evaluation (and therefore confirmation) could be conducted.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was TE, born 1989;

    b) TE's death occurred on 22 February 2024 at The Alfred Hospital, 55 Commercial Road, Melbourne Victoria, from 1(a) 95% Total body surface area burns and inhalational injury sustained in a vehicle fire; and

    c) his death occurred in the circumstances described above.

33. Having considered all the circumstances, including the method used and specific actions taken, such as purchase of items, email and money transfer, I am satisfied that TE's death was the consequence of his actions and that he had the intention of taking his own life.

COMMENTS

Pursuant to s67(3) of the Coroner's Act 2008, I make the following comments connected with the death.

34. It is well known that people under investigation for alleged sexual offences are at a heightened risk of ending their own life.[14] Statistics compiled by the Coroners Prevention Unit (**CPU**) demonstrate that between 2009 and 2022, there were 150 suicides of people being investigated for sexual offences.[15] The CPU noted that there are certain times during the police investigation that the alleged person is at a great risk of suicide or self-harm. Of the deaths related to allegations of sexual assault against adults, 32% occurred following interview but prior to charges being laid.[16] This timepoint resonates with TE's experience.

35. On the basis that TE was interviewed by Victoria Police two months prior to his death which concerned allegations of sexual assault, I considered whether the SOCIT member who engaged with him acted in accordance with relevant Victoria Police Standards as outlined in the Victorian Police Manual. Having evaluated the conduct of the interviewer, I find that the interaction between police and TE was reasonable and accorded with the requirements of the

[14] Coroners Prevention Unit, 'Suicide Among Males Investigated for Alleged Sex Offences' (Issues Brief, 20 May 2024).
[15] The Coroners Prevention Unit was formed in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU provide a range of research, data and policy analysis upon request of the coroner.
[16] Coroners Prevention Unit, 'Suicide Among Males Investigated for Alleged Sex Offences' (Issues Brief, 20 May 2024). page 19.

Victoria Police Manual.[17] TE made no disclosures of any intention to self-harm during these interactions and police provided him with information regarding supports he could access if needed.

36. Whilst there is no clear indication, on the evidence before me, that TE directly attributed the new allegations or a second police interview to a deterioration in his mental state, it is possible that his involvement in a second legal process added to his existing stressors.

37. I acknowledge the incredible efforts of community members and other commuters who, whilst on their way to work, stopped to render assistance to TE and in the process put themselves at significant risk. The community is well-served by such altruistic conduct, demonstrated by Mr Faruk, Mr Paine, Mr Karagounis, Dr Cooper, Associate Professor Menon, and Dr Atkinson, in such confronting circumstances and an escalating level of danger at the scene.

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

DIRECTIONS

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

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

AH, Senior Next of Kin

The Alfred Hospital, Frankson Hospital and Peninsula University Hospital, C/O Bayside Health

First Constable Chase Spencer, Victoria Police, Coronial Investigator

[17] In force in December 2023.

Signature:

Coroner Therese McCarthy

Date: 29 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.