IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 1218

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

Amended pursuant to *Section 76 of the Coroners Act 2008* on 2 July 2019[1]

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Kyle Horne
Date of birth:	9 November 1998
Date of death:	15 March 2018
Cause of death:	I(a) Hanging
Place of death:	57 Piperita Street, Ferntree Gully, Victoria

[1] This document is an amended version of the Inquest Finding into Kyle Horne's death dated 13 December 2019. A correction to paragraphs 44 and 57 has been made pursuant to Section 76 of the *Coroners Act 2008* (Vic). In an email dated 15 January 2020, Annabelle Mann, General Counsel at The Royal Children's Hospital, advised that AMAZE is not based at The Royal Children's Hospital. Paragraphs 44 and 57 has been amended to reflect this correction.

INTRODUCTION

1. Kyle Horne was a 19-year-old man who lived in Ferntree Gully at the time of his death. He was the beloved son of Selina and Mark Horne and the brother of Jacob.

2. Mr Horne's medical history included high functioning autism.

3. Mr Horne was a talented sportsman. He achieved a blackbelt in karate in 2016 and won state, national and world championship titles in basketball.[2]

4. On the evening of 15 March 2018, Mr Horne's stepfather Michael Tunney, found Mr Horne hanging from a rope ligature in the home's garage.

THE PURPOSE OF A CORONIAL INVESTIGATION

5. Mr Horne's death was reported to the Coroner as it appeared to be unexpected and unnatural and so fell within the definition of a reportable death in the *Coroners Act 2008.*

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. The Coroner's Investigator, Senior Constable Callum Scott, prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist who examined Mr Horne, treating clinicians and investigating officers.

8. During the coronial investigation, Mrs Horne raised several concerns regarding her son's death and made an application for inquest. As a result of Mrs Horne's concerns, I requested additional statements from Maddison Rippon and the Senior Constable Scott.

9. Following advice from the Coroners Prevention Unit (CPU),[3] I obtained data from the Victorian Suicide Register (VSR) regarding suicides of people diagnosed with autism for the period 2009-2015 and an expert report from Professor Robyn Young, Clinical Psychologist.

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[2] Coronial brief, Statement of Selina Horne dated 25 April 2018, 35; Coronial brief, Statement of Jacob Horne dated 25 April 2018, 43.

[3] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

Professor Young's Report is intended to provide a better understanding of Autism Spectrum Disorder (ASD), specifically the implications it may have when developing or ending relationships and the impact of this on a person's mental health.

10. I have based this finding on the evidence contained in the coronial brief, Professor Young's expert report and the data obtained from the VSR. In the coronial jurisdiction facts must be established on the balance of probabilities.[4]

IDENTITY

11. On 15 March 2018, Michael Tunney visually identified his stepson Kyle Horne, born 9 November 1998.

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

BACKGROUND

13. At approximately three years of age, Mr Horne was diagnosed with high functioning autism. Mr Horne's family '*learnt as much as possible about the disorder*' and '*created an environment adapting to his needs*'.[5]

14. In approximately 2011, Mr Horne began attending the Heatherwood School at Donvale, a secondary school for students with mild disabilities.[6]

15. Whilst attending the Heatherwood School, Mr Horne met Maddison Rippon, a fellow student. They commenced a relationship in approximately August 2013.[7]

16. Around June 2017, following Mr Horne's completion of Year 12 at the Heatherwood School, he commenced work experience at the Tirhatuan Lakes Golf Course.

17. Mr Horne was formally employed on a full-time basis at the golf course in September 2017, as a first-year apprentice groundsman. Mr Horne's employer Michael Elijah stated that Mr Horne, '*was a fantastic worker*'[8] and '*was always reliable*'.[9]

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[4] This is 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.

[5] Coronial brief, Statement of Mark Horne dated 25 April 2018, 28.

[6] Coronial brief, Statement of Selina Horne dated 25 April 2018, 35.

[7] Coronial brief, Statement of Maddison Rippon dated 15 April 2018, 17.

[8] Coronial brief, Statement of Selina Horne dated 25 April 2018, 35.

[9] Coronial brief, Statement of Michael Elijah dated 16 April 2018, 12.

18. In December 2017, Ms Rippon told Mr Horne that she needed a break from their relationship to sort out her feelings.[10] Following the separation, Mr Horne and Ms Rippon remained in contact and continued to see one another.[11]

19. Around Christmas 2017, Mr Horne advised his work colleagues that he and Ms Rippon had separated. Although Mr Horne appeared '*a bit down*',[12] Mr Elijah stated that there was no '*distinct change in his demeanour*'[13] whilst at work and he continued to be '*a great worker*'.[14]

20. Over the Christmas period, Mr Horne spoke to his father as to his '*sadness and frustration*'[15] regarding Ms Rippon breaking off the relationship and that he had wanted '*to ask Maddie,* (Ms Rippon) *to marry him*'.[16] He assured his father that he was '*okay*'[17] and that he was '*keeping himself busy going out with friends*'.[18]

21. In January 2018, Mr Horne caught up with his father telling him that Ms Rippon '*wanted to get back to together but he had told her no*'.[19] Mr Mark Horne stated that Mr Horne told him that Ms Rippon had changed Mr Horne's Facebook password and that she was '*causing trouble and starting fights*' with his friends by pretending to be him on Facebook.[20]

22. Mr Horne's mother noted that on several occasions that Mr Horne sustained injuries due to self-harm, including a bruise to his face, and that he promised her he would no longer harm himself.[21]

23. Throughout January and February 2018, Mr Horne and Ms Rippon would see each other on Wednesday evenings, but they reportedly argued often, which according to Mrs Horne was '*mentally and emotionally effecting*'[22] Mr Horne.[23]

24. Mr Horne spoke to his brother about his worries regarding friendships and Jacob was also concerned that Mr Horne was physically harming himself.[24]

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[10] Coronial brief, Statement of Maddison Rippon dated 15 April 2018, 18.
[11] Coronial brief, Statement of Selina Horne, dated 25 April 2018. 36.
[12] Coronial brief, Statement of Michael Elijah dated 16 April 2018, 13.
[13] Coronial brief, Statement of Michael Elijah dated 16 April 2018, 13.
[14] Coronial brief, Statement of Michael Elijah dated 16 April 2018, 13.
[15] Coronial brief, Statement of Mark Horne dated 25 April 2018, 29.
[16] Coronial brief, Statement of Mark Horne dated 25 April 2018, 29.
[17] Coronial brief, Statement of Mark Horne dated 25 April 2018, 29.
[18] Coronial brief, Statement of Mark Horne dated 25 April 2018, 29.
[19] Coronial brief, Statement of Mark Horne dated 25 April 2018, 29.
[20] Coronial brief, Statement of Mark Horne dated 25 April 2018, 29.
[21] Coronial brief, Statement of Selina Horne, dated 25 April 2018. 38.
[22] Coronial brief, Statement of Selina Horne, dated 25 April 2018. 37.
[23] Coronial brief, Statement of Selina Horne, dated 25 April 2018. 37-38.

25. On 8 March 2018, Mr Horne presented to his general practitioner, Dr David Morley, at the Ferngate Medical Centre in Ferntree Gully with Mr Tunney's support, to request a Mental Health Care Plan. Mr Horne cited his relationship as a stressor and, according to Mr Tunney, told Dr Morley that he was feeling depressed.[25] Dr Morley provided Mr Horne with a referral to a psychologist.[26]

26. In the week prior to Mr Horne's death, Mrs Horne did not notice anything out of the ordinary but was aware that Mr Horne felt '*sad*'[27] at the time.[28]

27. On or about 10 March 2018, Mr Horne spent the weekend with his father and his stepmother, Karyrn, at their bush property. Mr Horne spoke to his father the night before they left. Mr Horne was '*excited*'[29] and told his father that he was going to a concert with other family members.[30]

28. On 13 March 2018, Mr Horne presented to Dr Morley with his brother, requesting a medical certificate as he was unwell. According to Dr Morley, Mr Horne did not exhibit any symptoms of psychological distress during the consultation.[31]

29. Around this time, according to Jacob, Mr Horne received a telephone call from Ms Rippon, and overheard what sounded like an argument.[32]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

30. On the morning of 15 March 2018, Mr Tunney drove Mr Horne to work. Mr Horne said that he would see Mr Tunney that evening.

31. According to Mr Elijah, Mr Horne '*seemed fine*'[33] whilst at work but still appeared to be physically unwell having reportedly vomited earlier. Mr Horne told Mr Elijah that he was '*physically exhausted*'[34] so could not do any overtime and Mr Elijah told him to go home.[35]

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[24] Coronial brief, Statement of Jacob Horne dated 25 April 2018, 45.
[25] Coronial brief, Statement of Dr David Morley dated 23 April 2018, 10; Coronial brief, Statement of Michael Tunney dated 26 June 2018, 25.
[26] Coronial brief, Statement of Selina Horne, dated 25 April 2018. 36.
[27] Coronial brief, Statement of Selina Horne, dated 25 April 2018. 38.
[28] Coronial brief, Statement of Selina Horne, dated 25 April 2018. 38.
[29] Coronial brief, Statement of Mark Horne dated 25 April 2018, 30.
[30] Coronial brief, Statement of Mark Horne dated 25 April 2018, 30.
[31] Coronial brief, Statement of Dr David Morley dated 23 April 2018, 10.
[32] Coronial brief, Statement of Jacob Horne dated 25 April 2018, 45.
[33] Coronial brief, Statement of Michael Elijah dated 16 April 2018, 13.
[34] Coronial brief, Statement of Michael Elijah dated 16 April 2018, 13.
[35] Coronial brief, Statement of Michael Elijah dated 16 April 2018, 13.

32. At approximately 3.00pm, Mr Horne contacted Ms Rippon asking her if she wanted to catch up to talk. Ms Rippon said that she was unable to do so that day, but that they would catch up the following week. Ms Rippon stated that Mr Horne asked her, '*do you still love me*'[36] and '*do you still want to be with me*',[37] telling her that he felt '*rejected*'[38] as he had intended to propose to her. Ms Rippon stated that she was unable to answer his questions and he became emotional. Before the phone call ended, Ms Rippon stated that Mr Horne told her, '*I need you Maddi, you're the only person*'.[39]

33. Mr Horne attempted to phone his mother at 3.47pm, but she was with a client at work. Mrs Horne attempted to call him several times around 4.05pm, but he did not answer.[40]

34. At approximately 5.00pm, Mr Tunney arrived home and called out to Mr Horne. He did not receive a response but assumed that Mr Horne was sleeping as he often did after work. A short time later, Mr Tunney went outside to move the car and located Mr Horne unresponsive hanging from a rope ligature attached to the roof of the garage.[41]

35. Emergency services were called, and Mr Horne was declared deceased.

CAUSE OF DEATH

36. On 16 March 2018, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Mr Horne's body and provided a written report, dated 20 March 2018. In that report, Dr Ross Young concluded that a reasonable cause of death was 'I(a) *hanging*'.

37. Toxicological analysis did not identify the presence of any common drugs or poisons.

38. I accept Dr Young's opinion as to cause of death.

Intent

39. I am of the view I can be satisfied that the evidence supports a finding that Mr Horne hanged himself with the intention to end his own life.

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[36] Coronial brief, Statement of Maddison Rippon dated 15 April 2018, 18.
[37] Coronial brief, Statement of Maddison Rippon dated 15 April 2018, 18.
[38] Coronial brief, Statement of Maddison Rippon dated 15 April 2018, 18.
[39] Coronial brief, Statement of Maddison Rippon dated 15 April 2018, 18.
[40] Coronial brief, Statement of Selina Horne, dated 25 April 2018. 39.
[41] Coronial brief, Statement of Michael Tunney, dated 26 June 2018, 26.

Further Investigation

40. On 1 November 2018, the Court received correspondence from Mrs Horne, in which she expressed concerns in relation to her son's death and requested an inquest.

41. In response to the matters raised by Mrs Horne, a further statement was requested from Ms Rippon, which was not forthcoming. Her mother, Debbie Marshall sent an email on Ms Rippon's behalf to the Court dated 5 April 2019. In her email, Ms Marshall stated that Ms Rippon and Mr Horne's '*relationship got pretty rocky in the end*' and that her daughter had '*called for a break near the end as she felt she needed time out*'.[42]

42. Senior Constable Scott prepared a further statement dated 1 March 2019, detailing his attempts to obtain a further statement from Ms Rippon and his unsuccessful attempts to retrieve the messages between Mr Horne's and Ms Rippon's Facebook accounts.

43. At the advice of the CPU, I obtained data from the VSR regarding suicides of people diagnosed with autism for the period 2009-2015 and an expert report from Professor Robyn Young, Clinical Psychologist

44. At my direction the CPU also sought advice from AMAZE, a Victorian peak body with a remit to educate and raise awareness about ASD, but they did not have sufficient resources to assist with this investigation.

Data request to the Victorian Suicide Register

45. On 5 February 2019, at my direction, the CPU requested the following information from the VSR:

    (a) The proportion of suicide deceased with diagnosed and suspected autism (relevant deaths) by age group.

    (b) The proportion of relevant deaths with comorbid mental illness diagnoses.

    (c) The proportion of relevant deaths whereby the deceased had engaged with a health practitioner proximate to their death (within 12 months of the death).

    (d) The proportion of relevant deaths whereby relationship breakdown was identified as a contributing trigger or factor in the death.

[42] Email from Ms Debbie Marshall to the Coroner's Court of Victoria dated 5 April 2019.

46. The findings of the search were as follows:[43]

(a) There were 24 recorded suicide deaths of Victorians who had an autism diagnosis between 2009 and 2015; that is, 0.6% of the total suicide population for the period. A further 10 suicide deceased (0.2% of the total suicide population) had suspected autism.

(b) Of the 24 suicide deaths with an autism diagnosis, the highest proportion were aged 18 to 24 (39.2%). Notably, almost all deceased with both diagnosed and suspected autism were male.

(c) The majority of suicide deceased with both diagnosed (87.5%) and suspected (70.0%) autism had diagnosed comorbid mental illness.

(d) The majority of suicide deceased with both diagnosed (87.5%) and suspected (90.0%) autism received treatment for mental illness within 12 months of suicide. A lower proportion received treatment within six weeks of suicide (54.2% and 70.0% respectively).

(e) One-third (33.3%) of suicide deceased with diagnosed autism and almost one-quarter (20.0%) of suicide deceased with suspected autism experienced relationship breakdown at the time of their death.

Expert report from Professor Young

47. Following advice from the CPU, I sought an expert report from Professor Robyn Young, Clinical Psychologist. Professor Young's report details information that is known about suicide in people diagnosed with Autism Spectrum Disorder (ASD), especially in the context of a relationship breakdown. The report is not specifically about Mr Horne but instead provides advice '*about autism and intimate relationship breakdown, and the impact, if any, this may have on a young person, particularly on their behaviours, including relationship to suicidal thinking.*'[44]

48. The report does not specify any easy answers and, given Professor Young's observations about the impact of individual differences for each person, does not lend itself to a system-focussed recommendation.

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[43] I note that this evidence is based on the available evidence contained in the coronial briefs in each case and that there may be additional autism-spectrum suicides that have not been captured due to lack of diagnosis and/or lack of reference to the diagnosis or suspected diagnosis in the evidence obtained for the coronial brief.

[44] Expert Report by Professor Robyn Young dated 10 July 2019.

49. Professor Young noted that there are a number of risk factors among ASD individuals that may lead to suicidal ideation. Studies such as Balfe et al (2013) found 40% of their sample of 42 adults with ASD had suicidal thoughts, with 14 percent having made an attempt. There was also comorbid anxiety (51%) and depression (35%). Social difficulties were also noted in this group with:

(a) 95% having been bullied

(b) 91% had trouble reading other people's feelings

(c) 86% had trouble responding to other people's feelings

(d) 77% felt left out of things

(e) 63% felt misunderstood

(f) 42% had trouble showing their own feelings.

50. Professor Young observed that the profile of many people with ASD include risk factors for suicide such as childhood adversity, stressful life experiences and events, social isolation, lack of social support, poor-interpersonal problem-solving skills – all of which have been linked to suicide in other studies as supported by data from Cassidy et al (2014). In their study of 355 individuals with ASD 62% had experienced suicidal ideation which is nine times more likely than the general UK population which was were the study was conducted. This risk was increased if the individual also reported experiencing depression.

51. In a study of 24 individuals with high functioning autism, Stokes, Newton and Kaur (2007) found that the ASD group differed significantly from the neuro-typical participants in the length of time they pursued a relationship when there was no response from the person, when there was a negative response from the person, and when there was a negative response from the person's family or friends. Parent reports showed that ASD individuals were significantly more likely to believe that a person '*must reciprocate their feelings, to show obsessional interest in a person, follow them, monitor their activities, make threats against the person or threaten self-harm.*'

52. Professor Young acknowledged that most of the research discussed within her report considers suicidal ideation, rather than suicide. Further she noted that she was unable to locate any data comparing the link between suicidal statements and suicides among ASD individuals and how this compares with the neuro-typical population. Professor Young

stated that it could be that youth with ASD may make suicidal statements due to becoming overwhelming, lacking and '*incapable of applying more effective functional communication, emotional regulations and general coping skills to manage their distress*'.[45]

53. Professor Young concluded that the studies suggest that, although estimates are varied, ASD individuals experience a greater degree of suicidal ideation than individuals from the general population. However, studies show that suicidal ideation was usually accompanied by co-morbid depression, social isolation, and experience of childhood adversity such as bullying, all of which are common in ASD individuals yet not diagnostic features of the disorder. Some authors further speculated that poor interpersonal problem-solving skills, lack of social support and insistence on sameness (which may cause an exaggerated response to a regular event) may act as triggers in times of stress.

Conclusion

54. Based on the evidence contained in the coronial brief, Professor Young's expert report and the VSR's data, I am satisfied that I can make the requisite findings without holding an inquest into Mr Horne's death.

[45] Expert Report of Professor Robyn Young dated 10 July 2019; Brereton et al., 2006; Gillott et al., 2001 Wood and Gadow 2010

RECOMMENDATION

55. A key feature of the *Coroners Act 2008* is the emphasis given to the coroner's prevention role. I am of the view that there is a prevention focus to this investigation, given the VSD's data shows that one-third of suicide deceased with diagnosed autism and almost one-quarter of suicide deceased with suspected autism experienced relationship breakdown at the time of their death.

56. I further note that there is room to raise awareness through education and training across primary care (general practitioners), mental health and private practitioners regarding the suicide risks for adolescents, young adults and adults with ASD.

57. I make the following recommendation pursuant to section 72(2) of the *Coroners Act 2008* that:

    The Department of Health and Human Services and the Chief Psychiatrist work with AMAZE to identify opportunities to increase the access by private practitioners, primary care, and public mental health services to information, education and training specific to the risk of suicide for adolescents and adults with Autism Spectrum Disorder especially in the context of relationship breakdown and social stressors.

FINDINGS AND CONCLUSION

58. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Kyle Horne, born 9 November 1998, died on 15 March 2018 at Ferntree Gully, Victoria, from hanging in the circumstances described above.

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

60. Pursuant to section 73(1A) of the *Coroners Act 2008*, I direct this finding be published on the internet.

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

Mrs Selina Horne, senior next of kin.

Mr Mark Horne, senior next of kin.

Ms Penny Armytage, Chairperson, The Royal Commission into Victoria's Mental Health System.

Ms Julie Inman Grant, The eSafety Commissioner.

Dr Neil Coventry, The Office of the Chief Psychiatrist.

Ms Kym Peake, Secretary, The Department of Health and Human Services.

Ms Fiona Sharkie, Chief Executive Officer, AMAZE.

Mr John Stanway, Chief Executive Officer, the Royal Children's Hospital.

Senior Constable Callum Scott, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH
DEPUTY STATE CORONER
Date: 13 December 2019