**FORM 38**

Rule 60(2)

**REDACTED FINDING INTO DEATH WITHOUT INQUEST**

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

**Court reference:** 3651/09

In the Coroners Court of Victoria at Melbourne

I, PARESA ANTONIADIS SPANOS, Coroner

having investigated the death of:

**Details of deceased:**
Surname:
First name: B
Address: Langwarrin, Victoria 3910

without holding an inquest:

find that the identity of the deceased was B also known as B born on the 2nd February, 1992

and that death occurred on or about 27th July, 2009

at Langwarrin, Victoria 3910

from: 1(a) HANGING

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. B was a 17 year old secondary student who resided with his family. He had no significant medical history and no known depression or other psychiatric illness. According to his family, B was usually happy, loved a good laugh and loved to party, but had grumpy moments like any 17 year old.

2. On 27 July 2009, B's mother returned home from work at around 3:20pm. She opened the garage door to drive her car in as usual, and found B hanging from one of the rafters, with a ladder nearby. Emergency services were called by a neighbour, but ambulance officers arrived to find B already deceased. Police also attended and commenced their investigation of B's death. This finding is based on the investigation and brief of evidence compiled by one of the attending police officers, Constable Kristen Fyans, from Frankston Police Station who concluded that there were no suspicious circumstances and that B had intentionally taken his own life.

3. Police ascertained that B had been in a boyfriend-girlfriend relationship with a 14-15 year old girl for the twelve month period preceding his death. According to his family, the relationship had been somewhat volatile, culminating in a breakdown of the relationship on or shortly prior to 27 July 2009. On that and the preceding day, there had been an exchange of angry and abusive text messages and mobile phone discussions between B and his girlfriend. Included in these exchanges were implied threats made by B (at around 1:00pm on 27 July 2009), to self-harm or take his own life. His girlfriend notified B's brother of her concerns, but it was too late.

4. On the same day, B was in communication with his best friend, RR, via social networking media (MSN). RR told police that he thought B seemed depressed about the break-up of his relationship, 'over everything and sick of life', but he did not say anything about harming himself. RR replied to B's message by offering to go around after work, but the message was never received by B who had already logged off.

5. Police investigations included examination of B's mobile phone and computer. They found a long letter apparently written by B to his girlfriend indicating his emotional investment in the relationship, but no suicide note.

6. There was no autopsy as Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine performed an external examination in the mortuary, reviewed the circumstances and advised that it would be reasonable to attribute B's death to hanging, without the need for an autopsy. Dr Bedford identified a ligature mark and the ligature in situ, consistent with hanging, and found no evidence of natural disease or other traumatic injury.

7. Toxicological analysis of postmortem samples revealed no alcohol or other commonly encountered drugs or poisons.

8. I find that B intentionally took his own life by hanging.

COMMENTS:
Pursuant to Section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. In light of the circumstances in which B died, I asked the Coroners Prevention Unit (CPU)[2] to provide me with a report on suicides among school-aged youths. I made this request in the face of increasing media reporting of youth suicide, in order to ascertain whether youth suicide rates were in fact increasing, recognising that publicly available information on youth suicides is limited, and that it can be difficult to sort fact from opinion, in what is available. I was also concerned to identify any common features or trends which might inform efforts to develop prevention strategies in relation to youth suicide.

[2] The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public heath and safety.

2. The major findings of the CPU report were as follows -

2.1 In the period 2000-2010, suicides among those aged 13-18 comprised only a very small number (well under 5%) of all Victorian suicides, lower than for any other age group. Despite some fluctuation from year to year, the annual suicide rate among school-aged youths generally remained steady between 2000-2010, neither increasing nor decreasing.

2.2 There was a clear gender imbalance, with males comprising 68.0% and females 32.0% of all suicides in this group. Most of the youths were aged 16-18 (78.7%), the rest were aged 13-15 (21.2%). More youth suicides occurred in metropolitan regions (55.9%) than in rural regions (44.1%). However, considering the population imbalance between metropolitan and rural Victoria , the youth suicide *rate* was more than two times higher in rural regions than metropolitan regions. Most of the youths were students (59.9%) compared with 22.5% who were not studying but were otherwise employed.

2.3 Most youths suicided at their place of residence (59.0%) or at locations within easy walking distance of their place of residence (34.2%). There were no obvious differences in suicide method between older and younger youths, nor between youths living in rural and metropolitan regions, while the only notable gender difference was that a disproportionately high number of males used a firearm than females.

2.4 In almost two thirds (64.4%) of youth suicides, the deceased had communicated a desire or intention to suicide in either a discussion with a family member or friend, a note, a mobile phone text message, a posting on a social network website or some other means. Eighteen per cent had previously attempted suicide and 16.7% had previously engaged in self-harming behaviour.

2.5 In almost two thirds (64.4%) of youth suicides, the deceased had been exposed to at least one documented traumatic event or experience that may have been contributory, with the three most commonly occurring events or experiences being (in order) relationship breakdown, family conflict and challenges accompanying life transitions.

2.6 Where, as in 55.4% of youth suicides the deceased suffered a diagnosed or suspected mental illness, overwhelmingly the mental illness was depression. Additionally, 24.8% had a history of substance use or abuse, broadly defined. Alcohol was detected during postmortem examination in 16.2% of youth suicides and illicit substances in 13.2%.

2.7 There was, however, no *typical* socio-demographic profile of youth suicides between 2000 and 2010. The suicides occurred at all socio-economic levels, among youths with a wide variety of cultural and ethnic backgrounds, and diverse family structures and living arrangements.

2.8 Similarly, a wide variety of circumstances and behaviours preceded the youth suicides. For example, whereas in 64.4% of suicides the youth had in some way communicated or discussed their intention, 35.6% gave no such indication. Possible *triggers* for suicide ranged widely and included the deaths of family and friends, health problems, bullying, issues with sexual identity, relationship breakdowns, financial problems, commencing at a new school, mental ill health and social isolation. Furthermore, in a significant minority of suicides (at least 27.0%) there was no identified trigger or motive for the suicide.

3. The CPU report concluded that over the past decade, suicide among school-aged youths in Victoria has been a relatively rare event, and has occurred at a steady rate. Some recent commentary and media coverage has created the impression that youths are at elevated risk of suicide and that Victoria may be in the grip of a youth suicide epidemic, but the data does not support this.

4. The challenge is to interpret this data correctly. While some may take comfort, others may view this as cause for concern. For example, it could be said that funding and efforts directed towards youth suicide prevention initiatives have not notably decreased the youth suicide rate. An equally plausible explanation is that these initiatives have prevented a rise in the suicide rate. Whatever the case, every youth suicide has an impact on the family and friends of the deceased, as well as the wider community. Youth suicide is inarguably an important public health and safety issue, and prevention initiatives should continue.

TARGETED OR UNIVERSAL PREVENTION STRATEGIES?

5. At present, much of the discussion on youth suicide prevention appears directed towards identifying *at risk* groups for targeted interventions. The CPU report carries a number of implications in this regard. For example, the research confirms that many known risk factors for youth suicide - including particularly mental illness, previously expressed suicidal ideation, exposure to traumatic events and experiences, and relationship breakdowns - appear to be commonly present amongst youth suicides in Victoria, but this does not substantially advance our ability to predict suicide. Every year, thousands of young Victorians suffer a mental illness, for example, or break up with a boyfriend or girlfriend, but do not suicide in response. There would be gains to public health and safety therefore, if youth suicide research could re-direct some focus beyond identifying and quantifying the presence of known risk factors, to understanding why one youth may suicide in circumstances where others do not.

6. As already noted, there is no typical socio-demographic for youth suicide, possible triggers proximal to the suicide were highly diverse and in a large number of suicides, there was no prior declaration of intent and/or apparent triggers. Prevention strategies targeted towards *at risk* groups, whether based on socio-economic, demographic, behavioural, medical or other grounds, may not reach a number of those youths who suicide. It follows that there would seem to be a place for universal, as well as targeted, prevention strategies.

7. The death of B shared certain commonalities with a number of other Victorian youth suicides that occurred between 2000 and 2010. B was a secondary school student who was upset over a recent break-up with his girlfriend. He took his own life by hanging, in the garage of his family home, after expressing his intention to take his own life via mobile phone message. In noting these commonalities, the intention is not to rob B of his identity as an individual whose death was a great tragedy and loss to his family, friends and the wider community to which he belonged. Rather, it is to highlight that our understanding of youth suicide is incomplete and that what we lack is an understanding as to why B and a number of others have ended their lives when faced with circumstances that, at one stage or another, most Victorian school-aged youths will experience.

DISTRIBUTION LIST

- Dr Alison Clegg, Secretary, House of Representatives Standing Committee on Health and Ageing, the Parliament of the Commonwealth of Australia
- Ms Fran Thorn, Secretary, Victorian Department of Health
- The Hon Mary Wooldridge MP, Victorian Minister for Mental Health
- The Hon Mark Butler MP, Federal Minister for Mental Health and Ageing
- Ms Wendy McCarthy AO, Chair, Headspace National Youth Mental Health Foundation
- The Hon Nicola Roxon MP, Minister for Health and Ageing
- Dr Michael Dudley, Chairperson, Suicide Prevention Australia
- Ms Barbara Hocking OAM, Executive Director, SANE
- Ms Michelle Noon, Youth Program Manager, Youth BeyondBlue

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: 10 August, 2011