

FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

*Section 67 of the Coroners Act 2008*

Court reference: 4584/08

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of:

**Details of deceased:**

Surname: **HOLLAND**  
First name: **DAVID**  
Address: 287 Mickleham Road, Westmeadows, Victoria, 3049,

without holding an inquest:

find that the identity of the deceased was **DAVID HOLLAND** born on the 15th May, 1977,

and that death occurred on the 9th October, 2008,

at the base of the E. J. Whitten Bridge, Keilor East, Victoria 3033

from: 1(a) **MULTIPLE INJURIES IN A FALL**

Pursuant to Section 67(2) of the Coroners Act 2008, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Mr Holland had a history of depression treated by his general practitioner Dr Caitlin Tran with "Lexapro" (escitalopram, an SSRI antidepressant) since May 2007. As recently as 8 September 2008, Dr Tran had warned Mr Holland against ceasing this medication abruptly. According to his family, he had disregarded this advice and stopped taking the medication. He also had a history of previous suicide attempts.

2. Police investigation of the circumstances surrounding his death established that Mr Holland was last seen by a work colleague leaving work at about 5.00pm on 9th October 2008. His car was sighted at this time and appeared to have no panel damage. He showered and changed at home before going to the Gladstone Park Hotel. Bank records showed several ATM

withdrawals from his bank account totalling \$1,000.00 leaving a balance of less than \$60. It appears that he spent all this money, within the space of a few hours, on the poker machines and alcohol. According to his family he had a gambling problem and would, on occasions, spend his whole salary within hours of receiving it.

3. At some point Mr Holland returned home and trashed most of his belongings and the property itself which he shared with his father, before leaving in his car. A neighbour alerted by the noise, reported the incident to police who attended and found no-one at home. Bloodstains found later in his car suggest that he sustained cuts from broken glass found at the property. Shortly after 8.00pm, Mr Holland tried calling one of his friends but the call went unanswered.

4. At about 8.22pm Mr Holland was outside his car on the city bound lanes of the E. J. Whitten Bridge, Keilor Park, part of the Western Ring Road. A passing driver saw him take two steps towards the railing. When the driver looked back through his rear vision mirror, Mr Holland had disappeared. Emergency services were called and police arrived a short time later. They searched the area at the base of the bridge and eventually found Mr Holland face down near a walking track, some 60-70 metres beneath the bridge.

5. There was no autopsy as I allowed the family's objection to autopsy pursuant to section 29 of the *Coroners Act 1985*. However, Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (VIFM) conducted an external examination in the mortuary, reviewed the circumstances as reported by the police and post-mortem CT scans of the whole body, and advised that it would be reasonable to attribute Mr Holland's death to "*multiple injuries sustained in a fall*". Dr Burke identified incised-like injuries to the back of the right hand and finger joints, probably sustained while he was trashing his home, and multiple injuries comprising fractures and abrasions.

6. Toxicological analysis of post-mortem blood also undertaken at VIFM revealed ethanol (alcohol) at a concentration of 0.19g/100mL but no other commonly encountered drugs or poisons including no escitalopram ("Lexapro"). This is consistent with the indication from his family that Mr Holland had stopped taking his antidepressant medication some time prior to his death.

7. I find that Mr Holland jumped from the E. J. Whitten Bridge with the intention of taking his own life, and that he died as a result of multiple injuries he sustained in so doing.

#### COMMENTS:

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under section 69(2) of that Act):

1. In light of the circumstances, and in the interests of prevention of other deaths in similar circumstances, I asked the Coroners Prevention Unit (CPU)<sup>1</sup> for a report on the frequency of jump from height suicides from the E. J. Whitten Bridge and for a summary of the current literature on the nature and prevention of jump from height suicides. According to the CPU report, a review of jump from height suicides in Victoria dating back to 1989 based on coronial databases, shows that the E. J. Whitten Bridge is the site of the second highest number of deaths, being seven including Mr Holland's death, all males. The West Gate Bridge is by far the highest.<sup>2</sup> Other sites where two or more deaths have occurred include freeway overpasses and high rise buildings.

2. According to the report which cites the scientific literature on this issue, strategies for preventing jump from height suicide at bridge locations have focussed in large part on restricting access to the bridge or parts of the bridge. The most commonly advocated and widely studied approach is to restrict access to the edges of the bridge by construction of a physical safety barrier. I note that since March 2009, temporary barriers have been installed on the West Gate Bridge,<sup>3</sup> and time will tell as to the efficacy of this particular intervention.

3. In terms of strategies not predicated on restricting access, two main strategies have been proposed. The first is to encourage media not to report the method and location of suicides. A broad range of research indicates that reporting this information generally is linked with further similar suicides, and there is some evidence for such an effect in the case of jump from height suicide specifically. The second proposed strategy is to install free telephones linked to a help line at relevant sites, but the efficacy of this intervention has not been empirically established.

4. The broad thrust of this research and its ramifications, in particular as regards the E. J. Whitten Bridge, has been brought to the attention of relevant stake holders.<sup>4</sup>

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<sup>1</sup> The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the Coroner. The CPU assist the Coroner in formulating prevention recommendations and comments, and monitors and evaluates their effectiveness once published. The relevant report dated 4 February 2010 was prepared by CPU Team Leader Lyndal Bugeja and Case Investigator Jeremy Dwyer.

<sup>2</sup> These numbers are derived from coronial databases of closed/completed investigations and deaths which are still under investigation where the circumstances are suggestive of suicide.

<sup>3</sup> CPU is presently engaged in a joint project with the Australian Institute of Suicide Research and Prevention at Griffith University Queensland to examine the nature of jump from height suicide in Victoria and the impact of barriers on reducing suicides at the West Gate Bridge and other locations. The results of this research will be presented to Coroners in the near future.

<sup>4</sup> At my request, the CPU convened a meeting with relevant stake holders to discuss the broad thrust of this research and its ramifications, in particular as regards the E. J. Whitten Bridge, and to ascertain whether suicide risk assessment was a factor taken into account when designing infrastructure such as bridges. The meeting took the form of a round table discussion held at Coroners Court of Victoria on 6th May 2010. Representatives of VicRoads, VicTrack, Department of Transport and Victoria Police were in attendance as well as members of the CPU and myself. The data presented by CPU was not previously available to those attending, all of whom indicated an interest in receiving data in the future. The outcome of the meeting was that each stake holder was to indicate the type of data of interest to them and to nominate an individual or department to whom such coronial data could be sent. CPU will investigate the feasibility of providing such data, including seeking the approval of the State

RECOMMENDATION:

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation connected with the death:

1. That in the interests of prevention, VicRoads takes into account the risk of suicide when designing modifying or upgrading any infrastructure, particularly bridges, that could be a possible site for jump from height suicide.

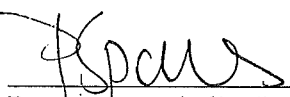
DISTRIBUTION OF FINDING:

Apart from Mr Holland's family, and VicRoads to whom the above recommendation is directed, I hereby direct the Principal Registrar of the Coroners Court of Victoria to provide a copy of this finding to the following, for their information:

1. Constable Timothy JACOBS, Investigating Member, Keilor Downs Police Station.
2. Officer in Charge, Keilor Downs Police Station.
3. VicTrack
4. Department of Transport

Signature:



  
Paresa Antoniadis SPANOS  
Coroner  
Date: 27th May, 2010

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Coroner.