IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 5525

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
*Section 67 of the **Coroners Act 2008***

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Casey Evan Cahill
Date of birth:	27 October 1999
Date of death:	10 October 2019
Cause of death:	1(a) Multiple injuries sustained on a train impact (pedestrian)
Place of death:	Near Berwick Railway Station, Berwick, Victoria

INTRODUCTION

1. On 10 October 2019, Casey Evan Cahill was 19 years old when he took his own life. At the time of his death, he lived at Melbourne.

THE CORONIAL INVESTIGATION

2. Casey'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. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Casey's death. The Coroner's 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.

6. This finding draws on the totality of the coronial investigation into Casey's death, 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 evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

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

Identity of the deceased

7. On 11 October 2019, Casey Evan Cahill, born 27 October 1999, was visually identified by his mother, Teresa Cahill.

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

Medical cause of death

9. Forensic Pathologist, Dr Gregory Young, from the Victorian Institute of Forensic Medicine **(VIFM)**, conducted an inspection on 11 October 2019 and provided a written report of his findings dated 14 October 2019.

10. Toxicological analysis of post-mortem samples identified the presence of ethanol,[2] methadone,[3] methylamphetamine and amphetamine,[4] cannabis, metabolites of cocaine, and aripiprazole.[5]

11. Dr Young provided an opinion that the medical cause of death was *"1(a) Multiple injuries sustained on a train impact (pedestrian)"*.

12. I accept Dr Young's opinion.

Circumstances in which the death occurred

13. Casey's short life was significantly affected by mental ill health and substance abuse. He suffered from depression, persisting psychotic symptoms, suicidal ideation, and had previously self-harmed.

14. Casey's mother, Teresa Cahill, identified that Year 7 was a turning point in her son's life. He had previously been a well-behaved child but after moving to a different high school campus, *"he never seemed happy"*. After moving to another high school in the hope that this would make him happier, Casey's behaviour declined, and he started using drugs. Mrs Cahill stated,

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[2] Alcohol.
[3] Methadone is a synthetic narcotic analgesic used for the treatment of opioid dependency.
[4] Amphetamines is a collective word to describe central nervous system stimulants structurally related to dexamphetamine. One of these, methamphetamine, is often known as 'speed' or 'ice', which is a strong stimulant. Amphetamine is also a metabolite of methamphetamine, benzfetamine, and selegiline. Amphetamines stimulate the central nervous system, causing persons to become hyperactive and more aroused. Blood pressure and heart rate are also increased.
[5] Aripiprazole is an antipsychotic drug.

"Casey just started to get worse and worse and over time my happy little boy just disappeared".

15. In Year 10, he was moved to another high school. Casey began missing school and his anger *"was out of control"*. Sadly, Casey's parents continued to see him deteriorate. He could no longer stay at home and started living in refuges and using 'harder' drugs. It is evident that dispite his significant struggles, his parents continued to love and support their son.

16. At the time of his death, Casey was receiving treatment from Headspace Youth Early Psychosis Program, Narre Warren Continuous Care Team, which is part of Alfred Health. His psychologist had referred Casey to the Program in February 2017 in the context of a declining level of functioning over the previous 12-month period.

17. As part of the Program, Casey was linked to a case manager, peer support, and vocational consultant worker but declined to receive individual therapy. His parents, Teresa and Shane, were also provided with parent sessions.

18. During this period of treatment, Casey was admitted as a psychiatric inpatient on several occasions and presented to a hospital emergency department on at least two occasions while substance affected. He was prescribed aripiprazole, which improved his mental health and interpersonal relationships. However, Casey struggled with compliance and was subsequently prescribed a depot injection to improve medication consistency.

19. At the time of his death, Casey was living in emergency accommodation in Melbourne organised by Front Yard Youth Services. He was also referred to The Southern Eastern Consortium of Alcohol and Drug Agencies to provide treatment for his substance misuse, which he accessed intermittently. He undertook two detoxification programs in early 2019.

20. Mrs Cahill stated that she last saw her son approximately a week and a half before his death. She had taken him back to the family home where he had taken a nap. On the drive back to his accommodation, Casey exhibited aggressive behaviour because he had wanted to stay at the family home; he hit the car's sunroof and broke it. Mrs Cahill stated that he was in the worst state that she had ever seen him. She had always been able to calm him down but on that day she could not. She noted that he called her a few days later to apologise for the broken sunroof. She said, *"He was such a beautiful person but the drugs just changed him"*.

21. A few days later, Casey returned to the family home for a short time. This was the last time Mr Cahill saw his son.

22. On 7 October 2019, Casey was *"exited"* from his accommodation for three days due to breaking the accommodation rules. He was provided with alternative accommodation at a Motor Inn, but it is unclear whether he stayed there. He was last seen by Front Yard staff on 8 October 2019.

23. On 8 October 2019, Casey missed a review with his community treatment team. Mr and Mrs Cahill attended, and discussions centred on looking at options of changing the depot treatment, including a potential oral trial of paliperidone. This was in the context of Casey's residual psychotic symptoms, which Mr Cahill had noted were more evident in the week leading up to depot medication administration. The consideration of compulsory treatment under mental health legislation was also discussed given concerns for Casey's ongoing functional decline.

24. On 10 October 2019, Casey did not attend his depot appointment.

25. At approximately 7.10pm on 10 October 2019, Casey placed himself in front of a Pakenham to Melbourne bound train near Berwick Railway Station. Although the train driver saw Casey approach the train and sounded his whistle, he was unable to stop the train in time. Casey suffered fatal injuries and died at the scene.

26. Dr Timothy Chew, consultant psychiatrist at Alfred Health, stated the Headspace Youth Early Psychosis Program conducted a review after Casey's death. Recommendations from the review included consideration of an emphasis on prioritising a family meeting at the initial engagement point, to support family engagement from the very beginning of the service, and ongoing recognition of the service gap that is present in the area of youth homelessness.

FURTHER INVESTIGATIONS

27. In November 2019, the Department of Health and Human Services (**DHHS**) contacted the Court's Coroners Prevention Unit (**CPU**)[6] regarding concerns that between August and October 2019, seven young males in the Casey and Cardinia local government areas had suicided. There was also a concern that two suicides of young males in Gippsland may have been related to one or more of the suicides in Casey and Cardinia.

[6] 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.

Evidence of statistical clustering

28. The DHHS was concerned that the suicides represented a potential statistical cluster, being a group of deaths that share commonalities (for example socio-demographics, occurrence in time, occurrence in space) to a greater degree than might be expected by chance.

29. After reviewing the data, the CPU concluded that seven suicides of males aged 24 years and younger linked to Casey and Cardinia (through location of death and/or location of usual residence) in the three-month period from August to October 2019, could accurately be described as a 'statistical cluster'.

Evidence of social clustering

30. The DHHS was concerned that at least some of the seven deceased linked to the Casey and Cardinia areas knew one another and that the two deceased in South Gippsland knew people who had suicided in Casey and Cardinia. The CPU describes personal links between people who have suicided as 'social clustering'.

31. To investigate social clustering among the nine deaths, the CPU recommended I obtain further information about Casey with the intent of determining whether Casey knew any of the other young men who had taken their own lives. One of the ways to find out this information was through Casey's social media accounts(s). I will discuss the difficulties in accessing this information below.

32. The CPU reviewed the coronial brief for evidence for each of the deceased to determine whether any of them knew each other, as well as more general evidence on social connections such as where each deceased went to school, the main health services they had contact with, and so on.

33. The evidence revealed that two of the deceased had a social connection. This did not include Casey. On this basis, the CPU concluded social clustering did not link the nine deaths to one another.

Evidence of thematic clustering

34. Given the strong evidence of statistical clustering, the CPU also reviewed the coronial briefs to establish whether there were any commonalities in the stressors the deceased experienced before death – what the CPU refers to as 'thematic clustering'.

35. Overall, the CPU concluded that there were no themes common to all of the deaths. However, certain themes recurred across multiple deaths at a time. The main such themes the CPU identified were:

(a) in six deaths there was evidence of parental separation when the deceased was a child. In most of these deaths there is evidence of the negative impact this separation had on the deceased;

(b) in five deaths, including Casey's death, there was evidence of serious breakdown in the relationship between the deceased and his parent(s);

(c) in five deaths there was direct or indirect evidence of emerging mental ill health that was either undiagnosed, or which was only treated intermittently in a community setting (for example by a general practitioner); and

(d) in five deaths, including Casey's death, substance misuse was part of the context.

Department of Health and Human Services (DHHS) response

36. In November 2019, immediately after the CPU confirmed for the DHHS that the suicides of concern had definitely occurred, the DHHS activated its suicide postvention response for the region. The elements of the response are described in an email dated 1 July 2019 from Deborah Hubbard, DHHS Senior Advisor, and they included:

(a) meetings with Primary Health Networks to engage them in the postvention protocol and response;

(b) collaboration between DHHS and the Department of Education and Training on a coordinated response;

(c) engagement with the City of Casey and City of Greater Dandenong; and

(d) capacity creation at the Headspace services in Narre Warren and Dandenong.

Conclusion regarding linked suicides

37. Based on analysis of the available coronial brief material in the nine suicides, the CPU concluded as follows:

(a) the suicides in Casey and Cardinia represented a statistical cluster, but not a social cluster;

(b) the DHHS were concerned that the two suicides in South Gippsland were related to the suicides in the Casey and Cardinia areas, however the available evidence does not support this and does not suggest they were related to one another either; and

(c) themes were identified across multiple deaths at a time, but not all deaths.

Subsequent six suicides

38. A further six probable suicides occurred in Casey and Cardinia among males aged 24 years and younger, between December 2019 and March 2020. Considered in the context of the historical data, the CPU advised that these appear to be an extension of the statistical cluster discussed above. There did not appear to be any obvious links between these six deaths and the nine deaths initially reviewed.

Difficulties in obtaining information from Casey's social media account

39. As noted above, to assist the CPU determine whether there was a social cluster of suicides, the CPU recommended I obtain information from Casey's social media account(s) to determine whether he may have known any of the other young men who had taken their own lives.

40. I therefore requested Senior Constable Joshua Milligan, Coroner's Investigator, to conduct an interrogation of Casey's social media accounts, amongst other investigations.

41. Senior Constable Milligan spoke to Mrs Cahill about whether Casey had any social media accounts. Mrs Cahill informed him that Casey's Facebook account was under the pseudonym 'Case Huskii'. This account was set to 'private'.

42. In accordance with usual Victoria Police procedure to obtain access to a Facebook account, Senior Constable Milligan made a request to the International Crime Cooperation Central Authority at the Federal Attorney-General's Department. His request was subsequently refused because the investigation did not involve a criminal offence.

43. I then issued a formal request by way of *Form 4 Document or Prepared Statement Required to be given to the Coroner* and under section 42 of the Act to Facebook Australia Pty Ltd requesting:

(a) a printout of all posts made by Casey between 10 October 2018 and 10 October 2019;

(b) a list of Casey's friends on Facebook;

(c) a printout of all direct private messages between 10 October 2018 and 10 October 2019;

(d) a list of all closed and public Facebook groups of which he was part;

(e) a list of all Facebook pages that Casey had liked between 10 October 2018 and 10 October 2019; and

(f) a printout of all photos Casey had posted and been tagged between 10 October 2018 and 10 October 2019.

44. On 18 December 2019, I received a letter from Gadens, the legal representative of Facebook Australia Pty Ltd. That letter informed me that Facebook Australia was the wrong entity for the purpose of the Form 4, and objected to the request because:

(a) for Australian users, Facebook is operated and controlled by Facebook Inc, a company organised and existing under the laws of Delaware, United States of America, and its principal place of business was in Menlo Park, California;

(b) Facebook Australia Pty Ltd is a separate entity, independent of and legally distinct from Facebook Inc. Facebook Australia Pty Ltd does not own, operate, control, or host the Facebook service and therefore could not assist with my request; and

(c) any inquiries relating to Australian users of Facebook could be directed to the correct entity at its address in California.

45. Gadens further advised that a disclosure of an account would be limited to basic subscriber information upon proper services of a valid legal process. Basic subscriber information would therefore not include the content of communications, such as messages, timeline posts, and photos. Given my jurisdiction is limited to Victoria, I would therefore be unable to formally request this information from Facebook Inc.

46. This advice was disappointing and, in practical terms, brought my investigation into Casey's connection with the other young men who had taken their lives and an exploration of the reasons that led him to take his own life to an end.

47. While this coronial investigation did not involve a criminal offence, seeking answers about why a young man in the prime of his life had taken his life was nevertheless important. Given that many young people use social media as their primary form of communication, social media companies hold the key to an abundant repository of information that may reveal the tragic reason(s) for their decision to take their own life and whether their death was preventable.

48. The Victorian Suicide Register **(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.

49. The primary purpose of gathering suicide data in the VSR is to assist Coroners with prevention-oriented aspects of their 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 the individual death, which in turn can lead to recommendations to reduce the risk that further such suicides will occur in the future.

50. 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.

51. It is therefore important coroners have the ability to obtain information from all relevant sources – social media is a source that has the ability to furnish information otherwise unobtainable or unknown.

52. Obtaining social media information for a coronial investigation is for an important public health purpose – to understand suicides and work toward reducing preventable deaths. As the use of social media is now so ubiquitous amongst young people, obtaining this information is also relevant in other coronial investigations, such as when allegations of bullying are made and need to be investigated.

53. It is clear there is already an available process for criminal matters through the International Crime Cooperation Central Authority at the Federal Attorney-General's Department. In the

hope that this avenue can somehow be expanded to coronial investigations, I intend to make a comment addressed to the Victorian Attorney General, the Hon. Jaclyn Symes, and the Federal Attorney General, the Hon. Christian Porter, seeking a solution so that coroners can obtain information from social media companies for the purpose of assisting their coronial investigations.

FINDINGS AND CONCLUSION

54. Pursuant to section 67(1) of the Act I make the following findings:

    (a) the identity of the deceased was Casey Evan Cahill, born 27 October 1999;

    (b) the death occurred on 10 October 2019 near Berwick Railway Station, Berwick, Victoria, from multiple injuries sustained on a train impact (pedestrian); and

    (c) the death occurred in the circumstances described above.

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

COMMENT

Pursuant to section 67(3) of the Act, I make the following comment:

I have referred to the difficulties I encountered in this coronial investigation in accessing social media information. This has been an unnecessary impediment to obtaining information for an important public health purpose, namely, to understand if there are social links between young people in this cluster and potentially reduce the number of preventable deaths. It may well be that a combined State and Federal response is required for a solution to obtain this information from social media companies for the purpose of assisting coronial investigations.

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

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:

Teresa Cahill, senior next of kin

Shane Cahill, senior next of kin

The Hon. Jaclyn Symes, Attorney General, Victoria

The Hon. Christian Porter, Attorney General, Australia

Senior Constable Joshua Milligan, Victoria Police, Coroner's Investigator

Signature:

CAITLIN ENGLISH

DEPUTY STATE CORONER

Date: 10 March 2021

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 six 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.