IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 004922

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of STEPHANIE JEAN WINBERG

without holding an inquest:
find that the identity of the deceased was STEPHANIE JEAN WINBERG
born on 18 September 1991
and the death occurred on 16 October 2009

from:

1 (a) COMPRESSION OF THE NECK IN CIRCUMSTANCES OF HANGING.

Pursuant to section 67(2) of the ***Coroners Act 2008***, I make findings with respect to **the following circumstances:**

INTRODUCTION AND PURPOSE

1. This investigation examined the circumstances and contributing factors relating to the death of Stephanie Winberg. Before I make my findings on these circumstances and factors, I wish to convey my sincere condolences to Stephanie's parents, Mr Colin and Ms Tracey Winberg and her family and friends. The unexpected death of a young person is devastating for parents, family and friends, and my purpose in conducting this investigation 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

1. The circumstances surrounding Stephanie Winberg's death were fully investigated by Victoria Police.
2. Stephanie Winberg was an 18-year-old female who lived in the family home at the above address with her mother, Tracey Winberg, father, Colin Winberg, younger brother, and two cousins. Stephanie was a student at St Ignatius College in Drysdale at the time of her death.
3. Stephanie had a complicated medical history as a child with urological, bowel and pain problems. She had an eating disorder with restrictive dietary intake, loss of weight and body image issues. Stephanie also had a history of major depressive disorder and, after witnessing a close friend being hit by a car and dying in her presence in April 2009, she developed post traumatic stress disorder. Stephanie suffered from recurrent nightmares, flashbacks and lowered mood.
4. Stephanie had been seeing psychologist Natalie Hodgen, paediatrician Dr David Fuller and psychiatrist Dr Peter O'Keefe around the time of her death. She saw Ms Hodgen from early 2007, who treated Stephanie with cognitive behavioural therapy and with a focus on building resilience and self esteem. Ms Hodgen last saw Stephanie on the date of her death, 16 October 2009. She stated that Stephanie conversed openly and that her suicide risk had not changed '*in that she continued to have occasional thoughts to end her life but with no clear plan or intent*'. Ms Hodgen stated that Stephanie reported looking forward to her end of school celebrations and had planned a trip to Queensland with friends. She had made an appointment for their next session.

5. Dr Fuller stated that Stephanie first presented to him in mid-2007 for her eating disorder, and had had admissions to The Geelong Clinic for nutritional rehabilitation. Dr Fuller stated that in 2009, whilst Stephanie continued to experience issues with body image, she was able to eat adequately, generally resist purging and maintain an adequate weight, until the death of her friend, which was a cause of major ongoing distress. Dr Fuller prescribed fluvoxamine to treat Stephanie's anxiety in March 2009 but stated that this was discontinued, then recommenced in May 2009 and continued until the time of her death. Stephanie was admitted to the Geelong Clinic again in August 2009, and Dr Fuller reviewed her on 7 October 2009 upon her discharge. He noted that she reported no intention, even on direct questioning, to take her life.

6. Dr O'Keefe treated Stephanie at the Geelong Clinic from 2008. He noted a history of post traumatic stress disorder after the death of her friend and stated that additional stressors for her included attempting to complete her VCE, conflicts with her parents, alienation from some of her peer group, and worries about the welfare of another friend who had also witnessed the death of their friend. Upon her discharge from the Geelong Clinic in October 2009, Dr O'Keefe stated that she was prescribed fluoxetine, quetiapine and augmentin duo. He noted that Stephanie appeared to have had a positive experience during her inpatient stay.

7. A close friend of Stephanie's stated that she was the subject of bullying and taunting by other students at school, and that the death of their friend had a profound impact on her. She reported seeing her on the date of her death at school, and noting nothing out of the ordinary.

8. Stephanie's former boyfriend stated that they maintained a close friendship after their relationship ended. He stated that 'things started to get worse' for Stephanie after their friend's death and he witnessed her experiencing flashbacks. He had some contact with her on 16 October 2009 by text message. They had a brief argument via text message, before she began asking how he would remember her. This worried him and he continued to send text messages. Stephanie's last response was sent at around 6.54pm.

9. Ms Winberg stated that Stephanie had suffered mild post traumatic stress disorder following an incident where a relative held a knife to Mr Winberg's throat, in the context of a dispute over custody of their nephews (Stephanie's cousins), whose parents died in a motor vehicle collision. Ms Winberg also stated that Stephanie had been bullied at school by some students, with one female student 'leading' the bullying in particular, and that this student would make negative remarks and spread rumours. Her brother also stated that Stephanie was being bullied by other students. Mr Winberg stated that in his view, despite Stephanie's medical history, the bullying was her main stressor.

CIRCUMSTANCES OF THE INCIDENT

10. On the evening of Friday 16 October 2009, Mr and Ms Winberg left the house to go out for dinner. Stephanie, her brother and cousin were home together. Her brother stated that Stephanie appeared 'normal', and went outside at about 7.30pm for a cigarette. He saw her briefly from the upstairs balcony, before returning inside.

11. When Stephanie had not returned inside after about 20 minutes, her brother went outside to look for her. Her cousin stated that he was a little concerned as it was exactly six months since her friend's death. Her cousin came to assist her brother, and they found Stephanie hanging from a rope attached to a tree on the right side of the house, with a plastic chair tipped over on the ground nearby. They telephoned Mr Winberg and 000.

12. Mr and Ms Winberg returned home and Mr Winberg lifted Stephanie down and attempted CPR, whilst her cousin conveyed instructions from the 000 operator. Paramedics arrived a short time later and continued CPR and resuscitative efforts, but they were unable to revive Stephanie and confirmed that she was deceased.

THE MEDICAL CAUSE OF DEATH

13. No autopsy was performed. However, an external examination of Stephanie's body and post mortem CT scanning (PMCT) were performed, which revealed the cause of Stephanie's death to be *compression of the neck in circumstances of hanging.* The external examination was consistent with the reported circumstances, and there was no evidence at PMCT of significant natural disease or other major trauma to the body of a type likely to have contributed directly or indirectly to death.[1]

14. Post mortem toxicology testing revealed the presence of fluoxetine (for treatment of major depressive disorders) at ~0.4mg/L and within the therapeutic range. Ethanol (alcohol) and other drugs or poisons were not detected.

[1] Medical investigation report of Deputy Director of the Victorian Institute of Forensic Medicine, Associate Professor David Ranson, dated 9 November 2009.

Findings pursuant to section 67 of the *Coroners Act 2008*

15. I find that:

    a. the identity of the deceased was Stephanie Jean Winberg; and

    b. Stephanie died of compression of the neck in circumstances of hanging, on 16 October 2009, at her home, in the circumstances described above with the intention of taking her own life.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comment(s) connected with the death:

16. During the investigation of Stephanie's death, it came to the attention of the Coroners Court of Victoria that seven persons[2] aged 18 years and under residing in the City of Greater Geelong had suicided during 2009, six prior to Stephanie's death. This was compared to one in 2008 and one in 2007. It is also significant to note that there were no suicides amongst usual residents of the City of Greater Geelong aged 18 years and under in 2010, one in 2011, one in 2012 and two in 2013.[3] This retrospective examination of suicides amongst persons aged 18 years and under showed that during 2009, the City of Greater Geelong experienced a suicide cluster,[4] as defined by the Centres for Disease Control and Prevention. On this basis, assistance was sought from the Coroners Prevention Unit (CPU)[5] 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.

17. In November 2013, an inquest was held into three Geelong deaths of secondary school students at different campuses of the same school (and not Stephanie's school). The inquest examined evidence about the various factors that can contribute to suicides among young people. The CPU review identified four factors that warranted further examination and / or input from external organisations:

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

[3] 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).

[4] *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).

[5] 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.

a. the presence and association between exposure to suicidal behaviour in the social network and an individual's risk of suicide.

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.

18. Questions of causation in suicide are always complex. In this case, the Winberg family believed that a particular student at Stephanie's school caused significant distress for her, and was likely the key, even causal, stressor for her at the time of her death. Whilst I do not express a view about the issue, I note and understand that the family hoped that the impacts of this student's behaviour would be brought to her attention, whilst at the same time recognising that Stephanie was struggling with other significant stressors such as the traumatic death of her friend.

19. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role.[6]

20. It is important to stress that coroners are not empowered to determine the guilt of any person, or the extent of any civil liability arising from her death. A Coroner must not even include in a finding or comment any statement that a person is, or may be, guilty of an offence.[7] Having said that, I note and accept that bullying is serious and destructive and can have severe effects on a young person's physical and mental health, that it can take many forms and can include intimidating social behaviour.

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[6] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf the Coroners Act 1985 where this role was generally accepted as 'implicit'.

[7] Section 69(1) of the *Coroners Act 2008*.

21. The evidence before me also enables me to form the view that Stephanie was very well-supported by her parents, family and friends as well as her treating clinicians. Her parents were clearly providing as much support as possible, were well aware of her physical and mental health issues and took appropriate steps to ensure that Stephanie received the medical care she needed. Stephanie's adoring family were actively working on improving her confidence and self-esteem, and could not have reasonably taken any further action to prevent the terrible outcome for her.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

22. In light of the information I received and have considered, I believe there is an opportunity to reinvigorate suicide prevention activity in Victoria. To that end, I restate the recommendation made in the deaths of Zac Harvey, Taylor Janssen, Chanelle Rae and Taylah Mahon 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:

Mr Colin and Ms Tracey Winberg, senior next of kin
Ms Ann Gardner, Barwon Health Mental Health Service
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
Ms Sandra Craig, National Centre Against Bullying, Alannah and Madeline Foundation
LSC Wayne Macarthur, Victoria Police, Coroner's Investigator.

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**