IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 005245

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Adam James Southern
Date of birth:	23 January 1980
Date of death:	Between the 3 September 2024 and 4 September 2024
Cause of death:	1a : NECK COMPRESSION 1b : HANGING
Place of death:	16/62 Northern Highway Echuca Victoria 3564
Keywords:	Suicide; Mental health; Family Violence

INTRODUCTION

1. On 4 September 2024, Adam James Southern was 44 years old when he was found deceased in his home. At the time of his death, Adam lived alone at 16/62 Northern Highway Echuca Victoria 3564.

2. Adam was born to parents, Greg and Carol Southern, and grew up with two younger siblings in the Echuca region. Adam completed Year 11 studies and undertook an apprenticeship as a Boilermaker and eventually started his own business as an Arborist in the tree lopping industry.

3. Adam was reported to have developed issues with substance abuse in his adolescence and was known to use cannabis and other illicit substances. Adam was reported to experience a decline in his mental health following financial issues in his tree lopping business and became reclusive from his immediate family.

4. Adam met HW and they commenced a relationship around the middle of 2020. HW reported that the relationship was very tumultuous and Adam drank quite heavily since 2022. In the month lead up to Adam's death, HW reported that he had mentioned that he didn't have much to live for and she recommended that he speak to a counsellor to get assistance.

THE CORONIAL INVESTIGATION

5. Adam'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.

6. 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.

7. 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.

8. Victoria Police assigned Leading Senior Constable Steven Taylor to be the Coronial Investigator for the investigation of Adam's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Adam James Southern 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.[1]

10. In considering the issues associated with this finding, I have been mindful of Adam's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

11. On 3 September 2024, Adam's friend Craig McBeath, caught up with Adam and noted that he looked 'scruffy' and was trying to find drugs to use later that evening. Craig left the premises and returned the next day on 4 September 2024 at around 7:40 pm.[2]

12. Craig knocked on Adam's unit door but didn't get any response. Craig could hear a radio from inside Adam's unit.[3] Craig went into the unit and found Adam hanging from a noose that was attached to the ceiling and called emergency services.

13. Police members arrived at 7:49 pm to assist Craig but Adam exhibited no signs of life and was pronounced deceased onsite.[4]

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[1] 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.

[2] *Coronial Brief*, Statement of Craig McBeath.

[3] Ibid.

[4] *Coronial Brief*, Statement of Leading Senior Constable Steve Taylor.

Identity of the deceased

14. On 4 September 2024, Adam James Southern, born 23 January 1980, was visually identified by their friend, Craig McBeath.

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

Medical cause of death

16. Forensic Pathologist Dr Melanie Archer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination on 6 September 2024 and provided a written report of her findings dated 19 September 2024.

17. The post-mortem examination revealed evidence of a ligature in situ, with an underlying ligature mark in keeping with the described hanging scenario.

18. Toxicological analysis of post-mortem blood samples identified the presence of ethanol (~0.02 g/100mL) and Methylamphetamine (~0.03 mg/L).

19. Dr Archer provided an opinion that the medical cause of death was 1(a) NECK COMPRESSION in the setting of 1(b) HANGING, and I accept her opinion.

FINDINGS AND CONCLUSION

20. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[5] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

21. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Adam James Southern, born 23 January 1980;

[5] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

b) the death occurred on sometime between 3 September 2024 and 4 September 2024 at 16/62 Northern Highway, Echuca, Victoria, 3564, from 1(a) NECK COMPRESSION in the setting of 1(b) HANGING; and

c) the death occurred in the circumstances described above.

22. Having considered all of the circumstances, I am satisfied that Adam intentionally took his own life.

COMMENTS

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

23. In the months preceding his death, Adam was involved in a several family violence incidents with HW that were reported to the police. HW had confirmed that she experienced several incidents of Adam attending her residence during the night and banging on windows and doors aggressively whilst demanding to see her. HW reported that this occurred on 20 July 2024, 29 July 2024 and 31 July 2024 following a recent separation earlier in July 2024. HW reported the above incidents to police on 1 August 2024 and police applied for an interim Family Violence Intervention Order (**FVIO**) protecting HW from Adam. The interim FVIO was served on Adam on 10 August 2024 and is likely to have contributed significantly to a decline in his mental health.

24. When police members attend a family violence incident, attending members can make referrals through the Victorian Police Risk Assessment and Risk Management Report 'L17'. At the time Adam was served with the interim FVIO, a referral was recommended by investigating police members for the Men's Referral Service (**MRS**) to contact Adam to offer support. The MRS is a national counselling, information and referral service for men who have or are alleged to have used violence and is operated by the organisation, No To Violence (**NTV**). When a referral is made to the MRS, family violence perpetrators receive a response from support agencies when it is appropriate to do so and doesn't place the victim at risk. This policy ensures that the police serve a FVIO on alleged perpetrators before the men's referral service makes contact, ensuring that the alleged perpetrator isn't surprised by the fact that there is an FVIO in place (and potentially cause more harm to the affected family member).

25. In this case, Adam was ultimately never contacted by the MRS, as the service was unable to confirm that police had served him with the interim FVIO. This is a systemic issue identified across coronial investigations where an alleged family violence perpetrator has an active referral on the L17 portal system for MRS to make contact but never receives support.

26. In his investigation into the death of *Richard Powell*[6], the former State Coroner, Judge Cain, received confirmation from NTV that 62% of L17 referrals between 1 January 2017 and 30 June 2020 were unactioned. NTV confirmed that all after hours referrals between midday Friday to 4 pm Sunday are handled by the men's referral service, any referrals which are not actioned are returned to an Orange Door[7] or other local intake providers for follow up. NTV further confirmed that of the unactioned referrals, 61% of them were due to the alleged perpetrator having not been contacted by Victoria Police, this is policy to protect victims in case the alleged perpetrator becomes aware of actions against them without an interim FVIO in effect.

15. The issue of lack of follow up actions from the MRS in this case and other similar cases remains a systemic concern. Whilst this doesn't raise a specific prevention opportunity in relation to Adam's death, it means that he never received referrals for support to engage with specialist services that assist men who use violence against women and children. This includes further mental health service supports that may have had an impact on the ultimate outcome in this case.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) That the Minister for Prevention of Family Violence and the Department of Families, Fairness and Housing - Family Safety Victoria explore improvements to policies and procedures for Orange Door referrals to the Men's Behaviour Change Program. Referrals should remain open for at least 30 days before closure can be authorised.

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

[6] COR 2017 000126.
[7] The Orange Door is a specialist service that assists people who are experiencing or using family violence or who need support with the care and wellbeing of children and young people.

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.

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

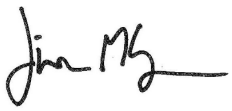
Carol Southern, Senior Next of Kin

Deputy Secretary Melanie Heenan, Family Safety Victoria, Department of Families, Fairness and Housing

The Hon. Melissa Horne, Minister for Prevention of Family Violence

Leading Senior Constable Steven Taylor, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 15 July 2026

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.