CORONERS COURT

NEW SOUTH WALES

Inquest:	**Inquest into the death of SR**
Hearing dates:	18-20 March 2015
Date of findings:	2 April 2015
Place of findings:	State Coroner's Court, Glebe
Findings of:	Deputy State Coroner HCB Dillon
Catchwords:	**CORONERS –– Death in police operation** – Mandatory inquest – Cause and manner of death – Self-inflicted harm – Fall onto railway car from bridge – Emergency electrical power stoppage by Sydney Trains – Whether process efficient – Performance by Sydney Trains staff – Performance by NSW Police officers
File number:	2013/00246399

Representation:	Mr I Fraser (Counsel Assisting) instructed by Ms L Molloy (Crown Solicitor's Office) Mr D Jordan SC instructed by Ashurst (Sydney Trains) Mr B Haverfield instructed by Mr S Robinson, Office of the General Counsel (NSW Commission of Police) Parents of SR (unrepresented)
Findings:	I find that SR died on 13 August 2013 at the St George Hospital as a result of a combination of blunt force injuries to his chest and head, occasioned when, with the intention of taking his own life, he deliberately jumped from a railway bridge into the path of a train approaching Kogarah Railway Station. He subsequently fell from the roof of the train onto the station platform during the course of a police rescue operation, striking his head.
Non-publication orders:	Pursuant to ss 74 and 75 Coroners Act, ordered that there be no publication of any material that may identify SR, any of his relatives or EC.

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IN THE CORONERS COURT
GLEBE
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This is an inquest into the death of SR on 13 August 2013 at the St George Hospital. He was only 18 years old when he jumped from a railway bridge at Kogarah in an attempt to commit suicide by landing in front of an approaching train. He was hit by the train but landed badly injured on the roof. Before he could be safely rescued, he fell from the roof of the train onto the platform, sustaining a serious injury to his head.

2. All inquests, of their nature, are distressing but this one was particularly agonising for a number of reasons. SR was young and heartbroken; he was not killed instantly as he appears to have hoped he would be; his suffering on the roof of the train was witnessed by large numbers of people who were unable to approach him due to the high voltage wires above the train; and he fell from the roof of the train only a minute or two before a rescue team arrived on the scene. Railway staff and police officers who were at the scene were traumatised by SR's death. Several of them broke down when giving evidence at the inquest, a most unusual scene in a courtroom. All of them had been deeply moved by SR's death and by their inability to save him.

SR

3. As a child, SR had been a polite, cheeky boy with a sense of fun. He was much-loved by his many friends who continue to remember him and mourn him. He was generous and big-hearted. In the months after he completed his HSC in 2012, however, he underwent a number of very stressful experiences, including the break-up of his relationship with his girlfriend. He also revealed that he had been the victim of sexual assault by a relative and he was bashed and robbed by an acquaintance, suffering severe facial injuries. The robbery, which was committed by someone known to SR, left a significant psychological mark on him as well. It is unnecessary to dwell on those details except to say that they obviously played on SR's mind.

4. By May 2013, it appears that SR had begun to contemplate suicide. That month he was assessed at the Shellharbour Hospital and diagnosed as suffering a major depressive illness. He was admitted to the hospital where he continued to think to about suicide for some time. By June, however, he appeared to be more settled. He was discharged from the hospital on 11 June into the care of his mother but he went to live with his grandmother in Kogarah. He had a job installing shade cloth.

5. After his discharge, although he appears to have been compliant with his prescription medications, he was also smoking marijuana regularly and using alcohol perhaps in an effort to make himself feel more relaxed and at ease.

6. In August, SR's mental health seems to have deteriorated. He gave up his job and was sleeping into the afternoon. He also began disclosing information to his father that, in retrospect, might be interpreted as his way of getting certain things in order before he took his own life. One of the many tragic aspects of his death is that his life was cut short before he had developed the experience of life that would have taught him that he could live through periods of heartbreak and disappointment.

The coroner's functions and the nature of the inquest

7. A coroner's primary role is to investigate sudden and unexpected deaths with a view to identifying the person who has died; the date and place of his or her death; the cause of death and the manner or circumstances in which that death took place. Under s. 23 of the *Coroner's Act 2009*, an inquest is mandatory when a death occurs as a result of, or in the course of, a police operation.

8. In a society in which the rule of law prevails, a police force is not a law unto itself. It is accountable to the society it serves to protect. It has been observed that:

> *"The purposes of a s.23 Inquest are to fully examine the circumstances of any death in which Police …… have been involved, in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."* (Waller's Coronial Law & Practice in New South Wales 4th Edition at para [23.7] (page 106))

9. The purpose of an inquest of this nature is to discover the facts behind a sudden and unexpected death that occurs during the course of a police operation and to draw whatever conclusions are appropriate from those facts. This inquest is not a quasi-criminal trial of the involved officers or railway staff. Nor is it a witchhunt or a whitewash. Rather it is an inquiry into how it happened that SR died while an operation was being carried out with the intention of saving his life.

The issues

10. Apart from the statutory issues (identity, date and place of death, cause and manner of death), this inquest has investigated a number of issues related primarily to the manner or circumstances of SR's death:

- What were the circumstances of SR' death? In particular:
    i. What were the circumstances of SR being struck by the train?

ii. What were the circumstances regarding SR's fall from the train onto the platform?

iii. How long did it take for Sydney Trains staff to remove power from the relevant section and to issue a Rescue Power Outage clearance confirming its removal, and what communication took place in this regard?

- What are the applicable policies and procedures of Sydney Trains, and were those policies and procedures complied with?
- Has Sydney Trains made any changes to policies or procedures in response to this incident?
- Was the response of Police appropriate?

What happened? The circumstances of SR's death

11. On 13 August, SR's father had planned to work with SR doing some painting. SR, however, was not feeling well, or so he told his grandmother and father. When Mr R spoke to SR at about 11.30 he thought that SR sounded upset.

12. One of the main reasons that SR was upset was that he was still trying to keep in touch with his ex-girlfriend EC and could not adjust to the break-up she had initiated. He had a very emotional conversation with his mother about this and other matters troubling him before walking out of the house some time after 1pm.

13. At about 1.50pm, SR called EC from the railway bridge at Kogarah. He was crying as he spoke to her and told her that he was going to jump.

14. At about 2pm, a train approached the bridge from Rockdale Station. It was travelling at about 80 kph. About 200-300 metres from Kogarah Station, the driver, Mr Mark McLachlan, who was about to start braking anyway, saw SR standing on a safety platform attached to the bridge. He believed that SR was going to jump so he immediately applied the emergency brakes.

15. EC was still on the phone to SR at this time. Over the phone she heard the train approaching and called out to SR not to jump. He did not answer her. Then she heard a loud bang.

16. SR had mistimed his jump so that instead of landing in front of the train, he hit the destination board and was thrown onto the roof, receiving significant internal injuries as he did so.

17. The train pulled into Kogarah Station with SR lying on the roof. He was in great pain and asking for help and for someone to call his mother. The station duty manager, Ms Mannal Papacostas, and PC Sen Con Benjamin Short, who was on the platform waiting for a train, tried to reassure SR and keep him reasonably calm and on top of the train while emergency services came to rescue him and Sydney Trains worked to isolate the overhead power lines to enable emergency services personnel to climb onto the roof and rescue SR.

18. PC Sen Con Short called '000' to ask for emergency services to attend urgently. At least one other person, a school student who had witnessed SR's fall into the path of the train, also called '000'. These calls resulted in a number of police officers rushing to the station from the Kogarah Police Station and the local area. The Ambulance and Fire & Rescue services were also despatched.

19. While this was being done, the police officers on the platform tried to find ways of improvising some protection for SR. Unsuccessful attempts were made to find something to cushion his fall and to improvise a way of reaching him to keep him steady on the top of the train. There were no ladders of sufficient length and no other things immediately available at the station that would have enabled police or anyone else to climb to the roof. Police cars are not equipped for a complex rescue operation involving high-voltage electricity.

20. This may have been fortunate because PC Sen Con Short told the inquest that he would have liked to climb up and hold SR where he was until rescue teams arrived. But this may have placed both of them at risk from the overhead lines. One of the lesser known hazards of high-voltage electricity lines is that it is not always necessary to touch the line to be electrocuted. Because electricity will always seek the quickest way to earth, it can arc from a high-voltage line towards a person who approaches too close. If a person is in the course of being electrocuted, a second person touching that person will also be electrocuted. It was necessary both to de-energise the overhead lines and to await the arrival of rescue specialists before SR could be lifted from the roof of the train.

21. The procedure for isolating sections of the power lines for Sydney trains is complex and requires strict safety guidelines to be followed. I will deal the question of how the power line at Kogarah was isolated and why it took 17 minutes before emergency services personnel were cleared to climb onto the train roof in more detail below. The critical fact, however, is that for that period, due to the dangers of high voltage lines, emergency services were unable to secure and rescue SR.

22. At about 2.18pm, SR sat up on the train roof, shifted his legs over the side of the train, then slipped and fell onto the platform. PC Sen Con Short was unable to catch him as he fell. He struck his head on the platform in front of Leading Sen Con Mark Butler, who had been talking to SR. LSC Butler immediately cradled SR's head. In one of the most moving moments of the whole inquest, he described making eye contact with SR who appeared to understand that another person was trying to look after him, then SR's eyes went blank. LSC Butler was in tears as he described this moment.

23. Dr Chris Georgiou and Nurse Carla Colarusso, who were passengers at the station, immediately attended SR and assisted PC Sen Con Short and LSC Butler to stabilise him until paramedics arrived about four minutes after SR had fallen.

24. SR was transported to St George Hospital but he had sustained fatal injuries and could not be resuscitated. He was diagnosed at the hospital as suffering a catastrophic head injury. A later autopsy found, however, that SR had suffered multiple broken ribs and severe internal injuries. The forensic pathologist, Dr Kendall Bailey, who examined SR gave evidence at the inquest that the internal injuries alone would probably have been

fatal but thought that that a possible closed head injury SR suffered when he fell to the platform could not be excluded as a contributing factor. . Dr Peter Grant, the emergency physician who had carriage of SR's case at St George Hospital, reviewed the x-rays taken during the limited autopsy and agreed, stating:

> I would concur with Dr Bailey's finding of blunt force injury as the cause of death. It would also be my opinion that the witnessed closed head injury was likely to have been a contributing factor.

How did Sydney Trains respond?

25. Apart from applying emergency brakes, the driver of the train, Mr Mark McLachlan, notified the rail operations centre by hitting the emergency button on the train's radio, and then spoke with the relevant signaller. Two guards, one of whom was off-duty, realised that something had happened when the train came to a sudden stop. Both guards spoke to the Rail Management Centre to explain the situation. This set in motion the process of isolating and de-energising the section of power line supplying electricity to the train.

26. While that was being done, the duty manager of Kogarah Railway Station, Ms Pappacostas assisted police, especially PC Sen Con Short, in attempting to reassure SR that help was on its way, and to comfort him. In recounting what had happened that day, she broke down in tears. She behaved with great compassion and exemplary professionalism in very difficult and frustrating circumstances.

27. For both SR's family and myself as coroner, a live question was why the process took 14 or 15 minutes. In an emergency such as this one, it is self-evident that the power lines ought to be de-energised and isolated as quickly as is consistent with the safety of emergency personnel, railway staff and, of course, members of the public involved.

28. I was told during the inquest that the current process had been developed following the Waterfall railway disaster in 2003 and the subsequent Special Commission of Inquiry headed by The Hon Peter McInerney QC. During the Waterfall incident, due to fears that they may be electrocuted, it had taken about an hour and a half before ambulance officers, police and others could undertake rescue operations safely.[1] The Waterfall Commissioner, not surprisingly, found this to be unacceptably long.

29. The current process was explained by Mr Paul Cassar, the control and co-ordination manager at the Infrastructure Control Centre (ICON) at Central Station and Mr Christopher Huntley, an Electrical System Operator with Sydney Trains.

30. According to Mr Paul Cassar, a highly experienced railway engineer, Sydney Trains is one of the few railway networks in the world that uses a Rescue Power Outage process even in life-threatening situations. Rescue Power Outage process does not physically disconnect high-voltage overhead wires from the electricity supply. From the ICON centre, using a computer system, electrical systems operators can de-energise sections

[1] See *Special Commission of Inquiry into Waterfall Rail Accident Final Report* Vol 1, Sydney 2005 pp 71- 75.

of line by remotely operating circuit-breakers. Evidence was given by Mr Cassar and two electrical system operators, Mr Huntley and Mr Vladimir Blagus, that this process does not necessarily result in a complete loss of power for various reasons. For example, insulators may not work properly due to rainwater or dust interfering with them. Only a complete physical isolation of the section, including earthing the overhead wire to the train line, absolutely guarantees that the overhead wire is safe to approach.

31. For this reason, only expert rescue teams, which have been trained to work in high-voltage areas, and which are equipped with appropriate protective equipment and clothing, are permitted to work close to de-energised overhead wiring during a Rescue Power Outage.

32. Mr Huntley was on duty at the ICON centre on the afternoon of 13 August 2013. At 2.03pm the electrical system operators were telephoned by a train controller at the Rail Management Centre who told him there was a person on top of a train at Kogarah Station and that they needed to "drop the power".

33. A group of four electrical system operators work each shift at ICON. They control the electrical supply for the whole Sydney Trains network. The system runs on 1500 volts DC. An electrical cable carrying enough energy to drive trains will instantaneously deliver a fatal electrical shock to any human being who touches it.

34. Before anyone could approach SR on the top of the train, therefore, the section of overhead wiring above him had to be isolated and de-energised by the use of circuit-breakers that are located at various points along the network. Shutting down a busy section of the Sydney Trains network has ramifications for the whole network. Train controllers, signallers and electrical system operators must work together as quickly as possible both to remove the life-threatening hazard but also to ensure that trains do not continue into the area that is being isolated.

35. A train that crosses from an energised section of overhead wire into a de-energised section may bridge the two sections and re-energise the isolated section. For safety reasons, therefore, it is critical that buffer zones be created around the section of overhead lines that is being isolated. Train controllers must communicate with trains and with signallers to manage the movement of trains in and approaching the critical zone. (They must also, of course, manage the flow-on effects, but they come later once the emergency has been dealt within the isolated section of line.)

36. Once the call was received in the ICON, all four of the electrical system operators on duty worked together to identify the section of line to be isolated. Each electrical system operator has a set of A3-size diagrams for the whole of the network. The team in the ICON was a very experienced group and knew exactly which diagrams were needed. The diagrams show, among other things, the locations of all circuit-breakers and their identifying numbers.

37. In an emergency, all the electrical system operators work together in checking diagrams, cross-checking and communicating with the train controllers.

38. The isolation of the overhead line above the train on which SR was lying was completed by about 2.06pm. In total, 19 circuit-breakers had been opened. Mr Huntley called Operations at 2.06pm and notified them that the power supply between Wolli Creek and Rockdale on the 'down Illawarra' line (the line to Wollongong) and all tracks between Rockdale and Carlton (a buffer zone) was down.

39. In his statement Mr Huntley then explained the checking process that is carried out before rescue crews are permitted to work under overhead lines:

> After dropping the power urgently, we have to go back through the diagrams in a careful manner to check that we had de-energised everything that we needed to and that it had been done correctly. At the same time, we continue to perform our other duties as electrical system operators (which include dealing with telephone and alarms which are raised in [the computer system that controls the electrical system]. When an incident occurs, it is a dynamic situation and is dealt with differently each time depending on the circumstances at the time include the complexity of the lines required to be de-energised and workload.
>
> The general process for reviewing the area that has been de-energised involves identifying the location of the incident, identifying the required sections to be de-energised, checking the diagrams for the correct sections to de-energise and checking that the correct circuit breakers have been opened on the [computer] system. Once this is verified, the information is written onto the Rescue Power Outage [RPO] form. In completing the form, you are usually undertaking a further check that the correct circuits have been de-energised and that no additional circuits should be de-energised. These checking processes are important because we need to be sure that the circuits which are de-energised are correctly identified and effective before allowing rescue workers to access the area…
>
> The usual process is that another person would check the RPO form and sign it as checked…

40. Mr Huntley stated that the usual process had been followed on the afternoon of 13 August 2013 and that 'the RPO was issued as quickly as possible'. Until the RPO is issued and notified to Operations rescue crews are not permitted into the affected zone.

41. In retrospect, although it made no difference to the outcome for SR, the process would probably have been accelerated if Mr Huntley had not also started to arrange for field staff to attend the relevant sub-station while simultaneously taking responsibility for completing the RPO document. Perhaps a couple of minutes or so could have been shaved off the time taken. This was conceded by Sydney Trains to be a lesson learned.

42. That said, because we do not know what else was going on at the time Mr Huntley made those arrangements with field staff, or whether someone else was available to do that task, it would be unfair to criticise Mr Huntley on this point.

43. Could the original check by Mr Huntley have been conducted more quickly? This was a question only raised by Mrs R in final submissions. She pointed out that, according to the documentary evidence presented to the court, Mr Glen Royles (who had not given

oral evidence or been questioned), had apparently completed the cross-check within a couple of minutes of Mr Huntley filling out the RPO form.

44. Her question was a reasonable one but came after the conclusion of the evidence. Adjourning the inquest to obtain further evidence would have delayed concluding the inquest for several months. I have decided not to do that.

45. Nevertheless it appears to me that the answer to the question is reasonably straight-forward. Mr Royles was working on the same problems as Mr Huntley. He would have been able to cross-check Mr Huntley's RPO form because he had access to all the diagrams and computer pages as well as Mr Huntley. In his statement, Mr Royles indicates that he may have assisted Mr Huntley with the process as he prepared the form, but he now cannot recall. He may have taken his own notes of the various circuit-breakers he had opened and other operations he had performed. By the time that he cross-checked the RPO form, he was obviously familiar with that section of the network because he had been working on it himself. Anyone familiar with an environment can move through it much more quickly and efficiently than a person exploring it for the first time. Further, in practical terms, some of Mr Huntley's work had already been cross-checked by Mr Royles as Mr Royles had been working on those sections himself and checked them previously. While we do not have it directly from Mr Royles or Mr Huntley or Mr Cassar, therefore, it does not appear to me to be surprising that the final RPO cross-check could be completed within a much shorter time than the original emergency removal of power, or the initial RPO check completed by Mr Huntley.

46. Unfortunately, just before that notification could be issued, SR fell to the platform. A NSW Fire Brigade rescue team arrived a few minutes later.

How was the police operation conducted?

47. While a significant number of police officers were involved in the incident, only a few had any direct involvement with SR. PC Sen Con Short was off-duty, waiting on the platform when he heard a loud bang as the train approached the platform. He saw a person on the roof. He called the '000' emergency line and spoke to SR who was in pain, telling him to stay where he was because help was on the way.

48. A short time later a number of other officers arrived but were unable to mount the roof of the train because they were warned that the overhead wires should be regarded as live until verified by Sydney Trains. All the officers on the platform were concerned for SR's safety and several times officers encouraged him to stay where he was and to try to relax while help was coming. Inspector Rafic Ajaka tried to find a mattress or cushion to place on the platform underneath SR in case he fell but was unable to.

49. Evidence was given by Ms Papacostas that railway stations do not generally have ladders or mattresses or such items because they might be used for inappropriate and, indeed, dangerous purposes by unauthorised people.

50. A crew from Fire & Rescue NSW was also despatched but, like the police, they would have been unable to ascend to rescue SR until given clearance to work underneath the

overhead electricity lines. As it happened, the clearance was given a very short time before they arrived on the scene.

51. A question that occurred to members of SR's family was whether the police officers who were on the platform when SR fell could have done more to catch him or break his fall. PC Sen Con Short in fact tried to do that but found it impossible to hold SR. Unfortunately, the laws of physics are very rigid and unforgiving. The force that struck PC Sen Con Short as he tried to catch SR was very great. SR weighed about 92 kgs. He fell from a height of about three metres. In this situation, force is measured in Newtons by the formula *mass x acceleration*. A *newton* is the force needed to accelerate one kilogram of mass at the rate of one metre per second squared. Gravity causes falling objects to accelerate at a rate of about 9.8 metres per second.

52. Even with some friction being applied as he slid off the train, it would have taken SR less than a second to hit the platform once he fell. Due to the variables involved, without conducting a scientific test it is impossible to measure or even estimate the force that struck PC Sen Con Short but it must have been very substantial. It took considerable courage even to attempt to catch SR. Catching him was physically impossible and breaking his fall was not much easier even if everything had gone well.

53. In both his witness statement and his oral evidence at the inquest, LSC Butler described stepping back when SR fell as he was concerned about being injured. In my view, LSC Butler, not a very large man and 57 years of age, probably acted instinctively when he did so. He had only a split second in which to react. If he flinched, this is not surprising: falling towards him was a large young man weighing over 90 kgs from a height of approximately three metres.

54. If at that moment LSC Butler had attempted to help PC Sen Con Short this may have helped marginally but he also may have impeded Short's attempt to help SR. There was almost no time for LSC Butler to prepare or brace himself as SR fell. He had a split second only in which to react both to SR falling and Short lunging forward to try to catch SR. In such circumstances, although he appears to be highly self-critical, I do not believe that he is deserving of criticism. In my view, LSC Butler demonstrated considerable moral courage in frankly stating that he had been frightened by SR's fall. His caring attitude towards SR both before and after SR's fall deserves commendation and respect. He behaved, as did other police officers and railway staff, like Good Samaritans, caring for and showing compassion to a badly hurt stranger. Unfortunately, neither he nor PC Sen Con Short were blessed with superhuman strength as well.

55. In my view, the involved officers behaved as well as anyone in such a situation could be expected to. They had the agonising experience of watching and speaking to SR trying to soothe him as they waited for a rescue team to arrive and for notification that the live wires powering the train had been isolated and de-energised. It was obvious to all who saw the police witnesses who gave evidence that the officers were deeply affected by SR's death and their experience of being unable to save him at the station. They were all experienced officers who had previously attended scenes at which people had committed suicide on railway tracks but this was an entirely novel situation for them

and the railway staff – very few people survive being hit by a train. None of them had faced the situation of such a person lying injured on top of a train.

56. In summary, the police operation was conducted as well as the circumstances allowed. The officers immediately on the scene reacted quickly and efficiently to arrange for a rescue team to attend urgently. They identified the danger to SR as he lay on the roof of the train and they sought to reassure him that help was on the way and to keep him as calm as possible. They also sought, to no avail, to find things with which they could improvise a soft landing for SR if he fell. Each of the officers who gave evidence deserves commendation for their humanity towards SR. His death was not their fault.

Conclusions

57. SR is no statistic but it is worth noting that last year, the Australian Bureau of Statistics reported that suicide is now the single most common cause of death among people in the 15-24 years age group. It is more common than deaths in motor accidents. More than 200 young men and 100 young women take their own lives in Australia per annum – about one every day.[2]

58. The Australian Institute of Health and Welfare (AIHW) has reported that intentional self-harm, including attempted suicide, is a substantial cause of hospitalisations in young people. In 2010–11, 26,000 people in Australia were hospitalised for intentional self-harm and, of these, 29% were aged 15–24. Young women aged 15–19 had hospitalisation rates for self-injury almost 3 times those for young men (421 and 141 cases per 100,000 respectively).[3]

59. In 2013, Kids Helpline, Australia's national telephone crisis and counselling service for those aged 5-25 years, facilitated 9,649 counselling sessions with children and young people who were assessed by the counsellor as having current thoughts of suicide. Kids Helpline also responded to 15,948 contacts from children and young people aged 5-25 years who were assessed to have self-injury and self-harming behaviour.[4] The objective fact is that Australian young people are at greater risk of death or physical harm from a major depressive illness than from war or terrorism. Governments recognise the problem and large resources have been and continue to be committed to it but it remains a most intractable issue.

60. The death of a troubled 18 year old in the circumstances of this case is a tragedy, not only for SR and his family and friends, but for the wider community. Despite the efforts of police and other emergency service personnel, of railway staff, and others who were more intimately involved in his life, he died very prematurely. We cannot know where SR's life may have led had he survived this incident but, given his good character, his generosity of spirit, his capacity for friendship and the obvious intelligence of his parents, which no doubt he inherited, we can assume that he would have grown into a young man with a real contribution to make to our society.

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[2]http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2013~Media%20Release~Changes%20in%20Australia's%20leading%20causes%20of%20death%20(Media%20Release)~10041

[3] *Australia's health 2014*. Australia's health series no. 14. Cat. no. AUS 178. Canberra, 2014 p.13

[4] Kids Helpline Overview 2013, http://www.kidshelp.com.au/upload/22957.pdf

61. SR was much-loved by his family and others who knew him. Their grief and pain due to his death has been increased by the manner of his death. Few experiences are more agonising for parents and families than the loss of a child. And a death by suicide of a young person is even more troubling. I hope that their many happy memories of SR, of his love for them and theirs for him, will in time ease the heartbreak and sadness his family and friends feel. And I hope that they will also accept my very sincere condolences.

Findings s 81 Coroners Act 2009

62. I find that SR died on 13 August 2013 at the St George Hospital as a result of a combination of blunt force injuries to his chest and head, occasioned when, with the intention of taking his own life, he deliberately jumped from a railway bridge into the path of a train approaching Kogarah Railway Station. He subsequently fell from the roof of the train onto the station platform during the course of a police rescue operation, striking his head.

Magistrate Hugh Dillon
Deputy State Coroner