IN THE CORONERS COURT
OF VICTORIA
AT GEELONG

Court Reference: COR 2009 003500

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: CHANELLE AMY RAE

Delivered On:	28 November 2014
Delivered At:	Coroners Court of Victoria Railway Terrace, Geelong Victoria 3220
Hearing Dates:	18 - 20 November 2013
Findings of:	JUDGE IAN L GRAY, STATE CORONER
Representation:	Ms E Gardner appeared on behalf of the Department of Education and Early Childhood Development
Police Coronial Support Unit Assisting the Coroner:	Senior Sergeant Jen Brumby.

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of CHANELLE AMY RAE

AND having held an inquest in relation to this death on 18 - 20 November 2013
at GEELONG
find that the identity of the deceased was CHANELLE AMY RAE
born on 22 May 1995
and the death occurred on 17 July 2009

from:

I (a) COMPRESSION OF THE NECK IN CIRCUMSTANCES OF HANGING.

in the following circumstances:

INTRODUCTION AND PURPOSE

1. This inquest examined the circumstances and contributing factors relating to the death of Chanelle Rae. Before I make my findings on these circumstances and factors, I wish to convey my sincere condolences to Chanelle's parents, Mr Ian and Ms Karen Rae and her family and friends. The unexpected death of a young person is devastating for parents, family and friends, and my purpose in holding this inquest was to explore whether any lessons can be learnt, which might prevent similar deaths in the future.

2. This prevention role is one of two parallel functions of the modern coronial system. The first involves the findings that I must make under the *Coroners Act 2008* (Vic), which requires, if possible, that I find the:

   - identity of the person who has died
   - cause of death (and for our purposes this usually refers to the medical cause of the death)
   - circumstances surrounding the death.

3. It is the investigation I am permitted to conduct surrounding the circumstances of a death that gives rise to my ability to consider broader issues of public health and safety. These considerations form the second parallel purpose of a coronial investigation into a death. This purpose has been enshrined in the Preamble of the *Coroners Act 2008* (Vic), which sets out that the role of the coroner should be:

   - to contribute to the reduction of the number of preventable deaths and
   - promote public health and safety and the administration of justice.

RELEVANT HISTORICAL FACTS

4. Chanelle was a 14-year-old female and was the youngest of three children to Ian and Karen Rae. There was no evidence that Chanelle had experienced any significant medical or mental ill health during her life or in the period proximate to her death.

5. Chanelle attended the Minerva Road campus of Western Heights Secondary College (WHSC). She had many friends at school and was well liked. Chanelle was heavily involved in the Geelong Football Club and would always attend weekend games.

CIRCUMSTANCES OF THE INCIDENT

6. On Thursday 16 July 2009, some conflict occurred between Chanelle and a group of her school friends, which resulted in the friendship group splitting. It appeared that they were able to resolve the conflict and returned to normal.

7. On Friday 17 July 2009, Chanelle attended school as usual, and was picked up by her father at the end of the day. He stated that she was in good spirits. At around 4.00pm when they arrived home, Chanelle spent some time chatting to friends online using 'MSN', an instant messaging service. Chanelle was in the computer room whilst Mr Rae was preparing dinner.[1]

8. Chanelle sat down with her family for dinner about two hours later, and was in good spirits. She returned to the computer after dinner and was chatting online with friends when she had an argument with a friend, which made her very upset. She left the computer and went to speak to her mother. Ms Rae stated that Chanelle said she wanted to die and recounted her argument with her friend online. Ms Rae stated that they spoke for about half an hour and that Chanelle then seemed okay, and left quite happy. Ms Rae stated that she believed Chanelle must have returned to the computer after their conversation.[2]

9. A short time later, at about 8.25pm, Mr Rae returned from visiting his next door neighbour. He noticed that the curtains in Chanelle's room at the front of the house were disturbed. Mr Rae went inside and went searching for Chanelle, and found her hanging by a black cable from the curtain rail in her bedroom. He called Ms Rae and they cut the cable to lift her down, called 000

[1] Statement of Mr Ian Rae dated 13 January 2010, page 1.

[2] Statement of Ms Karen Rae dated 17 October 2013, page 2.

and performed CPR under instruction of the telephone operator.[3] Paramedics arrived and continued CPR, but Chanelle was deceased.

10. Chanelle's death was one of three deaths heard as part of the inquest, the relevant factors for which will be the subject of separate findings. However, any overlapping circumstances and factors will be covered in all findings.

FINDINGS AS TO UNCONTENTIOUS MATTERS

11. In relation to Chanelle's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. Her identity, the date, place and medical cause of her death were never at issue. I find, as a matter of formality, that Chanelle Amy Rae, born on 22 May 1995, aged 14, died at her home on 17 July 2009.

THE MEDICAL CAUSE OF DEATH

12. Nor was the medical cause of death controversial. On 20 July 2009, an external examination of Chanelle's body was performed by Deputy Director of the Victorian Institute of Forensic Medicine (VIFM) Associate Professor David Ranson, who also reviewed the circumstances as reported by the police and post-mortem CT scanning of the whole body (PMCT). A/Prof Ranson noted the presence of a mark around the neck and, based on the circumstances and his findings, commented that a cause of death of *compression of the neck in circumstances of hanging* could be entertained. A/Prof Ranson did not find any evidence at PMCT of significant natural disease or laryngeal bony injury, and noted that no features of potentially significant injury, apart from the ligature mark, were seen on external inspection. Post mortem toxicological analysis of blood did not reveal the presence of ethanol (alcohol) or any other drugs or poisons.

FURTHER INVESTIGATION

13. The Coroner's Investigator, Senior Constable Shane Johnson prepared a brief of evidence comprising a series of statements from Chanelle's parents and friends. This also included an appendix of photographs of the incident scene.

14. During the investigation of Chanelle's death, it came to the attention of the Coroners Court of Victoria that seven persons[4] aged 18 years and under residing in the City of Greater Geelong

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[3] Statement of Mr Ian Rae dated 13 January 2010, pages 1-2.

had suicided during 2009, four prior to Chanelle's death and two after. This was compared to one in 2008 and one in 2007. It is also significant to note that there were no suicides amongst usual residents of the City of Greater Geelong aged 18 years and under in 2010, one in 2011, one in 2012 and two in 2013[5]. This retrospective examination of suicides amongst persons aged 18 years and under showed that during 2009, the City of Greater Geelong experienced a suicide cluster[6], as defined by the Centres for Disease Control and Prevention. On this basis, assistance was sought from the Coroners Prevention Unit (CPU)[7] to review the evidence provided by Victoria Police to identify and examine the presence and patterns of contributing factors to these deaths to inform recommendations for prevention.

15. The CPU review identified four factors that warranted further examination and / or input from external organisations:

    a. the presence and association between exposure to suicidal behaviour in the social network and an individual's risk of suicide.

    b. media treatment of youth suicide, including:

        i. the potential for media coverage of youth suicides to trigger further suicides among vulnerable and impulsive young people; and

        ii. the potentially intrusive and distressing nature of reporters' behaviour towards a grieving family whose child has suicided.

    c. the presence and role of bullying and cyber-bullying on youth suicide.

    d. the local post-vention response by:

        i. the Department of Education and Early Childhood Development (DEECD), including Western Heights Secondary College, and

        ii. Barwon Health.

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[4] Court Reference Numbers: 20090405; 20090665; 20091426; 20091767; 20093500; 20093966; 20094922.

[5] During this seven year period, the City of Greater Geelong experienced the highest frequency of suicides of young people aged 13-18 years in the State of Victoria. When the population of 13-18 year olds was accounted for, the City of Greater Geelong ranked sixth in the state for females (8.3 suicides per 100,000 population) and equal eighteenth in the state for males (6.7 suicides per 100,000 population).

[6] *A group of suicides or acts of deliberate self-harm that occur closer together in space and time than would normally be expected on the basis of statistical prediction and/or community expectation* (Centres for Disease Control, 1994).

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

16. The CPU coordinated the identification of and engagement with organisations and individuals who provided written submissions on the four factors. On the issue of media treatment of youth suicide I received information from the Australian Press Council (APC)[8] and the Hunter Institute of Mental Health (HIMH). On the issue of bullying and cyber-bullying I received information from the Alannah and Madeline Foundation. On the issue of the post-vention response, I received information from Barwon Health, the Barwon Adolescent Taskforce and the DEECD.[9]

17. Whilst the inquest examined the above factors, it should be noted that not all of the issues were relevant to all three cases.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

18. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Chanelle's death was on the circumstances in which she died. The inquest into Chanelle's death was held jointly with inquests into two other deaths, being Zac Harvey and Taylor Janssen. The inquest examined the circumstances surrounding each of the three young people, Zac Harvey, Taylor Janssen and Chanelle Rae, in the lead up to and immediately proximate to death.

19. The inquest was held jointly because the deaths of each of the young people were linked as they were all young adolescents who took their own lives at their homes, were students of WHSC at the time of their deaths, and their deaths all occurred in the same year. Both Zac and Taylor's deaths are also linked as they were in a relationship until shortly before their deaths.

Exposure to Suicide via the Social Network as a Risk Factor

20. In terms of exposure through social networks, there was evidence that some of the young people had attended or were current students of WHSC and were therefore known to each other. I asked the CPU to provide advice on the association between exposure to suicidal behaviour in the social network and an individual's risk of suicide.

21. The CPU identified and reviewed 54 original research studies conducted between 1967 and 2009 that examined the association between exposure to suicidal behaviour[10] in the social

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[8] The Australian Press Council is the peak organisation for promoting good standards of media practice as well as the principal body with responsibility for responding to complaints about Australian newspapers.

[9] Note that useful information was also received from a large number of other organisations to inform this investigation.

[10] Suicide behaviour was defined in accordance with the Centres for Disease Control and Prevention as: suicide, suicide attempt or suicidal ideation.

network[11] and an individual's risk of suicide. The CPU concluded that although no study reported evidence of a direct causal relationship between exposure to suicidal behaviour of a person in the social network and suicide, an association was reported in the majority of studies. Despite the absence of a cause and effect relationship, the CPU advised that a risk management approach should be applied immediately following a suicide in accordance with the established body of evidence on effective post-vention responses to maximise the safety of persons exposed to and affected by the suicide of an individual in their social network.

22. Chanelle's death occurred following the deaths, from suicide, of four other Geelong youths earlier in 2009. There was no evidence that Chanelle was personally acquainted with any of these individuals. However, Chanelle was aware of the deaths of Zac and Taylor, and was particularly touched by Taylor's death. At the inquest I heard evidence from Ms Karen Rae that Chanelle was exposed to information about Taylor's death via the print and social media, discussed in more detail below[12].

Exposure to Suicide via the Media as a Risk Factor

23. By way of background, the tension between media reporting as a matter of public interest[13] and the preservation of public health and safety, and in this case the adverse effects of exposure to suicide, has been sought to be addressed by the guidelines titled *Reporting Suicide and Mental Illness: A Mindframe Resource for Media Professionals* developed by the HIMH and other collaborators. These were informed from empirical evidence that showed the manner in which suicide is reported in the media has an impact on suicide at the population level and that young people may be particularly vulnerable to this exposure[14].

24. It must be emphasized that the guidelines are not intended to censor the media's reporting of suicide, instead guide the media to report suicide in a manner that minimizes the risk of

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[11] Social network was defined as: a formal or informal linkage, association, or network of individuals or groups that share common interests, contacts, knowledge or resources.

[12] Inquest transcript pages 31-32.

[13] The Australian Press Council has defined public interest as: *A matter is in the public interest if it is of substantial and widespread significance, not merely something in which many people may be interested. In the current context, it may often be helpful for the assessment to be made at editorial level after seeking advice from an appropriate mental health expert. It may also be necessary to consult public officials or other people with special knowledge of the likely impacts of publication in the particular case* (Australian Press Council, 2011).

[14] Tousignant M, Mishara BL, Caillaud A, Fortin V, St-Laurent D. The impact of media coverage of the suicide of a well-known Quebec reporter: the case of Gaëtan Girouard. *Social Science & Medicine.* 60(9):1919-1926,2005; Pirkis J, Blood RW. Suicide and the media: Part I. Reportage in nonfictional media. *Crisis.*22:146-154,2001; Sisask M, Varnik A. Media roles in suicide prevention: a systematic review. *International Journal of Environmental Research and Public Health.*9(1):123-138,2012.

subsequent suicides in the community. In fact, the media are a critical advocate for suicide prevention as they can reach a large proportion of the community and can influence the public's opinion and behaviour. This is crucial to advancing suicide prevention if we are to dispel myths, reduce stigma, educate the public about identifying behaviours indicative of suicide, promote suicide reduction interventions and provide support to members of our community affected by suicide.

25. As indicated above, concerns were raised by the family of Chanelle Rae about the volume, prominence and content of reporting about the deaths of Zac and Taylor. They believed that she was deeply affected by the newspaper reporting of the deaths of Zac and Taylor and that this influenced Chanelle's decision to take her own life[15]. At the inquest this was supported by Ms Elizabeth Jones (on behalf of DEECD) who submitted that the extensive media reporting on the three student deaths added to the trauma experienced by the community, adversely impacted the community, impeded recovery and added further complexity to managing the deaths.[16]

26. In response to Ms Rae's concerns and the research evidence, I requested the CPU to identify newspaper articles on the topic of youth suicide published in Victorian newspapers during 2009 and 2010 and assess the content of these articles in accordance with the *Reporting Suicide and Mental Illness: A Mindframe Resource for Media Professionals.*

27. The CPU advised that in the lead up to Chanelle's death in July 2009, 48 articles were published on the topic of youth suicide in Victoria, 31 (64.6%) of which were published in the Geelong Advertiser (two in March, 19 in April, four in May, four in June and two in July)[17]. What was positive to note was that a review of the 31 Geelong Advertiser articles showed no item reported the suicide method or location, and only one was published in a prominent location. With the exception of one, all items included some discussion about the need to raise awareness of available services through products, community activities and websites. This demonstrates a level of understanding of the guidelines and the role the media can play in health promotion.

28. Despite this, 28 of the 31 articles made specific reference to Geelong, including 17 that reported the identities of one or more of the Geelong youths who had previously suicided and / or

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[15] Inquest transcript pages 31-32.

[16] Ibid page 33.

[17] This is compared to 37 articles on youth suicide published for the same period (1 January to 17 July) in 2010, 13 (35.1%) of which were published in the Geelong Advertiser.

WHSC[18]. In addition, in 25 of the 28 articles, one of more of the Mindframe guidelines for responsible reporting of suicide was not adhered to. More specifically, in over 50% of the articles (n=16), suicide was not reported in context, no contact information was provided about help seeking services (n=12), the word "suicide" was frequently included in the article headline (n=11) and included an interview with the bereaved (n=10).

29. Given the complexity of the application of some of these guidelines[19], these articles were also provided to and an expert opinion was sought from the HIMH on whether the nature and frequency of newspaper reporting on youth suicide in Geelong during the period leading up to Chanelle's death was appropriate and consistent with guidelines on media reporting of suicide.

30. In her expert opinion, the Acting Director of the HIMH Dr Jaelea Skehan stated that the initial newspaper articles focused on reporting the individual deaths which, given the research evidence, may have presented a risk[20]. Dr Skehan then noted that the focus of the articles shifted to an exploration of the issue of suicide more generally. Following a concern from local services that the newspaper reporting may be increasing the risk to other young people in the area, Dr Skehan reported that the newspaper partnered with local services. Dr Skehan concluded her expert opinion by noting that despite guidelines for reporting suicide being in place for over a decade and that the Australian Press Council now also have standards consistent with the Mindframe guideline, they are neither compulsory or enforceable and journalists' understanding and application of them is variable.

31. The APC was also provided with the articles identified by the CPU and approached to provide an additional assessment of these articles against the APC guidelines in place at the time and those implemented in 2011. Dr Derek Wilding, Executive Director of the APC advised that he was unable to provide an assessment of the articles due to resource constraints and that this presented a potential conflict to their role in assessing complaints about individual articles.

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[18] Whether to report an individual instance of suicide is discussed in standards 3 and 4 of The Australian Press Council's Standards Relating to Suicide provided to the court in November 2011. In summary, these standards state that when deciding whether to report an individual instance and / or the identity of a person who had died by suicide, account should be taken of whether at least one of the following criteria is satisfied: (a) reporting the death as suicide / identification is clearly in the public interest; OR (b) clear and informed consent has been provided by appropriate relatives or close friends; OR (c) no appropriate authority has requested that the report be withheld or delayed to avoid a high risk of inducing further suicides. Note these standard were published in August 2011, two years following Chanelle's death and replaced the Advisory Guidelines in place in 2009. The court was not provided with a copy of the 2009 Advisory Guidelines and they no longer appear to be publicly available.

[19] Machlin A, Skehan J, Sweet J, Wake A, Fletcher J, Spittal M, Pirkis J. Reporting suicide: interpreting the guidelines. *Australian Journalism Review*. 34(2):45-56, 2012.

[20] Expert Opinion of Dr Jaelea Skehan, Acting Director Hunter Institute of Mental Health, page 1.

However, Dr Wilding did provide some useful material about how the APC would apply their standards relating to suicide to these articles.

32. Having considered all this evidence, I accept Ms Rae's concern about the nature and volume of newspaper reporting about youth suicide in the lead up to Chanelle's death, particularly the impact the details of the suicides of Zac and Taylor had on Chanelle's state of mind. These concerns were shared by local services at the time and in retrospect, experts in this field raise the possibility that the manner of the initial reporting of the suicides in Geelong may have presented a risk of subsequent suicides by other vulnerable young people.

33. I do not however consider that it is possible to draw a causal connection between the nature and volume of reporting of youth suicide by individual newspapers and the death of Chanelle. I also acknowledge that the concerns expressed by local services in this regard were accepted and the nature of subsequent reporting of youth suicide shifted. I accept Dr Skehan's observation of the variations in understanding and application of the guidelines amongst journalists. This highlights the need for continuing efforts by these experts and the APS to promote and continually refine the guidelines in accordance with the evidence-base to ensure the media's critical role in suicide prevention is optimized.

Media Representatives' Approaches to the Bereaved

34. Ms Karen Rae gave evidence at the inquest about the manner in which she was approached by journalist Mr Danny Lannen to be interviewed about Chanelle's death. She testified that she felt compelled to participate in an interview as Mr Lannen commented that "*there will be a story with or without you*"[21].

35. Ms Rae was a compelling witness. Her evidence of Mr Lannen's attendance at her home in the period immediately following her daughter's death, and his comment that caused Ms Rae to feel compelled to be interviewed, leads me to form the view that Mr Lannen's conduct in this respect was insensitive and intrusive.

36. However, I note that while Ms Rae was upset by the comment, she conceded that she did not convey these feelings to Mr Lannen. In addition, she stated that he was respectful and he sought her consent on the content of the article before he published it. Mr Lannen was also invited by the family to attend and report on Chanelle's funeral, and upheld the wishes of her family. I note that Mr Lannen won an award for his work on the story.

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[21] Exhibit 4, Statement of Karen Rae and inquest transcript page 33.

37. The Geelong Advertiser stated that, in relation to Chanelle's death, the "*aspect of cyberbullying, the apparent cluster at [WHSC] and the running concern of parents sent a clear message that the Geelong Advertiser should publish*".[22] It stated that much of its reporting centred on strategies for parents to help their children build resilience, including information about forums, speakers and activities.

38. Further, Mr Lannen's statement, as well as those of the former and current editors of the Geelong Advertiser, evidences recognition of the need to approach the story carefully and sensitively. Mr Lannen stated that "*while reporting guidelines might have been interpreted as recommending against such overt presentation [of suicide], the Geelong Advertiser's judgement was that the placement weighed heavily in the public interest.*" He further explained that "*decisions were made with much consideration. The stories would never have gained such weight or prominence without the full support, and powerful testimonies, of the families involved.*"[23]

39. The guidelines on media reporting of suicide include some reference to how to approach the bereaved[24]. Ms Rae's testimony and Mr Lannen's statement are relatively consistent and generally, Mr Lannen's approach largely adheres to the guidelines.

Bullying and Cyberbullying

40. During the initial investigation of Chanelle's death, the possibility was raised that she was subjected to cyberbullying in the hours leading up to her death during an MSN exchange with a school friend. Given the significant implications such allegations now carry, I sought a submission from the National Centre Against Bulling (NCAB)[25], an initiative of the Alannah and Madeline Foundation (AMF),[26] to inform myself of how these behaviours are defined.

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[22] Exhibit 5, Statement of Peter Judd dated 14 August 2009.

[23] Exhibit 5, Statement of Danny Lannen dated 15 November 2013.

[24] The Mindframe guidelines for media professionals state: *Take care interviewing family and friends. Respect people's grief and privacy in the period immediately after a death. Consider delaying interviews as people bereaved by suicide may be vulnerable or at risk of suicide themselves.*

[25] The National Centre against Bullying (NCAB) is a peak body working to advise and inform the Australian community on the issue of childhood bullying and the creation of safe schools and communities, including the issue of cyber safety.

[26] The Alannah and Madeline Foundation, established in 1996, is a national charity established to protect children from violence and its devastating effects. It provides care for children who have experienced or witnessed violence and run programs which prevent violence in the lives of children. It plays an advocacy role and is a voice against childhood violence.

41. The NCAB provided a comprehensive submission[27], which outlined various definitions, including that of cyberbullying. The NCAB advised that:

> *Cyberbullying is overt or covert bullying behaviours using digital technologies. Examples include being sent derogatory or harmful text messages/pictures/video clips/emails or having them posted on the internet or sent to others. It can also be the deliberate exclusion of someone from social networking spaces. Cyberbullying can happen at any time. It can be in public or in private and sometimes only known to the target and the person bullying. In general bullying does not usually consist of single episodes of social rejection or dislike, single episode acts of nastiness or spite, random acts of aggression or intimidation, mutual arguments, disagreements or fights.*

42. When this definition was applied to the circumstances of Chanelle's death and in particular the MSN exchanges, it became apparent cyberbullying did not occur. When this was put to Ms Karen Rae at the inquest, she agreed that in her view cyberbullying was not a factor in Chanelle's death.[28]

Post-vention Response by the Department of Education and Early Childhood Development

43. DEECD provided detailed submissions on its programs and available resources in relation to: suicide; mental illness; suicide prevention; and bullying and cyberbullying. The submissions detailed a range of programs, aimed at different age groups and levels as appropriate.

44. DEECD explained in its submission that each Victorian Government School operates in an environment of devolved decision-making, and that it is the responsibility of each school Principal and School Council to make decisions about individual programs and resources that are most appropriate for the needs of their students.[29]

45. At inquest, Ms Kris Arcaro on behalf of the department, explained that there are no mandatory programs in schools in relation to the above matters, but that broadly, the DEECD states that schools must ensure a safe, supportive and respectful environment. In achieving this, schools can then choose which particular programs they implement, including programs that are not

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[27] Exhibit 11, Submission of the Alannah and Madeline Foundation and the National Centre Against Bullying.

[28] Inquest transcript page 48.

[29] Submissions of DEECD dated 11 November 2013, Exhibit 8, page 1.

developed by DEECD.[30] However, in practice, schools would usually look to the DEECD for advice on sound, evidence-based programs.[31]

46. Ms Arcaro emphasised that the work of the department focuses on prevention, health promotion and early intervention, and that most of its resources hold this focus. She also provided details at inquest as to the key focus of the present government on building resilience in schools, and programs that support this.[32] Ms Arcaro also explained that, in addition to providing schools with programs, the DEECD also provides direct support to school and young people, via its team of psychologists, social workers and youth workers, and that this resource is available to all schools.

47. I am satisfied, from the evidence of the DEECD, that at the department level, there are sufficient ongoing support services for staff, students and their families through various means. Ms Arcaro stated that the position of the DEECD is that schools should also work in partnership with community agencies that are in their local government areas in order to derive maximum benefit from the available supports.

48. I asked Ms Arcaro whether resources were available for students to access support privately, should they not wish to discuss a matter with teachers, other school support staff or anyone else. Ms Arcaro referred to the Headspace school support service, which offers an e-counselling service that young people could access directly. The Headspace initiative had not been implemented in 2009 and was not therefore available at the time of the three deaths.[33]

49. The DEECD also made very helpful submissions regarding support and resources available at WHSC specifically at the time of Taylor and the other students' deaths. Ms Elizabeth Jones of the DEECD gave evidence at inquest on this issue.

50. In 2009, WHSC had approximately 1200 students spread across two campuses. Zac and Taylor were students at the 'Quamby' campus, and Chanelle was a student at the 'Minerva Road' campus. The school's student support services officers included the college chaplain, student wellbeing coordinator, a health promotion nurse and student support service officers in the

[30] Inquest transcript page 88.

[31] Ibid page 89.

[32] Ibid pages 94-5.

[33] Inquest transcript pages 96-7.

Barwon South Western regional office. The school also had relationships with, and access to external support services.[34]

51. Preventative strategies available at the WHSC at the time of the three deaths in 2009 included:

- targeted health and wellbeing days
- mental health promotion
- development of a code of learning behaviours
- a requirement that all students complete work and attain accreditation in the school's 'Acceptable Use of Technology' policy
- staff training in the 'Habits of Mind' framework to integrate into student learning
- parent forums on challenging behaviour, adolescence and safe use of technology
- all students being assigned a home group and teacher mentor
- peer monitoring
- promoting student participation and engagement through the school's Student Action team format
- restorative practices framework to respond to incidents of concern
- relationships with local police who would present to groups of students, and individual students after an incident of concern.[35]

52. In addition, WHSC was involved in mental health promotion and suicide prevention strategies that were available in the Geelong community.[36]

53. Following the deaths, DEECD submitted that WHSC closely monitored all students to identify who might be at risk and in need of further support and assistance, and that there were up to 78 students receiving necessary support at one time. The health and wellbeing of WHSC staff was also being closely monitored, with extra staff being provided from neighbouring schools as well as relief staff, and a community liaison officer was engaged.[37]

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[34] Submissions of DEECD dated 11 November 2013, Exhibit 8, page 30.

[35] Exhibit 8 above, pages 30-31.

[36] Ibid page 32.

[37] Ibid pages 34-5.

54. The school corresponded regularly with families after each death informing them of the death and providing information about care and support available to students, as well as community services for families. The school considered students that might be at risk and provided targeted intervention, follow up and monitoring given concerns about contagion.[38] WHSC provided additional ongoing support and monitoring following Taylor Janssen and Chanelle Rae's deaths, and following the suicide deaths of a student at Geelong College, Taylah Mahon, and a student at St Ignatius College in Drysdale, Stephanie Winberg.[39]

55. At inquest, Ms Jones elaborated on the department's submission that the extensive media reporting of the deaths adversely affected the students' recovery. She stated that as the media attention increased following the death of Chanelle Rae, the number of students potentially at risk and requiring support also increased. The school was required to seek additional psychological and counselling resources, and staff were also adversely impacted.[40] I accept this evidence, but note the positive features of media reporting of suicide, especially media that focused on the impacts of the deaths rather than the deaths themselves, and highlighted strategies for parents to communicate with their children, as well as the importance of seeking help.

56. Ms Jones also gave evidence that the work of the department's student support services network identified that some students had discussed or planned suicide, and that a pact of sorts had been arranged. This required additional and intensive support to the young people and their families.[41]

57. Ms Jones also addressed my question about the availability of a support service for students to access privately, prior to the introduction of the Headspace initiative. She explained that the school had a tutor system in place where a teacher identified as a key contact person for a student, and that information was provided to students routinely about other support services available to them outside the school.

58. Ms Jones testified at inquest that, by 2009, there was a large body of research around resilience, and that schools put supports and programs in place with this focus. In the case of WHSC, Ms

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[38] Submissions of DEECD dated 11 November 2013, Exhibit 8, pages 36-7.

[39] Ibid pages 35-43.

[40] Inquest transcript page 105.

[41] Ibid page 108.

Jones explained that the tutor group process aligned with the resilience model, by ensuring that students had an appropriate adult they could turn to for support.[42]

59. Ms Jones addressed the department's 'Guidelines to assist in responding to attempted suicide or suicide by a student', which were not in place in 2009. Ms Jones testified that the response of WHSC was very consistent with the guidelines,[43] and stated that WHSC was using all relevant and available policies and resources available to them in 2009, particularly the key document at the time regarding 'managing school emergencies'.[44]

60. I accept Ms Jones' evidence on each of these matters. I also accept that the WHSC was appropriately utilising 'relevant and available policies and resources available to them' at the time.

Post-vention Response by Barwon Health

61. Mr Chris Scanlon from Barwon Health Mental Health Service provided the Court with a helpful submission on: how health services were notified and responded to the youth suicides in Geelong; the impact they had on the local health system and the community; and any learning from the Geelong experience that may be translatable to other settings.[45] He also provided a best practice guideline titled *Talking about suicide with young people* developed by the Victorian Mental health Promotion Officers.

62. Mr Scanlon advised that the DEECD notified the Barwon Health Mental Health Service of the suicide incidents, who also convened a meeting between relevant local services to determine and resource an appropriate response[46]. The Victorian Department of Health resourced Barwon Health and Headspace Barwon for both short and long-term strategies, the implementation of which was overseen by a coordination committee.

63. In the short term, enhanced clinical services (mental health and suicide risk assessments and additional support consultations) were provided as a priority following an increased demand for assistance. Liaison with media outlets was also instigated following concerns about reporting practices that were outside the recommended guidelines that were creating additional angst in the community.

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[42] Inquest transcript page 120.

[43] Ibid page 121.

[44] Ibid.

[45] Ibid.

[46] Exhibit 13, page 1.

64. Education and training, which included Youth Mental Health First Aid (YMHFA) and Applied Suicide Intervention Skills Training (ASIST), was provided for school and school support staff. Mr Scanlon reported that this was beneficial as a longer-term strategy to strengthen the service system, with over 400 school personnel trained in 2011-2013.

65. Mr Scanlon reported that the 2009 youth suicides in Geelong had a significant impact on family, friends, schools, health services and the community. Since these events, Mr Scanlon believes that there has been a greater focus on coordination of services. He concluded his evidence with the comment that an evidence-based and timely response to events such as these will inform prevention and post-vention strategies. I accept Mr Scanlon's evidence on these matters. I agree with him on the importance of timely, coordinated local responses to events such as these.

Barwon Adolescent Task Force

66. A submission was also provided by a representative from the Barwon Adolescent Task Force. It contained a number of observations and suggestions including:

- the need to engage parents and caregivers to participate in generic education sessions from their child's early years (8-12 years) onwards to empower them to promote resilience and identify early warning signs
- introduce evaluations of resilience programs delivered in primary schools
- develop interventions focused on increasing protective factors for suicide, such as connectedness to community, family and / or significant other adult outside the family
- audit of schools with staff that have received ASIST training.

I note these and thank Barwon Adolescent Task Force for its contribution.

CONCLUSIONS

67. The suicide death of a loved one is an event that often leaves family, friends and the community with a great sense of loss and unanswered questions as to what happened and why. It can reverberate throughout a family for generations, and can impact upon both the memory of the deceased, and his or her surviving family.

68. I accept and adopt the medical cause of death as identified by A/Prof Ranson and find that Chanelle died from compression of the neck in circumstances of hanging, in circumstances where I am satisfied that she intended to take her own life.

69. Other than the recent argument with her friends, there is no other evidence of stressors in Chanelle's life that may have influenced her choice in the course of action she ultimately adopted.

70. Finally I wish to acknowledge and thank the many individuals and organisations that provided information and their expertise to this investigation. In particular, the Department of Education and Early Childhood Development, the Australian Press Council, the Hunter Institute of Mental Health, the Alannah and Madeline Foundation, Barwon Health and the Barwon Adolescent Task Force.

RECOMMENDATIONS

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

1. The World Health Organization (WHO) has recognised suicide as an issue of global public health significant and that suicide prevention should be a priority for governments and policy-makers.[47] The WHO, of which Australia is a member state, places the responsibility for prevention in ministries for health and suggests that national plans of action be developed in collaboration with relevant government and non-government agencies.[48]

2. In Australia, the Department of Health is the lead agency responsible for the National Suicide Prevention Strategy, comprising four inter-related components:

   - Living is for Everyone (LIFE) Framework[49]
   - National Suicide Prevention Strategy Action Framework[50]
   - National Suicide Prevention Programme (NSPP)[51]

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[47] World Health Organization. *Preventing suicide: a global imperative.* World Health Organization, Geneva. 2014.

[48] Krug EG, Mercy JA, Dahlberg LL, Zwi AB. The world report on violence and health. *The Lancet.* 360:1083-88, 2002.

[49] The LIFE framework sets the strategic policy framework for national action to prevent suicide, which includes a practical suite of resources. http://www.health.gov.au/internet/main/Publishing.nsf/Content/mental-nsps.

[50] Developed by the DHA and the Australian Suicide Prevention Advisory Council (ASPAC) to inform national leadership in suicide prevention and policy. http://www.health.gov.au/internet/main/Publishing.nsf/Content/mental-nsps.

[51] An Australian Government suicide prevention funding program for community based projects and national investment for population health approaches and support for infrastructure and research. http://www.health.gov.au/internet/main/Publishing.nsf/Content/mental-nsps.

- Mechanisms to promote alignment with and enhance state and territory suicide prevention activities.

3. While I accept that Departments of Health (in Victoria, the Victorian Department of Health), should 'lead' suicide prevention activities, this investigation has shown that other organisations at the local community level played a critical role in both the identification of and response to suicide.

4. One key organisation at the local level is Victoria Police. While it could be argued that suicide prevention is not the primary role of Victoria Police, they do have a public safety function and are required to report and investigate deaths from suicide for coroners. This mandate brings them into frequent contact with the issue of suicide. Members of Victoria Police have sought to be proactive on this issue and frequently contact the Court regarding local concerns with suicide they have identified.

5. Local health services also have frequent contact with persons experiencing a situational stressor or crisis event as part of their ongoing ill health and are therefore another important group involved in a local response. General practitioners and emergency departments are the front line health services that assist in these circumstances.

6. In addition to Victoria Police and local health services, local governments have recently taken the lead in responding to another youth suicide cluster in Victoria. While this investigation is still ongoing by another coroner, I note that the City of Casey has a dedicated youth suicide prevention information page on their website, which includes a link to the Suicide Awareness Youth Focussed Tool Kid (SAYFT) website containing information for young people, professionals and parents on prevention, immediate assistance, post incident and training.[52] The role of local government in suicide prevention has been previously recognised following a major inquiry into the nature and extent of suicide in Victoria in the late 1990s conducted by the Victorian Suicide Prevention Task Force. In their 1997 report, the need for the development of a municipal plan with targets for improving social and emotional wellbeing was identified.[53] In addition, the University of Melbourne's 2012 report titled *Developing a community plan for preventing and responding to suicide clusters* is a step-by-step guide for communities to

[52] http://www.casey.vic.gov.au/youth/programs-services/support/youth-suicide.

[53] Suicide Prevention Taskforce. Suicide Prevention Task Force Report. 1997. Page 116.

develop and activate a response to suicide.[54] While the report focuses on suicide clusters, it could have more general application.[55]

7. In light of all of this information, there is an opportunity to reinvigorate suicide prevention activity in Victoria. What appears to be lacking is:

   - ongoing gathering of real time intelligence on the frequency and rate of suicide in local communities
   - exchange of intelligence and advice between local community organisations and the state and national organisations responsible for suicide prevention
   - a nuanced understanding of the presence and combination of risk factors that might influence suicidal activity amongst groups in the community
   - a co-ordinated local response and recovery strategy in place that can be activated when concerns are raised in the community about elevated levels of suicidal behaviour

8. In the absence of community level involvement and integration into a broader Victorian suicide prevention plan or strategy, it is difficult to fathom how suicide reductions will be achieved in the short or long term. Having said that, the development of detailed plans and strategies are a time consuming task and given the complexity of suicide, it may be some time before such a strategy could be developed and implemented. The recommendations contained in the 1997 Suicide Prevention Task Force Report, the evaluations that followed and the University of Melbourne's report may be applicable.

9. I therefore recommend that the Department of Health together with Victoria Police, the Municipal Association of Victoria, the Royal Australian College of General Practitioners and the Chief Psychiatrist undertake a review of these reports and develop a policy framework that aligns, where appropriate, with the National Suicide Prevention Strategy.

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

Mr Ian and Ms Karen Rae, senior next of kin
Department of Education and Early Childhood Development c/o Ms E Gardner
The Hon. David Davis MLC, Victorian Minister for Health
The Hon. Kim Wells, MP, Victorian Minister for Police and Emergency Services

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[54] Lockley A, Williamson M, Robinson J, Cox G, Cheung YTD, Grant L, Pirkis J. *Developing a community plan for preventing and responding to suicide clusters*. Canberra, Commonwealth of Australia, 2012.

[55] Note that this resource was developed within the context of the Living Is For Everyone (LIFE) framework referred to above particularly Action Area 3: Improving community strength, resilience and capacity in suicide prevention.

The Hon. Mary Wooldridge, Victorian Minister for Mental Health

Mr Tim Bull, MP, Victorian Minister for Local Government

Dr Kevin Freele, Executive Director, Barwon Health

Leigh Bartlett, Barwon Adolescent Task Force

Dr Jaelea Skehan, Director, Hunter Institute of Mental Health

Dr Derek Wilding, Executive Director, Australian Press Council

Sandra Craig, National Centre Against Bullying, Alannah and Madeline Foundation

Geelong Advertiser c/o KellyHazellQuill Lawyers

Leading Senior Constable Shane Johnson, Coroner's Investigator, Victoria Police.

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

Dr Pradeep Philip, Secretary, Department of Health

Chief Commissioner Ken Lay APM, Chief Commissioner of Victoria Police

Dr Mark Oakley Browne, Chief Psychiatrist

Mr Rob Spence, Chief Executive Officer, Municipal Association of Victoria

Associate Professor Morton Rawlin, Chair Victoria Faculty, Royal Australian College of General Practitioners.

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: **28 November 2014**