IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 003816

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	XY
Date of birth:	2005
Date of death:	11 July 2022
Cause of death:	1(a) Gunshot wound to the head
Place of death:	Victoria

INTRODUCTION

1. On 11 July 2022, XY was 16 years old when he was found deceased at his home. At the time of his death, XY lived in Victoria with his parents and older sister.

2. XY was diagnosed with Autism at the age of three and was later diagnosed with Asperger's Syndrome at the age of seven. During his childhood, he received speech therapy, occupational therapy and assistance with communication and interaction skills. From ages seven to nine, he participated in a sports program in Traralgon for children with intellectual and physical disabilities. He played junior football and tennis with local sporting clubs and did mountain bike racing. He engaged well at school and had close friends there.

3. In the years prior to his death, XY was experiencing mental health issues. He asked his parents to take him to a doctor as he wanted to take anti-depressants. His parents took him to Headspace in Morwell, although XY never explained why he wanted to take anti-depressants. He attended Headspace on four or five occasions and his parents observed that he seemed to be "*doing ok*".

4. One of XY's friends observed cuts on XY's arms when they were in Year 8, which XY said was from barbed wire. His friend did not believe the answer but noted XY did not want to discuss it further. In late-November 2021, XY's mother observed cuts on his thighs and questioned him about it. He initially refused to discuss the issue, however he eventually agreed to see his general practitioner (**GP**) who prepared a mental health plan and referral to a psychologist. XY admitted during the consults with the GP to previous suicidal thoughts but denied active plans. He did not want further appointments with his GP. There was initial difficulty with XY seeing a psychologist due the COVID-19 pandemic and he then had difficulty finding a psychologist that he engaged well with.

5. XY did not report ongoing thoughts of suicide or self-harm to his treating clinicians or immediate family. He told his father that he did not feel depressed and that he received more benefit talking to his friends, some of whom had their own mental health issues.

6. However, there were occasions when XY said that he could hear voices in his headphones, that Elon Musk was trying to listen and implant something in his brain, and that Jeff Bezos could take over the world if he wanted to. Friends and family members who heard such comments thought XY was joking. In October 2021, XY attended a party where he

consumed alcohol, and his parents were asked to collect him as he was intoxicated. At home, XY was angry, upset and crying. He told his mother and sister that Elon Musk was spying on him, so his parents removed his computer from his room to placate him. At the time, his parents attributed this behaviour to XY being intoxicated.

7. In early-2022, XY reported to his girlfriend that "*he didn't have anything to live for, that he didn't want to live as he thought it was pointless*".[1] He also explained that he intended to use his father's firearm to end his life, however, would not do so when his father was present at home. About two months before his death, he also briefly posted an image of himself with a rifle barrel to his head online via the 'Discord' application, which his friends viewed, before he removed it. When his friends questioned him about the photo, he did not respond.

THE CORONIAL INVESTIGATION

8. XY'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.

9. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The 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.

10. 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.

11. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of XY's death. The Coroner's Investigator conducted inquiries on my behalf and submitted a coronial brief of evidence.

12. This finding draws on the totality of the coronial investigation into the death of XY 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

[1] Coronial brief (**CB**) 21.

narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

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

Circumstances in which the death occurred

13. On 23 June 2022, XY and his family travelled to Cairns for a family holiday. XY's parents did not observe anything unusual about his behaviour during the holiday, with his mother, MO, reporting that he "*seemed the happiest he'd ever been*".

14. However, XY's interactions with his friends using his mobile phone were entirely different in nature. Whilst he was in Cairns, he sent text messages to one of his friends, stating that "*he was considering suicide*" but probably would be unable to go through with it.[3] He described his thoughts on how he would do this and said he did not want to live.[4] His friend "*tried to talk him out of it*" but thought that XY was not listening.[5] The friend was so concerned about these conversations that he was relieved when he later received a message from XY stating that he did not take his own life. XY's friend told him that he was available if he needed to talk. XY asked his friend not to tell anyone about how he was feeling and not to save the messages. Whilst in Cairns, XY also sent messages to his girlfriend stating that he felt like jumping off a bridge, but he did not want to lose her or hurt his family.[6] XY's parents were unaware that these conversations were taking place, and it does not appear that his friend or girlfriend notified any adult about these conversations.

15. XY and his father, FA, returned to Melbourne on 7 July 2022, with the rest of the family due to return from the holiday a week later.

16. On 8 July, FA moved a rifle he owned from his farm to the family home, as they had been having problems with foxes at the property and FA told XY to tell him if he saw any foxes. FA placed the magazine, bolt, and ammunition in his bedside table drawer, and put the firearm out of view behind the wardrobe in XY's bedroom. FA did not think that the firearm could be seen unless actively looking for it, however XY

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[2] 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.

[3] CB 24.

[4] CB 24-25.

[5] CB 25.

[6] CB 18.

would have known it was in the house or the shed as he was aware it had been moved to the house. The firearm was registered, and FA held a gun licence, but storing the rifle and its components in this matter was not in accordance with legal requirements. XY previously used the firearm under the supervision of his father when shooting rabbits, but he did not have a firearms licence as he was underage.

17. On Saturday 9 July 2022, XY spent the day with his girlfriend at his house, watching television. She did not see him on 10 July 2022; however, she spoke to him via the Snapchat application throughout the day. She stated she did not observe anything unusual about his behaviour.

18. XY returned to school on 11 July 2022 for the beginning of Term 3 and saw his father in the morning before school, who did not observe anything unusual about him. XY sent a message to his girlfriend on Snapchat that day and she had no concerns about him; they planned to meet later in the week. During the day XY attended at the school welfare room briefly with a friend, volunteering to do small tasks in exchange for a canteen voucher. He was well known to the welfare service and had intermittent contact with the service over several years, but his interactions with them were no cause for greater concern. There was nothing concerning about his attendance at the service on that day, and his friends noted nothing of concern about his behaviour whilst at school.

19. After school, XY exchanged messages with his girlfriend. At about 5.00pm, FA called XY at home and informed him that he was running late and that there was food in the fridge. XY reported that he was going "*off riding with his friend*" and said, "*Gotta go, talk to you tonight*". His father said "*No worries. I love you*" and XY ended the call.

20. XY sent his last message to his girlfriend at about 5.45pm via Snapchat, in which he said, "*I'm sorry*". He did not respond to any further messages or calls from his girlfriend. FA returned home between 6.30pm and 7.00pm. He checked his son's bedroom and found XY lying supine on the floor, with a gunshot wound to the forehead and the rifle lying beside him.

21. FA immediately called 000 and requested assistance. He followed call-taker's instructions to perform cardiopulmonary resuscitation (**CPR**) until emergency services arrived. XY was unable to be revived and was declared deceased at the scene.

22. Police attended and investigated the scene. They discovered that at the time of his death, XY was playing music videos using YouTube on the computer in his room. The music video

playing proximate to his death was "*Life, I'm Over You*" by Zevia. Prior to that, a music video for "*Listen Before I go*" by Billy Eilish was played. Both songs appear to relate to suicidality, or contemplation of suicide, or could easily be interpreted to be.

23. After the death, some of XY's friends were discussing what happened and contacted his girlfriend. She sent them screenshots of messages XY sent to her. In the days leading up to his death, XY sent messages to his girlfriend in which he said that he felt "*like there's someone in his head telling him to make him pull the trigger a little further each time*" [7] and stated that he wanted his father to take away the gun. He also reported that the "*voice takes over sometimes…I just feel like there's always someone over my shoulder screaming at me to die*". Screenshots of messages XY sent to his friend whilst in Cairns were also shown to another friend after XY's death. The friend said he wanted to tell people at the time, but as XY did not want him to say anything, he did not want to break his friend's trust.

24. Following XY's death, police attempted to interrogate his phone and computer, however the passwords for both devices were not known to his family or friends and a full interrogation of the devices was not possible. As such, police were unable to download the contents of either device, to determine if XY was viewing content about suicide on social media or elsewhere online, other than viewing music videos which concerned suicide on the day of his death. XY did not leave any note or explanation for his decision.

Identity of the deceased

25. On 11 July 2022, XY, born in 2005, was visually identified by his father, FA.

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

Medical cause of death

27. Forensic Pathologist Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 12 July 2022 and provided a written report of her findings dated 13 July 2022.

28. The post-mortem examination revealed findings in keeping with the clinical history.

[7] CB 25.

29. Examination of the post-mortem CT scan showed a gunshot entrance wound to the middle of the frontal bone with internal bevelling. There were multiple metal fragments and two fractures radiating posteriorly from the entrance wound and terminating in the right and left parietal bones.

30. Toxicological analysis of post-mortem samples did not identify the presence of alcohol or any commonly encountered drugs or poisons.

31. Dr Baber provided an opinion that the medical cause of death was "*1(a) Gunshot wound to the head*".

32. I accept Dr Baber's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was XY, born in 2005;

    b) the death occurred on 11 July 2022 in Victoria, from gunshot wound to the head; and

    c) the death occurred in the circumstances described above.

34. Having considered all the circumstances, I am satisfied that XY intentionally took his own life.

COMMENTS

35. I have ultimately been unable to determine what specific factors led XY to take his own life. It is utterly tragic that the life of a child could end in this way, and with so little explanation available as to why. Whilst I am satisfied that XY intentionally took his own life, it is an uncomfortable finding to make for any 16 year old. It is difficult to assess what he really understood about his decision, and more difficult to believe he really appreciated the devastating grief that it would cause his family and friends, or the true consequences of his actions. Legally, he was on the cusp of adulthood, but as a teenager his brain development and maturation were not close to being complete. The decision to end his own life could not have been fully formed.

36. Whilst it is significant that XY had a background of self-harm and observed odd/paranoid type behaviours, his family did not believe that he was at acute risk in the period immediately prior to his death. I note that he had no known difficulties at school, in his friendship group or in his home environment. Nor was there any concern amongst his family and friends about his behaviour on the day of his death. His family members could not have anticipated his actions based on what was known to them at the time.

37. It is very concerning that unbeknownst to his parents, XY was frequently communicating to members of his social circle that he wanted to take his own life in the period leading up to his death. The communications show that XY was experiencing ongoing suicidality with planning, yet he did not disclose this to any adult or clinicians proximate to his death. It appears that his friends did not report this to any adult. The outcome may have been very different if such assistance was sought and resulted in his family knowing what he was communicating to his peers. At the very least, it is highly unlikely that a firearm would have been left in the home. He would therefore have been unable to take his own life in this manner, where the degree of lethality is so high and with no chance for reconsideration.

38. Despite the directness and persistence of the suicidal statements made by XY, this did not prompt any of his peers to seek adult assistance. They either did not believe he would go through with it or did not confide in any adult as XY explicitly asked them not to. I do not know what skills and knowledge (if any) they possessed regarding the best way to respond to this type of behaviour or how to seek appropriate assistance. One wonders whether there is now a degree of desensitisation to statements of this type amongst children and young people, who are part of a cohort where mental health issues, self- harm and suicidality are increasing at alarming rates.

39. The circumstances of this case are troubling for many reasons. Like so many other cases involving children who take their own life, this case raises much broader and complex issues about the way children are communicating with each other, and the increasing rates of suicide and suicidality in children. With every death of this type, more children are dangerously exposed to the suicide of one of their peers, and the ripple effect of that increasing exposure amongst a generation of children and young people is a cause for great concern.

40. It is beyond the scope of this investigation to assess to what degree the issues I have identified in this case are playing out more broadly in children and young people nationally, or to specifically determine what the most appropriate measures are to counter them. As such, I

have directed that a copy of this finding be provided to the Victorian Department of Education, and to the Assistant Minister for Mental Health and Suicide Prevention, Emma McBride. My hope is that the circumstances of XY's death will be highlighted and brought to the attention of those best resourced to assess how widespread these complex issues are, and what can be done on a broader scale to address them.

41. XY will clearly be greatly missed by all those who loved and knew him. I convey my sincere condolences to his family for their loss.

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

XY's parents, Senior Next of Kin

Department of Education

Assistant Minister for Mental Health and Suicide Prevention, Emma McBride.

Leading Senior Constable Myles Gerry, Victoria Police, Coroner's Investigator

I direct publication of this finding pursuant to s 73(1A) of the *Coroners Act 2008* in accordance with the rules.

I direct that the name of the deceased not be published and be referred to by way of pseudonym.

Signature:

Coroner Catherine Fitzgerald

Date : 11 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.