IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004573

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	JHT
Date of birth:	1997
Date of death:	7 August 2024
Cause of death:	1a: Neck compression 1b: Hanging
Place of death:	Pakenham South, Victorias

INTRODUCTION

1. On 7 August 2024, JHT was found deceased in his home in circumstances suggestive of suicide. He was 27 years old. At the time of his death, JHT lived in Pakenham South, Victoria, with his partner, LWF.

THE CORONIAL INVESTIGATION

2. JHT'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.

3. 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.

4. 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.

5. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of JHT's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. Coroner John Olle originally held carriage of this investigation, prior to his retirement in July 2025. I assumed carriage of this investigation on 28 July 2025.

7. This finding draws on the totality of the coronial investigation into the death of JHT 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]

[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

Background

8. JHT's parents affectionately referred to him as 'Roo'. This name stayed with him through his life. His parents described him as a happy child who helped those around him.

9. From when he was a baby, JHT had trouble sleeping and his mother took him to see a psychologist in his early teenage years to aid his poor sleep. At around this time, JHT began surfing, he loved being in the water and his mother reported that it also assisted with his sleep.

10. JHT had a difficult time at school as he experienced bullying and found building relationships challenging. His mother described JHT as hyper-sensitive and that he wanted others to like him. When he was 15 years old, JHT took the initiative to engage with Headspace, a youth mental health service.

11. In adolescence, JHT showed interest in building and construction and began building his own remote-controlled boats and cars. When he completed Year 10, he left school and started working in his family's construction business.

12. JHT moved out of his family home in 2017 and began working and living in Pakenham South. At work, JHT was considered a reliable employee and was respected by his colleagues.

13. At around this time, JHT became involved in the local four-wheel-drive (**4WD**) winch racing community. He enjoyed being part of the local club and started modifying the 4WD vehicles for races.

14. In 2019, JHT met LWF at her work. The two exchanged details and began dating shortly afterwards. In 2020, LWF moved into JHT's house. They spent their free time camping and attending 4WD events together.

15. JHT told to LWF that prior to their relationship, he was diagnosed with attention deficit hyperactivity disorder (**ADHD**) and depression and that he was taking antidepressant medication when he was 18 years old, but they did not work for him. During their relationship, LWF was not aware of whether JHT was taking medication for his mental health. LWF told the court that throughout their relationship, JHT talked about his mental health, and on

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

occasions LWF suggested JHT seek help from a professional. He refused as he did not believe seeing a counsellor or therapist would work.

16. However, JHT's dissatisfaction with his life—that he didn't make enough money, that he didn't own a house, and his desire to be further along in his career—weighed heavily upon him. LWF said that JHT had also told her that JHT had told her he suffered from insomnia and had recently consulted a doctor about it and he had been prescribed melatonin.

17. Early on in their relationship, JHT drank whiskey, but he and LWF found it made him depressed, so he began to drink rum instead. On nights he worked, JHT had the occasional pre-mixed can but otherwise only engaged in drinking on his days off work.

18. In around June 2024, LWF and JHT's relationship became more strained as LWF felt pressure trying to juggle all her responsibilities including two jobs and her university studies while JHT struggled with feeling that he was not where he wanted to be in his life and career. These tensions caused conflict between them.

19. In early July 2024, JHT found out that LWF had briefly become involved with another person which caused further conflict. JHT booked a session with LWF's counsellor for himself, and the couple had a session together after this. I have reviewed the notes from this counsellor.

20. At around this time, JHT took approximately one month of personal leave from work as his mental health was impacted by all of his life circumstances, his relationship, his career and his mental health.

21. LWF's mother flew to Melbourne to support her on Friday 2 August 2024 and LWF stayed with her mother at her grandmother's house over the weekend. LWF was in contact with JHT every day. On Monday 5 August 2024, LWF drove her mother to the airport and returned home to Pakenham South. According to LWF, that night felt normal and as though she and JHT had gone back to being themselves.

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

Circumstances in which the death occurred

22. On 7 August 2024, LWF left home at approximately 4.00am for work. When she left, JHT was still in bed. She returned from work between 2.30pm and 3.00pm and JHT was already home. LWF studied for a few hours and then had plans to go to the gym with her sister.

23. JHT became upset with LWF as she planned to go to the gym with her sister, despite plans they made in the weeks prior to begin going to the gym together. Following this interaction, JHT went to the garage and LWF stayed home. She didn't attend the gym that evening.

24. At 4.24pm, JHT heard a sound and text messaged LWF to ask if that was her leaving, to which she replied that it was not. At 6.08pm, LWF texted JHT to tell him she was going to pick up dinner, but she did not receive a reply.

25. When LWF returned with dinner, she parked the car and went to the garage. Once she lifted the roller door, she found JHT hanging from a rope fastened to an overhead rafter. It is difficult to imagine the effect this discovery has had on LWF, but LWF is to be commended for having acted so quickly, despite what must have been a shocking situation.

26. LWF called emergency services and cut the rope to lower JHT to the ground. The emergency services operator instructed LWF to commence cardiopulmonary resuscitation (**CPR**). LWF commenced CPR and continued until Ambulance Victoria paramedics arrived and took over. Despite every effort to revive JHT, Ambulance Victoria paramedics found no signs of life and JHT was declared deceased at 6.50pm.

27. In the garage, Victoria Police members found a half-filled bottle of scotch and a number of pre-mixed cans of rum. Police did not identify any evidence of suspicious circumstances regarding JHT's death and concluded that JHT's death was caused by suicide.

Identity of the deceased

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

Medical cause of death

29. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 8 August 2024 and provided a written report of his findings dated 22 August 2024.

30. The post-mortem examination was consistent with the reported circumstances.

31. Toxicological analysis of post-mortem samples did not identify the presence of any alcohol or other common drugs or poisons.

32. Dr Bouwer provided an opinion that the medical cause of death was '*1(a) Neck compression*' secondary to '*1(b) Hanging*'.

33. I accept Dr Bouwer's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was JHT, born 1997;

    b) the death occurred on 7 August 2024 in Pakenham South, Victoria, from neck compression secondary to hanging; and

    c) the death occurred in the circumstances described above.

35. Having considered all the circumstances, in particular JHT's history of depression, his history of attempting to find suitable mental health treatment and the challenges in his life and career, I am satisfied that JHT intentionally took his own life by hanging.

COMMENTS

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

36. The reasons JHT decided to take his life can be ascribed to several factors rather than a single factor. I have drawn inferences from the evidence contained in the statements of LWF and JHT's family which were provided to the Coronial Investigator. However, it is important to be cautious as to any conclusions that might be drawn as to why JHT took his life. I have made further inquiries as I saw fit. I have reviewed the witness statements which shed light on JHT's childhood, his relationship with LWF and his work history. JHT appears to have

had insight into his mental ill health and the challenges he had faced over some time and his need for support. This insight is best observed by his confidences to LWF about his mental health, his pursuit of LWF's counsellor for support and to assist with their relationship difficulties and the discussions LWF described him as having had with her about his life and career.

37. Having found that JHT's death was caused by hanging, it will now be recorded on the Victorian Suicide Register (**VSR**). The 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.

38. The primary purpose of gathering suicide data in the VSR[2] is to assist coroners with prevention-oriented aspects of 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 an individual death, which in turn can lead to recommendations to reduce the risk and make recommendations about such matters as support services and opportunities for prevention of suicide in future.

39. 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.

I convey my sincere condolences to JHT's partner and family for their loss.

[2] The VSR indicates the annual frequency of suicides occurring in the state of Victoria has been steadily increasing for the past decade, from 550 deaths in 2011 to a peak of 797 deaths in 2023, then 777 deaths in 2024. At the time of writing, the total figure for 2025 was not yet published, however I note that the aggregate monthly figure as at November 2025 was 717 deaths.[2] While this represented another slight reduction in the number of deaths in recent years, the prevalence of deaths by suicide is nevertheless concerning and warrants the continued efforts of this Court to identify opportunities for prevention and, in some cases, early intervention.

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

Senior Next of Kin

Leading Senior Constable Joshua Diemar, Coronial Investigator

Signature:

Coroner Therese McCarthy

Date: 24 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.