

IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: 3236/10

**FINDING INTO DEATH WITH INQUEST**

*Form 37 Rule 60(1)  
Section 67 of the Coroners Act 2008*

**Inquest into the Death of MICHAEL GEORGE PICHLER**

Hearing Dates: 18 November, 2011

Appearances: Senior Sergeant J Brumby, Police Coronial Support Unit - Assisting the Coroner

Findings of: AUDREY JAMIESON, CORONER

Delivered On: 18 November, 2011 (Ex tempore)

Delivered At: Coroners Court of Victoria  
Level 11, 222 Exhibition Street  
Melbourne Victoria 3000

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I, AUDREY JAMIESON, Coroner having investigated the death of MICHAEL PICHLER

AND having held an inquest in relation to this death on 18th November, 2011  
at Melbourne

find that the identity of the deceased was MICHAEL GEORGE PICHLER

born on 2nd August, 1953

and the death occurred on 19th August, 2010

at 201 Spring Street, Melbourne, Victoria 3000

from:

1a. INJURIES SUSTAINED IN A FALL FROM HEIGHT

**in the following circumstances:**

1. Mr Michael George Pichler was 57 years of age at the time of his death. He lived at 90 Rowell Avenue, Camberwell, with his wife Lexis Pichler. His medical history appears to have been unremarkable.
2. Mr Pichler was retired and he and his wife survived on their investment income. The Global Financial Crisis significantly affected their income, principally through the collapse of the Centro Property Group. In an effort to recoup his losses Mr Pichler invested in a farming enterprise, which turned out to be a scam. His subsequent losses were again significant. He was visibly upset and depressed as a consequence of these recent losses and on at least one occasion he spoke to Lexis about suicide.
3. Mr Pichler recognised his own anxiety and sought assistance from his general practitioner, who he attended on 12 August, 2010. He sought and was prescribed an anti depressant medication and the general practitioner completed a mental health care plan/assessment. When he returned on 16 August 2010, Mr Pichler described a lack of motivation and energy, insomnia and lack of appetite. He appeared more distressed in the context of information he had obtained about the side effects of his medication. The general practitioner telephoned a psychologist requesting an appointment for Mr Pichler within the next few days, although he was satisfied that Mr Pichler was not at risk to himself. The general practitioner also advised Mr Pichler to seek some legal/financial advice.
4. On 18 August 2010, Mr Pichler attended an appointment with his accountant in the morning. He subsequently reported to Lexis that he had been advised to sell some of their investment properties.
5. Later that day, at approximately 5.00pm, Mrs Pichler left their home to travel into the city to meet her sister to attend a cinema. When she arrived home later that evening she noticed that the family Volvo was not in the driveway. When she entered the home she found that her husband was absent. Mrs Pichler located a note which stated "*I have gone to Spring St. Bye! xx M.*" Mrs Pichler was immediately concerned for her husband's welfare. She telephoned for a taxi and Emergency Services

requesting the assistance of police. Mrs Pichler was concerned that her husband may have already committed or was attempting suicide.

6. Senior Constables Sharp and Jennings met with Mrs Pichler at the apartment building in Spring Street, and entered the secure building with Mrs Pichler. As they travelled to the 9th floor together, where the Pichler apartment was situated, Mrs Pichler provided details to the police of her suspicions of her husband's impending suicide. When they arrived on the 9th floor Senior Constable Jennings took the keys to the apartment from Mrs Pichler and moved ahead to open the front door. When the police entered the apartment, the lights were turned on and the police could see a balcony ahead of them. Almost simultaneously they heard a thud coming from outside. Senior Constable Sharp moved to the balcony and observed Mr Pichler on the ground below. Senior Constable Sharp moved quickly to where Mr Pichler was lying on the ground, but found him deceased. Senior Constable Jennings remained in the apartment with Mrs Pichler.

### **Investigations**

7. Dr Matthew Lynch, Forensic Pathologist with the Victorian Institute of Forensic Medicine, performed an external examination on the body of Mr Pichler and reported that his findings were consistent with injuries sustained in a fall from a height. Dr Lynch also reviewed a post mortem CT scan, which revealed multiple fractures involving the skull. Dr Lynch reported to the coroner that in the absence of a full post mortem examination a reasonable cause of death in the circumstances could be attributed to injuries sustained in a fall from height. Toxicological analysis identified the anti depressant medication Sertraline (Zoloft) at a level consistent with the therapeutic range.

8. The police investigation located notes that appeared to have been written by Mr Pichler enclosing detailed financial instructions to his wife, along with directions similar to those contained within a Will. The pot-plant on the balcony at the Spring Street apartment appeared to have been moved enabling Mr Pichler access to climb over the handrail. No suspicious circumstances were identified.

9. The Homicide Squad of Victoria Police conducted an investigation given the close proximity of police at the time of Mr Pichler's death. The internal investigation concluded that the police action on 19 August 2010, was appropriate and in line with the training that the attending members had been provided.

### **Jurisdiction:**

10. In the preamble to the *Coroners Act* 2008 the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for the purpose of finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety are referred to in other sections of the Act.<sup>1</sup>

<sup>1</sup> See for example, sections 67(3) & 72 (1) & (2)

11. Section 67 of Act describes the ambit of the coroner's findings in relation to a death investigation. A coroner is required to find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.<sup>2</sup> The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

12. A coroner may also comment on any matter connected with the death, including matters relating to public health and safety and the administration of justice.<sup>3</sup> A coroner may also report to the Attorney General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with a death which the coroner has investigated including recommendations relating to public health and safety or the administration of justice.<sup>4</sup>

### **Inquest:**

13. An Inquest was held pursuant to section 52(1) *Coroners Act* 2008. No witnesses were called. A summary of the circumstances and relevant issues were dealt with by way of summary from Senior Sergeant Brumby, Assisting the Coroner. Mrs Pichler was present in Court and indicated that she was satisfied with the accuracy of the summary.

### **Finding**

I accept and adopt the cause of death as identified by Dr Matthew Lynch and find that Michael George Pichler died from injuries sustained in a fall from height.

~~AND I find that the fall from height occurred in circumstances where Mr Pichler intended to take his own life.~~

AND I find no relationship between the presence of police and the cause of Mr Pichler's death and that at all times police were acting appropriately and in response to a request from Mrs Pichler for assistance.

AND further, although Mr Pichler had recently sought treatment for anxiety and depression, there is no evidence to support a finding that his death was preventable.

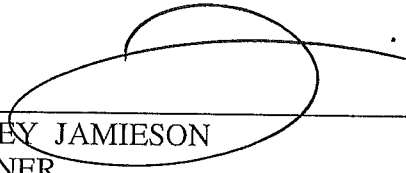
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<sup>2</sup> Section 67(1)

<sup>3</sup> Section 67(3)

<sup>4</sup> Section 72(1) & (2)

Signature:



AUDREY JAMIESON  
CORONER

22 November 2011

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

Mrs Lexis Pichler  
Senior Constable Jennings  
Senior Constable Sharp

