IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2024 001117

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

*Amended pursuant to section 76 of the **Coroners Act 2008** on 16 October 2024*[1]

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	Mr RGE
Date of birth:	10 February 2001
Date of death:	25 February 2024
Cause of death:	1(a) Multiple injuries sustained in a fall from a height
Place of death:	118 Kavanagh Street, Southbank, Victoria

[1] This document is an amended version of the Finding into Death Without Inquest regarding Mr RGE dated 24 September 2024. A correction to paragraph 2 has been made pursuant to section 76 of the *Coroners Act 2008* (Vic).

INTRODUCTION

1. On 25 February 2024, Mr RGE was 23 years old when he died in circumstances indicating he had taken his own life. At the time, Mr RGE lived alone in Southbank.

2. Mr RGE was born in China where he lived with his parents and younger sister. In about 2019, he migrated to Australia to complete his secondary school studies and later commenced a Diploma of Business at Deakin College.[2] During COVID-19 restrictions, he completed his studies online.

3. According to his father, Mr BJQ, Mr RGE was in regular contact with his family. His mother, Ms WDJ, stated that her son appeared to enjoy living in Australia and studying with people from different backgrounds. He never really discussed his studies with his family much and never mentioned any mental health-related issues. His family supported him by sending money to assist with his rent, food, and general living expenses. Mr BJQ described his son as a cheerful, kind-hearted, and virtuous person.

THE CORONIAL INVESTIGATION

4. Mr RGE's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr RGE's death. The Coroner's Investigator conducted inquiries on my behalf, including

[2] 'Deakin University, Burwood' amended to 'Deakin College' pursuant to section 76 of the *Coroners Act 2008* (Vic).

taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into Mr RGE's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[3]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Identity of the deceased

9. On 27 February 2024, Mr RGE, born 10 February 2001, was visually identified by his cousin, Mr MKA, who signed a formal Statement of Identification to this effect.

10. Identity is not in dispute and requires no further investigation.

Medical cause of death

11. Forensic Pathologist, Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 26 February 2024 and provided a written report of her findings dated 27 February 2024.

12. The post-mortem examination was consistent with the reported circumstances and the post-mortem CT scanning of the whole body showed multiple significant injuries sustained as a result of the fall.

13. Routine toxicological analysis of post-mortem samples detected acetone.[4]

14. Dr Baber provided an opinion that the medical cause of death was *"1(a) Multiple injuries sustained in a fall from a height"*.

15. I accept Dr Baber's opinion.

[3] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[4] Low levels of acetone in the blood are likely attributable to ketosis secondary to diabetes or a fasted state.

Circumstances in which the death occurred

16. In June 2022, Mr RGE's beloved grandmother passed away in China. Given the closeness of their relationship, he was understandably affected by her death.

17. During Christmas 2023, Mr RGE informed his cousin, Mr MKA, that he was experiencing some financial difficulties and they discussed Mr RGE moving in with Mr MKA and Mr MKA's mother in Point Cook the following year.

18. They subsequently made plans for Mr RGE to move to Point Cook on 25 February 2024. Mr RGE told his mother that he was happy to be moving in with his cousin when they discussed these plans.

19. Enquiries with Deakin University following Mr RGE's death indicated that he had a poor attendance record (average attendance was 39 per cent) with poor academic scores. He had only successfully completed one unit out of 17 units. Mr RGE had not used any counselling assistance offered by Deakin University.

20. The coronial investigation did not reveal any record of Mr RGE attending a general practitioner proximate to his passing.

21. On the evening of 24 February 2024, Mr MKA contacted Mr RGE via WeChat to confirm the arrangements for Mr RGE's move the following day. When Mr RGE did not reply, Mr MKA sent multiple follow-up messages and attempted to call that evening and the following day. Mr RGE did not respond to any of these messages or calls.

22. On 25 February 2024, Mr MKA continued trying to contact his cousin to no avail. Growing concerned, particularly after learning his mother had also not heard from Mr RGE since 21 February, Mr MKA contacted Victoria Police to request a welfare check.

23. Victoria Police members attended Mr RGE's apartment building at about 6.00pm that evening. The concierge escorted the members to Mr RGE's apartment on the 14th floor. Mr RGE did not respond to their knocks on the door. The door to the apartment was closed and locked. The police members could not hear anyone inside the apartment.

24. As the police members returned to the lobby floor, the concierge received a phone call from one of the building residents stated that they had just witnessed something fall past their balcony and there was a body on the ground outside. The police members were also notified of the same information.

25. The police members subsequently found Mr RGE on the footpath outside 118 Kavanagh Street, Southbank, and commenced administering cardiopulmonary resuscitation. Fire Rescue Victora members and Ambulance Victoria paramedics also attended the scene a short time later. Paramedics verified Mr RGE's death at 6.20pm.

26. Police members later gained access to Mr RGE's apartment. It appeared he had been packing up his belongings. A chair was located on the balcony. There were no suicide notes or other material indicating Mr RGE was intending to take his own life.

27. Senior Constable William Colliver, Coroner's Investigator, concluded that Mr RGE was experiencing several stressors at the time of his death. These included the death of his grandmother, the impact of COVID-19 restrictions as a student, residing away from his family, isolation, and poor academic performance.

FINDINGS AND CONCLUSION

28. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Mr RGE, born 10 February 2001;

    (b) the death occurred on 25 February 2024 at 118 Kavanagh Street, Southbank, Victoria;

    (c) the cause of Mr RGE's death was multiple injuries sustained in a fall from a height; and

    (d) the death occurred in the circumstances described above.

29. Having considered all of the evidence, including the lethality of means chosen, I am satisfied that Mr RGE intentionally took his own life. The evidence does not enable me to determine which particular life stressor or stressors caused or contributed to Mr RGE's decision. There is no evidence that Mr RGE sought medical or other professional assistance with whatever was troubling him or spoke or acted in such a way to cause his family to have concerns for his safety or welfare and to enable them to support him or take any protective steps before his passing.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

Victorian Suicide Register

30. The Victorian Suicide Register (**VSR**) is a database containing detailed information on suicides that have been reported to and investigated by Victorian Coroners between 1 January 2000 and the present.

31. The VSR indicates the annual frequency of suicides occurring in the state of Victoria has been steadily increasing for the past decade, from approximately 550 deaths in 2011 to a peak of 796 deaths in 2023.[5]

32. The primary purpose of gathering suicide data in the VSR is to assist Coroners with prevention-oriented aspects of their suicide death investigations. VSR data is often used to contextualise an individual suicide with respect to other similar suicides; this can generate insights into broader patterns and trends and themes not immediately apparent from the individual death, which in turn can lead to recommendations to reduce the risk that further such suicides will occur in the future.

33. So much is still unknown about suicide and, given that every suicide occurs in unique circumstances to a person with a unique history and life experience, possibly there is much we will never be able to quantify and understand. But through recording information about each individual suicide in the VSR, particularly information about the health and other services with whom the person had contact, and then looking at what has happened across time and across people, we hope the VSR can at least lead us to new understandings of how people who are suicidal might better be supported in our community.

Suicides of international students

34. Over the last several years, this Court has investigated a number of suicides amongst the international student cohort.

35. In 2019, Coroner Audrey Jamieson delivered her finding into the death of Zhikai Liu,[6] who took his own life after experiencing depression for which he did not seek help. Coroner

[5] Coroners Court Monthly Suicide Data report, August 2024 update. Published 16 September 2024.
[6] *Finding into death without inquest regarding Zhikai Liu*, COR 2016 001035, published.

Jamieson's finding outlined the data regarding the suicides of international students in Victoria between 2009 and 2015. This revealed the following:

(a) 27 deaths were identified;

(b) most of the deceased were male (22 out of 27);

(c) the deceased mainly came from Asia (24 out of 27);

(d) there was a lower prevalence of previous self-harm and suicide attempts in this cohort compared to Australian-born students;

(e) this cohort experienced more educational and financial stress than Australian-born students;

(f) there was a lower prevalence of diagnosed mental illness but higher proportion of suspected mental illness or no mental illness than Australian-born students; and

(g) there was a lower rate of attendance to a health service for a mental health related issue than Australian-born students who took their own life.

36. Her Honour referred to literature examining the mental health of international students which referred to cultural, financial, and linguistic stressors and noted that international students were less likely to seek assistance for their mental health.

37. While there was no evidence in that case, as is the case here, that Mr RGE's death would have been prevented had he engaged with mental health support, at the very least this would have created a prevention opportunity that did not otherwise exist.

38. To prevent similar deaths, her Honour made recommendations to the Department of Education to help implement strategies to engage international students with mental health support and inform interventions to reduce suicide.

39. Several years later, Coroner Simon McGregor conducted a cluster investigation into the deaths of five international students.[7] It became apparent that the university where these students studied provided a range of supports for students, including international students. However, there was an identified lack of engagement by the students involved. His Honour therefore framed the challenge for universities as: *how to encourage international students to engage*

[7] See for example the *Finding into death without inquest regarding FSB*, COR 2020 001132, delivered 2 October 2023, published.

with and seek help from existing university services in the first place when they experience mental health crises and/or suicidality. However, given none of the deceased in the cluster had engaged with **any** health services or disclosed their feelings to family or friends, the challenge was re-framed to: *how to encourage international students to seek help at all.*

40. During his investigation, his Honour commissioned Orygen[8] to prepare resources including a list of questions to ask universities about their health and wellbeing services, and an evidence-based Quality Evaluation Framework. The Quality Evaluation Framework identified 10 areas (five university-wide, five specific to international students) in which universities were recommended to review their policies, guidelines, and practices. The areas included mental health, suicide prevention and postvention, staff training in mental health and suicide awareness, initial orientation for international students, ongoing support for international students, and access to mental health services.

41. Coroner McGregor provided a copy of the Quality Evaluation Framework to the Suicide Prevention and Response Office of the Victorian Department of Health and recommended that the Department review the framework and consider whether a similar resource would assist universities to assess and review how they support international student health and wellbeing. Hs Honour further recommended the Department consider developing and maintaining a resource of this type to assist Victorian universities in implementing and reviewing their programs targeted at international student wellbeing.[9]

42. In February 2024, Professor Euan Wallace, Secretary of the Victorian Department of Health, responded to these recommendations. He noted that the Department would implement both recommendations as follows:

    (a) the Suicide Prevention and Response Office will review the framework commissioned for the cluster coronial investigation and its other work related to international students and consider the framework's utility to assist universities to assess and review how they support international student health and wellbeing. The Office will conduct the review in collaboration with the taskforce through its 2024 program, which was already in development at the time of the response; and

[8] Orygen is a not-for-profit mental health service and research institute dedicated to youth mental health.
[9] Coroner Jamieson went on to support these recommendations in a later finding and encouraged the Department of Health and universities to continually review the policies and programs they have available to international students to ensure that they are accessible, available, and reaching the intended audience. See the *Finding into death without inquest regarding Chenna Kesava Sai Prasangi*, COR 2021 004398, delivered 22 July 2024, published.

(b) in collaboration with the taskforce, the Department will consider developing and maintaining a resource to assist universities in implementing and reviewing their programs targeted at international student wellbeing. This will include consideration of how a resource may be reviewed and revised over time. This would allow new research, program design, and ideas for monitoring international student wellbeing to be shared and to encourage help-seeking among those who may be experiencing mental health crises or suicidality.

43. Given the work already undertaken in investigating suicides amongst the international student cohort, there is no need for me to make further recommendations to encourage or buoy further or ongoing work. The vulnerability of international students and the commonality of their stressors is well recognised.

44. It is axiomatic that the prevention lies not only in the support offered by universities, which appears sufficient, but how to **encourage** students to actually access the offered support. I look forward to the Department of Health's work to assist Victorian universities to monitor international student wellbeing and encourage help-seeking.

I convey my sincere condolences to Mr RGE's family for their loss.

PUBLICATION OF FINDING

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

DISTRIBUTION OF FINDING

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

Mr RGE's parents, senior next of kin

Secretary, Victorian Department of Health

Chancellor, Deakin University

Senior Constable William Colliver, Victoria Police, Coroner's Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 24 September 2024

Re-signed date: 16 October 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.