IN THE CORONERS COURT
OF VICTORIA
AT GEELONG

Court Reference: COR 2009 001426

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: ZACHARY STANELY HARVEY

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 ZACHARY STANELY HARVEY

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 ZACHARY STANELY HARVEY
born on 10 June 1993
and the death occurred on 6 March 2009

from:

1 (a) HANGING

in the following circumstances:

INTRODUCTION AND PURPOSE

1. This inquest examined the circumstances and contributing factors relating to the death of Zachary (hereafter referred to as Zac) Harvey. Before I make my findings on these circumstances and factors, I wish to convey my sincere condolences to Ms Harvey, Zac's Mother. 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) and
   - 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. Zac was the son of Margaret Harvey and was aged fifteen years and eight months when he died. He lived with his mother, was always well behaved and often kept to himself. Besides the typical issues that arise between a parent and an adolescent, they had a happy and stable home life. Zac had no medical history of physical or mental ill health and never spoke about any problems he may have been experiencing.

5. Zac attended Western Heights Secondary College (WHSC) and was an average student who rarely got into trouble. He was described as an outstanding sportsman and played football in addition to being a very talented cricketer who was vying for selection in the Victorian junior squads.

6. In 2007, Zac commenced a relationship with fellow WHSC student, Taylor Janssen. They reportedly had moments typical of any teenage relationship but would always resolve their issues and reconcile. The relationship was strong and Zac attended holidays with the Janssen family and was a regular overnight visitor at the Janssen household. They spent such a considerable amount of time together that Taylor's parents were concerned it was to the detriment to other friendships of both of them.[1]

CIRCUMSTANCES OF THE INCIDENT

7. On the evening of Sunday 1 March 2009, a series of text messages were exchanged between Zac and Taylor discussing the dissolution of their relationship. When Zac attended school the next day, he reported further informed Taylor that he no longer wished to continue their relationship. No reason was given to Taylor as to why Zac no longer wanted to see her, and this caused her some angst and resulted in intense arguments with Zac.[2] While not the type of boy to talk about his problems, Zac seemed calm and okay about the situation.[3]

8. On 6 March 2009, Zac was in class with Taylor when an argument developed between them in relation to Taylor sitting next to another boy. Zac left school immediately following this argument and returned home where he recounted the incident to his mother. It was

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[1] Statement of Mr Steven Janssen, father of Taylor Janssen dated 1 May 2009, page 1.

[2] Statement of a witness, dated 11 May 2009, page 1.

[3] Statement of Ms Margaret Harvey, dated 11 April 2009, page 1.

approximately 11:15am when Zac returned home from school. At approximately 12:15pm, Ms Harvey left to attend bingo and Zac remained at home.

9. Upon returning home at approximately 2:50pm, Ms Harvey caught a glimpse of Zac through the kitchen window in the built-in pergola and games room area. Ms Harvey went to Zac and realised that he had tied a nylon rope around his neck, with the remaining length of rope attached to the exposed roof beam. Ms Harvey noticed that there was blood on Zac's shirt. She ran from the room and called 000.

10. Police and ambulance paramedics arrived but resuscitation was not attempted as it was apparent that Zac had been deceased for up to three hours. It appeared that the nylon rope came from the garage that was located only meters away, and that Zac had cut the required length of rope. On the pool table in front of Zac was his mobile phone. It appeared that Zac had sent a text message to a friend that read, "tell Taylor sorry". No other written note was located indicating the reasons for Zac's actions, and there were was no evidence to suggest another party was involved.

11. Also of relevance to Zac's death was the subsequent suicide of his former girlfriend Taylor Janssen approximately three weeks later.[4] Taylor's death was one of three deaths heard as part of a joint inquest, the relevant factors for which will be the subject of a separate finding. However, any overlapping circumstances and factors will be covered in all findings.

FINDINGS AS TO UNCONTENTIOUS MATTERS

12. In relation to Zac's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity, the date, place and medical cause of his death were never at issue. I find, as a matter of formality, that Zachary Stanely Harvey, born on 10 June 1993, aged 15, died at his home on 6 March 2009.

THE MEDICAL CAUSE OF DEATH

13. Nor was the medical cause of death controversial. On 9 March 2009, an external examination of Zac's body was performed by Senior Forensic Pathologist Dr Matthew Lynch of the Victorian Institute of Forensic Medicine (VIFM), who also reviewed the circumstances as reported by the police and post-mortem CT scanning of the whole body (PMCT). Dr Lynch noted evidence of a

[4] Court Reference Number 20091767.

ligature mark, as well as scars on the anterior aspect of the left forearm with a pattern typical of previous "self harm". Dr Lynch did not find evidence of any occult trauma or natural disease process, and formulated the medical cause of Zac's death as *hanging*. Post mortem toxicological analysis of blood did not reveal the presence of ethanol (alcohol) or any other drugs or poisons.

FURTHER INVESTIGATION

14. The Coroner's Investigator, Senior Constable Brad Johnson prepared a brief of evidence comprising a series of statements from all persons present at the home on the afternoon of Zac's death, and from a friend of both Zac and Taylor. This also included an appendix of photographs of the incident scene as well as photos of the mobile phone recovered from the scene with a number of text messages that were left on the phone.

15. During the investigation of Zac's death, it came to the attention of the Coroners Court of Victoria that seven persons[5] aged 18 years and under residing in the City of Greater Geelong had suicided during 2009. This was compared to one in 2008 and one in 2007. It is also significant to note that there were no suicides amongst persons aged 18 years and under in 2010, one in 2011, one in 2012 and two in 2013[6]. This retrospective examination of suicides amongst persons aged 18 years and under showed that the City of Greater Geelong experienced a suicide cluster[7], as defined by the Centres for Disease Control and Prevention, during 2009. On this basis, assistance was sought from the Coroners Prevention Unit (CPU)[8] 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.

16. 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.

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

[6] 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).

[7] *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).

[8] 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.

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.

17. The CPU coordinated the identification of and engagement with appropriate 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 and the Hunter Institute of Mental Health. 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]

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

19. It is clear that Zac's death had a profound impact the police members investigating his death, as well as his family and loved ones. This is particularly in the context of the tragic suicide deaths of young people that followed. I acknowledge the difficult circumstances surrounding these deaths, and note the particular dedication and care undertaken by the coroner's investigators in these matters.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

20. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Zac's death was on the circumstances in which he died. The inquest into Zac's death was held jointly with inquests into two other deaths, being Taylor Janssen and Chanelle Rae. The inquest examined the circumstances surrounding each of the

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

three young people, Zac Harvey, Taylor Janssen and Chanelle Rae, in the lead up to and immediately proximate to death.

21. 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 all students at 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 as a Risk Factor

22. 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 suicidal behaviour.

23. The CPU reviewed 54 original research studies that were conducted between 1967 and 2009 based on suicide behaviour[10] and included an examination of exposure to suicidal behaviour in the social network.[11] 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. The CPU advised that a risk management approach should be taken to post-vention responses to persons potentially affected by suicidal behaviours of individuals in their social network.

24. Zac's death occurred following the deaths, from suicide, of two other Geelong youths earlier in 2009. There was no evidence that Zac was aware that these deaths had occurred, were acquainted with either person or, more importantly, was adversely impacted.

Media Treatment of Youth Suicide

25. In addition to the role of exposure to suicide via the social networks (that is friendship groups, peer networks, sporting clubs or work), was the role of exposure to suicide by the mass media.

26. Zac's death, and the subsequent death of Taylor, were widely reported in the two local newspapers: the Geelong Advertiser and the Echo. As such, there was a heightened awareness of the deaths in the community. This heightened awareness promoted through the media raised

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

[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.

concerns as there is research evidence that aspects of mass media reporting of suicide is associated with increased subsequent suicidal behaviour at a population level[12]. I will deal with the issue of the media reporting of suicide in more detail in my finding in to the death of Chanelle Rae.

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

27. The Department of Education and Early Childhood Development (DEECD) provided detailed submissions specifying its programs and available resources in relation to bullying, cyber bullying, suicide, suicide prevention and mental illness. The submissions detailed a range of programs, aimed at different age groups and levels as appropriate.

28. 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.[13] 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 developed by DEECD.[14] However, in practice, schools would usually look to the DEECD for advice on sound, evidence-based programs.[15]

29. 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.[16] 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

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[12] 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 2005;60(9):1919-1926; Pirkis J, Blood RW. Suicide and the media: Part I. Reportage in nonfictional media. Crisis. 2001;22:146-154; Sisask M, Varnik A. Media roles in suicide prevention: a systematic review. International Journal of Environmental Research and Public Health 2012; 9(1):123-138.

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

[14] Inquest transcript page 88.

[15] Ibid page 89.

[16] Ibid pages 94-5.

team of psychologists, social workers and youth workers, and that this resource is available to all schools.

30. 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.

31. 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.[17]

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

33. 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 Barwon South Western regional office. The school also had relationships with, and access to external support services.[18]

34. 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

[17] Inquest transcript pages 96-7.

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

- 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.[19]

35. In addition, WHSC was involved in mental health promotion and suicide prevention strategies that were available in the Geelong community.[20]

36. DEECD 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.[21]

37. 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.[22]

38. The school identified Taylor Janssen as being particularly at risk following Zac's death and maintained regular contact with her family. The school also 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.[23] WHSC provided additional ongoing support and monitoring following Taylor Janssen and

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[19] Submissions of DEECD dated 11 November 2013, Exhibit 8, pages 30-31.

[20] Ibid page 32.

[21] Ibid page 33.

[22] Ibid pages 34-5.

[23] Ibid pages 36-7.

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.[24]

39. 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 the media attention that 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.[25]

40. At inquest, Ms Jones also elaborated on DEECD submissions to the effect that it had been identified that some students had discussed or planned suicide, and that a pact of sorts had been arranged. Ms Jones stated that the work of the department's student support services network identified this and provided intensive support to the young people and their families.[26]

41. 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.

42. 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 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.[27]

43. 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,[28] 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'.[29]

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[24] Submissions of DEECD dated 11 November 2013, Exhibit 8, pages 35-43.

[25] Inquest transcript page 105.

[26] Ibid page 108.

[27] Ibid page 120.

[28] Ibid page 121.

[29] Ibid.

44. 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

45. 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.[30] He also provided a best practice guideline titled *Talking about suicide with young people* developed by the Victorian Mental health Promotion Officers.

46. 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[31]. 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.

47. 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.

48. 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.

49. 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

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[30] Inquest transcript page 121.

[31] Exhibit 13, page 1.

matters. I agree with him on the importance of timely, coordinated local responses to events such as these.

Barwon Adolescent Task Force

50. 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

51. 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.

52. I accept and adopt the medical cause of death as identified by Dr Lynch and find that Mr Harvey died from hanging in circumstances where I am satisfied that he intended to take his own life.

53. Other than the recent dissolution of the relationship between Zac and his girlfriend, there is no other evidence of stressors in Zac's life that may have influenced his choice in the course of action he ultimately adopted.

54. 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.[32] 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.[33]

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[34]
   - National Suicide Prevention Strategy Action Framework[35]
   - National Suicide Prevention Programme (NSPP)[36]
   - 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

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

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

[34] 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.

[35] 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.

[36] 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.

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.[37] 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.[38] 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 develop and activate a response to suicide.[39] While the report focuses on suicide clusters, it could have more general application.[40]

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

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

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

[39] 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.

[40] 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.

- 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:

Ms Margaret Harvey, 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
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
Mr Leigh Bartlett, Barwon Adolescent Task Force
Dr Jaelea Skehan, Director, Hunter Institute of Mental Health
Dr Derek Wilding, Executive Director, Australian Press Council
Ms Sandra Craig, National Centre Against Bullying, Alannah and Madeline Foundation
The Geelong Advertiser, c/o KellyHazellQuill Lawyers
Senior Constable Brad 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**