IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 5840

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Oliver Vincent Paul Cronin
Date of birth:	11 August 2006
Date of death:	25 October 2019
Cause of death:	1(a) Hanging
Place of death:	Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria
Key words:	Gaming disorder, behavioural issues, gaming disorder, teenager, intention, hanging, misadventure

INTRODUCTION

1. On 25 October 2019, Oliver Vincent Paul Cronin was 13 years old when he passed away in hospital. At the time, Oliver lived in Loch with his parents and siblings.

2. Oliver has spent most of his childhood in Loch. He was described as a happy and healthy child who was obviously cherished and loved by his parents and siblings.

3. In the years preceding his death, Oliver became interested in computer games, regularly playing Roblox, Minecraft, Clash of Clans, and Fortnite on multiple devices. In 2019, Oliver started high school. He was well-liked and had a wide circle of friends. His scholastic performance was relatively normal for a child his age.

THE CORONIAL INVESTIGATION

4. Oliver'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.

5. 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.

6. 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.

7. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Oliver'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.

8. This finding draws on the totality of the coronial investigation into Oliver'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]

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

Identity of the deceased

9. On 25 October 2019, Oliver Vincent Paul Cronin, born 11 August 2006, was visually identified by his father, Christopher Cronin, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

11. Forensic Pathologist, Dr Paul Bedford, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 28 October 2019 and provided a written report of his findings dated 1 November 2019.

12. Routine toxicological analysis of post-mortem samples did not detect any alcohol or any commonly encountered drugs or poisons.

13. Dr Bedford provided an opinion that the medical cause of Oliver's death was *"1(a) Hanging"*.

14. I accept Dr Bedford's opinion.

Circumstances in which the death occurred

15. In the 12 months preceding his death, Oliver appears to have become obsessed or addicted to computer gaming. This in turn affected his behaviour. He became irrational and aggressive at times. His parents tried to restrict his access to the gaming devices in an attempt to temper this behaviour, but this led to an escalation in Oliver's behaviour escalating to verbal and physical abuse against his parents and extreme temper tantrums. In the weeks preceding his death, Oliver was also involved in physical altercations with other students, which resulted in two short suspensions from school.

[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.

16. According to his parents, in the three days immediately before his death, Oliver's behaviour worsened. It was obvious that he needed help in controlling his emotions and his parents discussed getting professional help. It appears that Oliver was also cognisant of his behavioural problems as he often apologised to his family for his actions. However, when the possibility of professional help was raised with him, Oliver refused and became upset. His parents were unsure about where to seek assistance.

17. On the afternoon of 24 October 2019, Oliver returned home after school. Due to a recent school suspension, he was serving a week-long technology ban. However, when his father arrived home that evening, Oliver was found on his computer in his bedroom.

18. Sometime later, Oliver had an altercation with his brother. Their father intervened and Oliver reacted by pushing and hitting his father. Oliver was subsequently told he could not play basketball as planned that evening. This appears to have triggered a tantrum, during which Oliver exhibited physical and verbal abuse and other disturbing behaviour. His parents then thought it would be best that Oliver attend basketball to *"diffuse"* the situation, but he would not get in the car and his behaviour continued to escalate.

19. After some time, Oliver's father and siblings left the house. Oliver remained home with his mother, and they went for a short walk down to a laneway during which Oliver appeared to calm down. Oliver then returned home, and his mother went for a short walk around the block. Oliver's mother returned home to find him getting a drink from the fridge. She then went to take a bath.

20. About 25 minutes later, Oliver's mother exited the bathroom and observed Oliver motionless and suspended in a doorway with a cord around his neck. When she approached him, she observed that his lips were blue. She tried to lift Oliver, but he was too heavy. She ran to the kitchen to retrieve a pair of scissors and she cut the rope around his neck; Oliver fell to the ground. She telephoned Oliver's father and emergency services and began administering cardiopulmonary resuscitation (**CPR**). When Oliver's father returned home, he took over administering CPR. A defibrillator was retrieved from the local service station and applied.

21. The first emergency responders were Victoria Police members at 9.31pm. They took over CPR until responding Victoria Ambulance paramedics arrived at 9.33pm. It took time to stabilise Oliver as there were multiple cardiac arrests. At 11.13pm he was transported to the local oval by ambulance and airlifted to the Royal Children's Hospital (**RCH**).

22. Upon arrival at RCH, Oliver was immediately transferred to the Intensive Care Unit where he arrested again. He became progressively more unstable and was compassionately extubated at 2.45am the next morning and pronounces deceased at 2.55am.

23. Following Oliver's death, Victoria Police members examined the scene and took a number of measurements of the doorway where the incident occurred. The cord from the window winding mechanism above the door had been hanging there since the family had moved into the house. A loop had been tied into the rope and it was this loop that Oliver had used to suspend himself. The bottom of the loop in the rope was 137 cm from the floor; Oliver was 157 cm tall. A small two-step stool was found nearby at the time of the incident but is unknown whether the stool was already at that location at the time of the incident or whether Oliver had moved it there to better access the loop.

24. Detective Senior Constable Liza Burrows, Coroner's Investigator, provided an enlightened and compassionate conclusion in her summary in the coronial brief as follows:

> *"It is apparent that Oliver grew up in a loving family environment and was popular amongst his peers. It is also apparent that in the last 12 months, Oliver was starting to struggle with his temper and behavioural issues. These issues appeared to be intensified when gaming was involved. Like most children of his age, Oliver had a great interest in gaming, but it appears as though for Oliver it was becoming an obsession.*
>
> *From those closest to Oliver, there didn't appear to be any clear indication that he was depressed or had any suicidal thoughts. …*
>
> *It is my opinion that after the temper tantrum, Oliver was unable to control his anger and frustration and made a snap decision. I believe it is clear from inspecting the rope that Oliver did not tie the loop himself. I believe that due to his irrational state on the night in question, and also his young age, Oliver didn't have the ability to fully comprehend the consequences of his actions. It is possible that he had seen the rope hanging there with the loop already in place on previous occasions and considered the action. On the night in question he chose to place the loop around his neck and either step off the footstool or just let his weight go, which resulted in his death.*

FURTHER INVESTIGATION

Advice from the Coroners Prevention Unit

25. As part of my investigation and to assist my understanding or the contributing factors that led to Oliver's death, I obtained advice from the Coroners Prevention Unit[2] (**CPU**) about whether Oliver's gaming addiction was considered to be a mental disorder. I also sought information about what services are available to assist gamers and their families.

26. Oliver's history of concerning or dysfunctional gaming was approximately of one year's duration. The description of his behaviours suggests he would have met the definition of a gaming disorder as set out below. The description of Oliver's behaviour by his family in the coronial brief also suggest that he may have pre-existing contributing factors such as mood and anxiety and disruptive behaviours disorders, that would have required professional assessment. However, Oliver was resistant to help from his parents and professionals by the time they realised the extent of his reliance on gaming and the effects on his behaviours and impact on the family.

27. The CPU explained that gaming problems often appear in high school and usually affect males who play role-playing games and who spend time at home alone. Comorbidities may include mood, anxiety, personality disorders, social phobia, and disruptive behaviours disorders.

28. The CPU advised that while there is evidence about the existence of gaming addiction, its diagnosis and treatment are not well-understood or settled. More refinements are needed in the conceptualisation, measurement, factors, and clinical diagnosis, intervention, and prevention. Training and research are also needed in the sector.

29. Current assistance for children and families appears to be limited as described below.

Accessible professional help for children and adolescents

30. Most online help is under the umbrella of mental health, addiction, and gambling with gaming specific help not overtly evident. There are some self-help organisations, for example

[2] The Coroners Prevention Unit is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.

Computer Gaming Addicts Anonymous.[3] Many services advise children and adolescents to contact Kids Helpline or Lifeline in the first instance.

Accessible professional help for parents

31. Again, most online help is under the umbrella of mental health, addiction, and gambling with gaming specific help not overtly evident. There are private practitioners (mainly psychologists) who promote their specialities and interventions as including gaming disorder and provide initial helpful advice. There are also parenting sites that provide advice on how to monitor and control gaming.[4] Examples of a practical tool for parents online, but not easily located in a search engine search, are:

    (a) the Institute of Games extensive resource 'Parent's Guide to Gaming: Keeping gaming fun and safe';[5]

    (b) Headspace 'Understanding gaming: A guide for family and friends';[6] and

    (c) Relationships Australia South Australia 'Take Control' program.[7]

32. The Royal College of General Practitioners also provides a comprehensive guide for responding to gaming problems including 'Just one more level: Identifying and addressing internet gaming disorder within primary care'.[8]

Government advice

33. The Australian Government eSafety Commissioner and website offers a broad range of resources for parents, teachers, professionals etc., that are accessible and includes the following statistics about gaming:

    (a) 81% of children aged eight to 17 years have played an online game;

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[3] Gaming Addicts Anonymous, https://www.gamingaddictsanonymous.org/gaming-withdrawal-symptoms/#what-is-gaming-addiction, accessed 10 October 2022.
[4] eSafety Commissioer, Online gaming information for parents and carers, https://www.esafety.gov.au/sites/default/files/2022-01/eSafety%20parent%20guide%20to%20online%20gaming.pdf, accessed 10 October 2022.
[5] Institute of Games, Parent's Guide to Gaming, www.videogames.org.au, accessed 0 October 2022.
[6] Headspace, Understanding Gaming, https://headspace.org.au/assets/Uploads/Understanding-Gaming-FAF.pdf, accessed 10 October 2022.
[7] Relationships Australia, Take Control, www.rasa.org.au/takecontrol/, accessed 10 October 2022
[8] Royal College of General Practitioners, Just one more level: Identifying and addressing internet gaming disorder within primary care, https://www.racgp.org.au/afp/2016/january-february/just-one-more-level-identifying-and-addressing-int, accessed 10 October 2022.

(b) 64% have played a multiplayer online game with others;

(c) 52% have played with people they did not know;

(d) 17% have experienced bullying or abuse while playing a network game with others; and

(e) 34% have made an in-game purchase and this rose to 45% when they played a network game with others.

34. Advice for parents includes:[9]

> *In some cases, setting firm limits as a family may be enough to help address too much gaming. But there may also be underlying problems like depression and anxiety that are linked to problematic internet use.*

Expert report from Dr Daniel King

35. To further assist my understanding of these issues, I obtained an expert report from Dr Daniel King, Senior Research Fellow and Clinical Psychologist, and author of 'Policy and Prevention Approaches for Disordered and Hazardous Gaming and Internet Use: An International Perspective'.[10]

36. I asked Dr King to comment on the recent decision by the World Health Organization to add a new diagnosis to the 11th Revision of the International Classification of Diseases (ICD-11), the disorder generally, its prevalence, incidence, gaps and barriers to accessing services and treatments, the evidence-base for therapies, and possible prevention opportunities in public policy.

Gaming disorder classification and description

37. Dr King noted that 'problem gaming' has been recognised by researchers as a mental health issue since the 1990s. Early studies considered problematic gaming to be similar in nature to pathological gambling, based on observations of young players who would miss school to play arcade machines, steal money from parents or others to finance their play, and continue playing despite some awareness of the negative consequences.

[9] eSafety Commissioner, Gaming, https://www.esafety.gov.au/parents/issues-and-advice/gaming, accessed 10 October 2022.
[10] Prev Sci (2018) 19:233–249.

38. In 2019, The World Health Assembly approved the inclusion of Gaming disorder into the 11th Revision of the International Classification of Diseases (ICD-11). This has resulted in Gaming disorder (6C51) being recognised as a formal diagnosis as follows:[11]

> *Gaming disorder is characterised by a pattern of persistent or recurrent gaming behaviour ('digital gaming' or 'video-gaming'), which may be online (i.e., over the internet) or offline, manifested by: 1. impaired control over gaming (e.g., onset, frequency, intensity, duration, termination, context); 2. increasing priority given to gaming to the extent that gaming takes precedence over other life interests and daily activities; and 3. continuation or escalation of gaming despite the occurrence of negative consequences. The pattern of gaming behaviour may be continuous or episodic and recurrent. The pattern of gaming behaviour results in marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. The gaming behaviour and other features are normally evident over a period of at least 12 months in order for a diagnosis to be assigned, although the required duration may be shortened if all diagnostic requirements are met and symptoms are severe.*

39. Dr King noted that diagnosis of gaming disorder requires a comprehensive assessment by a psychiatrist or clinical psychologist to understand the individual, including their background, status, family history, among other important clinical considerations. Excessive gaming on its own is not sufficient evidence of gaming disorder as gaming is sometimes used as a tool to cope with other psychological issues, including depression and anxiety, and trauma, or stressful life events, including family discord or bullying.

40. However, while the World Health Organization has recognised the disorder, the Diagnostic Statically Manual (**DSM**), which is the primary clinical diagnostic tool used in Australia, does not include a diagnosis of a gaming disorder or any diagnosis that would cover someone playing video games to a harmful level but is included in the 'further research' section. The DSM-5 currently only recognises 'Gambling disorder' as a type of behaviour-based non-substance related addictive disorder.

[11] International Classification of Diseases 6C51 – Gaming disorder, includes 6C51.0 Gaming disorder predominately online; 6C51.1 Gaming disorder predominately offline; 6C51.Z Gaming disorder unspecified, https://icd.who.int/browse11/l-m/en#/http%253a%252f%252fid.who.int%252ficd%252fentity%252f1448597234, accessed 10 October 2022.

Gaming-related harms

41. Dr King discussed various harms that gamers may experience. While he noted that some users may spend too much money on gaming-related purchases, including hardware and software, most harms were health-related such as:

    (a) loss of weight due to restricted diet (or weight gain due to overeating);

    (b) physical pain issues due to poor posture and repetitive strain injuries; and

    (c) restricted and poor sleep and/or reverse sleep-wake cycle that results in fatigue and lethargy.

42. However, the primary way in which individuals with gaming disorder are negatively affected is a marked change in their priorities, which interferes with normal life activities, social interaction, and responsibilities. And when not playing gamers, a person with gaming disorder is often preoccupied with gaming, which affects their ability to engage in tasks and interaction with others. Dr King notes, *"Negative mood states (i.e., usually irritability, sadness, and boredom) accompany the times when the individual with gaming disorder is not playing or is less able to play."*

Prevalence and incidence

43. Dr King noted that while there have been multiple survey-based studies, the quality of evidence has largely been inconsistent. Estimates have ranged from less than 1% to greater than 10% across studies. Studies on prevalence and incidence is varied and relatively limited. Dr King estimated the incidence of problem gaming is likely to be less than 2%.

Gaps and barriers to accessing services and treatments

44. Dr King noted that clinics have now been established in the major cities of many countries in Asia (China, Japan, Hong Kong, Republic of Korea, Thailand, and India) and in some parts of Europe, North America, and Australasia. Services are most fully developed in Asia.

45. Japan is the world leader with the creation of the National Hospital Organization Kurihama Medical and Addiction Center in 2011 to provide the first specialist treatment for gaming disorder. The number of treatment facilities providing specialist treatment has increased to 28 throughout Japan by 2016.

46. Elsewhere clinical services are also being established, such as the Center for Internet Addiction and reSTART in the United States, clinics within the National Problem Gambling Service in London, United Kingdom, the Bellvitge University Hospital in Barcelona, Spain, and a specialist clinic at the University Hospital of Geneva.

47. Addiction services have taken the lead by adapting evidence-based approaches for substance disorders and gambling disorders to help those affected by excessive gaming, together with their families.

48. Other options include seeking private treatment from clinical psychologists or general mental health services in the public sector. In Australia, individuals or their guardians can obtain a mental health referral from their general practitioner for six Medicare-funded sessions with a psychologist (an additional four sessions may be provided with support from a general practitioner). However, Dr King was of the opinion that ten sessions is not likely to be sufficient to treat all cases of gaming disorder, nor other complex disorders with compounding issues of social disadvantage, trauma, and difficult family dynamics, among other issues.

Evidence-base for therapies

49. Dr King explained that gaming disorder is a complex phenomenon with several characteristics that require attention in treatment. Recommended psychological treatment involves a combination of cognitive behavioural therapy (**CBT**) and adjunctive strategies. CBT demonstrated high efficacy in reducing gaming disorder symptoms and depression and showed moderate efficacy in reducing anxiety. Gaming interventions such as controlled or reduced gaming or abstinence entirely are different options depending on the individual. However, Dr King emphasised that further studies are needed to assess long term gains as well as published treatment manuals.

Prevention

50. Dr King explained that there are three approaches to prevention:

    (a) primary prevention strategies refer to measures that target the general population, irrespective of known risk level, with the intent of holding gaming behaviour at low/safe levels. This approach assumes that all individuals who play games may be at risk to some degree and can therefore benefit from information and skills to prevent the occurrence of associated problems. Strategies include educational resources and public awareness campaigns and legislative or regulatory action;

(b) secondary prevention strategies focus on individuals more at risk of developing gaming related problems. Strategies would target groups of individuals such as school-based educational programs or workplace internet policies; and

(c) tertiary prevention strategies which target individuals who are already considered problematic gamers. Such interventions involve the provision of formal services where people with problems can seek assistance such as support groups, mental health services, and rehabilitation.

Prevention guidelines

51. Dr King explained that some health organisations and expert bodies have developed guidelines to assist parents to make more informed decisions about gaming activities in the home environment. Together, these guidelines suggest that parents should:

(a) learn about the types of games available on the market and the gaming preferences of their children to determine the suitability of game products;

(b) model healthy use of electronic media and avoid enabling excessive use;

(c) know the warning signs of problematic gaming, such as mood changes (e.g., the child is only happy when gaming), loss of sleep due to gaming, diminished interest in other activities, and lying about gaming and refusal to stop playing when asked;

(d) set limits on gaming time in advance and encourage playing games as a family activity;

(e) be familiar with who the child or adolescent plays with online, and ensure that personal information is not shared with strangers by discussing cyber-safety;

(f) negotiate how gaming devices are used and then employ the parental controls on gaming consoles (e.g., content restriction and time limits), and lock the option to spend money on games using credit cards and similar options; and

(g) support other interests and activities, especially non-screen-based activities such as sports or physical exercise.

Other prevention strategies

52. Dr King also outlined further possible prevention strategies as follows:

(a) standard regulations such as health warnings and technical measures to reduce use by minors; and

(b) software companies providing user guidelines for safe use.

53. In terms of prevention focussed government-led initiatives, Dr King suggested the following:

(a) governmental support for the gaming disorder classification in the DSM-5;

(b) discussion of problem gaming issues within relevant governmental forums and councils;

(c) recognising 'gaming disorder' within national addiction policy and health research priorities alongside gambling disorder, to enable more coordinated efforts in areas of research and intervention;

(d) gaming-related questions in national epidemiological health studies of young people;

(e) support for prevention campaigns and resources, such as school-based programs for young people as well as older users at-risk of developing significant gaming problems;

(f) general public education;

(g) screening instruments for problem gaming could be made more accessible and translatable to a general audience, such as in the form of an app or a website; and

(h) regulation to require transparency of monetised reward systems in online games.

54. Importantly, Dr King notes:

> *While parents are often influential, problem gaming prevention is more complex than having parents turn off devices or limit screen time in children. Prevention involves a coordinated effort by collaborating systems of care.*

Gaming issues in the Australian context

55. In his report, Dr King provided some illuminative statistics.

56. The Digital Australia Report 2020 commissioned by the Interactive Games and Entertainment Association (IGEA) was based on data that involved 1210 households and 3228 individuals of various ages in those households. The report stated that:

(a) 67% of Australians play video games;

(b) 53% of video game players are male, and 22% of players are aged under 18 years;

(c) the average daily playing time among males aged 15 to 24 years is 130 minutes per day, and 81 minutes per day for females in this group;

(d) 97% of Australian homes with children have video games;

(e) 60% of households have five or more screens;

(f) 80% of game households have more than one game device (e.g., personal computer, home console device); and

(g) 16% of game households have a virtual reality headset.

57. However, Digital Australia Report 2020 did not refer to problematic gaming.

58. The Australian Child and Adolescent Survey of Mental Health and Wellbeing 2015 surveyed 2967 young people aged 11-17 years in 2014. The study reported that, on average, males spent more time playing video games than females, even though males and females spend similar amounts of time using the Internet. Only 5.3% of males did not play video games compared with 24.8% of females. In terms of other age and gender differences, the 2015 study reported that:

(a) 96.3% of 11- to 15-year-old males and 81% of same-aged females played video games;

(b) relatively fewer 16 to17 year-olds played video games (90.6% of males and 62.4% of females played games); and

(c) 4.1% of males played video games for an average of nine hours or more on an average weekday, and 7.8% played games for an average of nine hours or more on weekends, compared with 0.9% and 1.4% of females.

59. The 2015 Australian Child and Adolescent Survey of Mental Health and Wellbeing screened for 'problematic' gaming and internet use and found 3.5% of males aged 11 to 15 years, 3.0% of females aged 11 to 15 years, 4.4% of males aged 16 to 17 years, and 6.5% of females aged 16-17 years met the criteria for problem gaming and internet use.

60. The research also identified that problem internet or gaming was more common among youth with mental disorders, particularly major depressive disorder.

61. The Australian Office of the eSafety Commissioner (2018) report presents the results of the Office's 2017 Youth Digital Participation survey, which included questions related to online gaming. The survey comprised a nationally representative random sample of 3017 young people aged 8 to 17 years. The eSafety Commissioner report states that:

(a) 81% of Australian young people aged 8 to 17 years have played an online game and 64% played with others (i.e., friends and strangers) in the 12 months prior to June 2017;

(b) playing online games with others was more popular with 14 to 17-year-olds (67%) than 8 to 13-year-olds (62%); and

(c) gaming was more popular among boys than girls (71% versus 51%).

Conclusion

62. As Dr King et al note in their article:[12]

> *All individuals born into industrialized societies will be raised in environments where digital technologies are ever-present, easily accessible, and an integral part of everyday life. A major challenge is to implement measures that can prevent as many of these individuals from engaging in forms of gaming and Internet use that cause significant harm or disruption to healthy functioning. Stakeholders, including governments, policymakers, researchers, educators, and clinicians, increasingly recognize that the rapid expansion of treatment services must also be complemented by a similar push for early preventative measures. The research base on disordered gaming and Internet use prevention is in its infancy but demonstrates some signs of effective and economical strategies, particularly in school-based education. There is a need for greater empirical evaluation of policies to identify best practice approaches across populations and regions.*
>
> …

[12] Daniel King et el, Policy and Prevention Approaches for Disordered and Hazardous Gaming and Internet Use: an International Perspective, Prev Sci (2018) 19:233–249, 247.

The way forward in prevention ultimately rests upon all stakeholders working together in the public interest, confronting the reality of the evidence base and developing practical, ethical, and sustainable countermeasure.

eSafety Commissioner

63. One of the roles of the Office of the eSafety Commissioner is to provide guidance about how to reduce risks that can be associated with technology to children and young people, parents, educators, and other professionals. For this reason and to further assist my investigation into prevention-focussed strategies, I sought assistance from the eSafety Commissioner and asked the Commissioner to comment Dr King's expert report and my proposed recommendations.

64. Acting eSafety Commissioner Rebecca Razavi kindly provided comment regarding the possible primary prevention and government opportunities identified in my proposed recommendations.

65. The Office of the eSafety Commissioner considers that the best approach to online issues and harms is from a holistic perspective, with a balanced consideration to the potential opportunities and benefits, along with the potential risks and harms that can be associated with technology.

66. When considering primary prevention approaches, given the embedded and fundamental role that technology plays in the lives of children and young people, the Acting Commissioner emphasised that it is important that strategies promote a long-term reduction in risk. It is also critically important that prevention strategies focus on empowering children to build appropriate digital literacy, social and emotional skills, and help-seeking behaviours that will keep them safe whilst engaging in their increasingly online world

67. When considering appropriate strategies to promote balanced and safe online use, it is important to tailor strategies to the individual needs of the child, type of online behaviour, and the values of the family.

68. eSafety's research indicates that some parents already use a range of strategies to manage online use, and these can be separated into three main categories:

    (a) enabling mediation (includes providing supportive guidance, encouraging help-seeking, and modelling through co-use);

(b) restrictive mediation (includes controlling access, moderating use, and setting rules); and

(c) technology mediation (using technological based tools to control, monitor, or limit use.

69. While restrictive and technical mediation may be beneficial for children of younger ages, older children will need strategies that empower them to develop critical skills and experience the full range of benefits from technology. The Commissioner outlined the key prevention strategies for families as follows:

(a) helping young people choose developmentally appropriate gaming experiences;

(b) setting family boundaries around game play and activities with clear consequences;

(c) helping young people understand the risks and protective behaviours to ensure safe game play;

(d) building young people's gaming literacy to help them understand features of games that are designed to encourage longer play or spending money; and

(e) engaging in co-play and encouraging young people to play games in shared areas to support positive and pro-social game play.

70. Where there are challenges in managing online use, families may need to consider the use of restrictive or technology mediated approaches – in balance with proactive strategies – to help set safe boundaries and limits on usage. The Acting Commissioner noted that these measures could include using parental controls on devices, creating rules about rooms or times that are device free, and setting time limits. She explained that it is important when using these measures that there are clear consequences, parents are transparent in their use, and that measures focus on working with the child to identify practical ways to make minor incremental reductions. In addition, if use becomes problematic, eSafety strongly recommends families engages a mental health professional to oversee the approach to managing online gaming and find strategies that work best for their family situation.

71. From a primary prevention perspective, the Commissioner supported an emphasis on the need to provide education in the form of school-based programs, or directly to parents, and practitioners providing clinical care. It is considered that the use of environmental or technology measures may be appropriate, when used in balance with other strategies that promote healthy use, but that the use of these measures needs to be navigated by the family

or professionals supporting the family. Strategies will be most effective when they are tailored to the individual circumstances of that child and the environment in which they are engaging in this behaviour.

72. Regarding my first recommendation, the Commissioner agreed there is an ongoing need to raise awareness of the impact of problematic gaming behaviours on wellbeing – in conjunction with promoting the benefits of gaming, and strategies that maximise balanced gaming behaviour. The Acting Commissioner noted that eSafety currently takes an active role in promoting healthy and safe online gaming behaviour (and other online behaviour) by providing information on their website and via free webinars and providing expert advice in strategic forums that influence curriculum and wellbeing initiatives in schools. eSafety is also working with industry and organisation globally to adopt Safety by Design principles, which put user safety and rights at the centre of the design and development of online products and services, including games.

73. Regarding my second recommendation, the Acting Commissioner noted the development of a robust evidence base is imperative to guide appropriate policy responses, prevention, and treatment programs. The development of such an evidence base relies on the cooperative work of a range of stakeholders:

    (a) academic institutions with a deep clinical research speciality in this field that can provide an in-depth description of risk and protective factors for disordered gaming, and design and evaluate prevention and treatment interventions that respond to this;

    (b) national agencies with a research function (e.g. Australian Bureau of Statistics, Australian Institute of Health and Welfare) that can coordinate population-level monitoring and identify emerging trends; and

    (c) funding bodies (e.g., National Health and Medical Research Council) who can provide the investment necessary to advance the evidence base.

74. The Acting Commissioner noted that perspectives and lived experiences of young people and their parents and carers must also be central in setting the agenda for the development of the evidence base. The needs of frontline workers/practitioners who support adolescents and young adults at-risk of problematic online gaming should also be included.

75. To achieve these goals, the Officer of the eSafety Commissioner was agreeable to working with parents, and frontline workers/practitioners, researchers and research institutions, other

government agencies, Not-For-Profits or industry, and/or to serving an advisory function on boards or steering committees.

Australian Psychological Society

76. I also provided Dr King's expert report and my proposed recommendations to the Australian Psychological Society (**APS**).

77. Dr Zena Burgess, Chief Executive Officer, explained that while the APS does not currently have an established a position regarding online gaming, it shared the concerns identified by Dr King in terms of the lack of a clinical diagnosis for gaming disorders recognised in the DSM-5 and the need for further research to establish prevalence and incidence. The APS is of the view that it would be premature to establish a position in the absence of this data.

78. For this reason, the APS fully endorsed the intent of my proposed recommendations to increase the commitment to research, along with the development of a standardised approach to the prevention of behaviours that may contribute to the occurrence of psychological harms resulting from gaming and gaming disorders.

79. While noting there is an urgent need for further research in this area, the APS suggested that there are steps that are still able to be made to support the prevention and treatment of this behaviour. In turn this would assist with results-based research. For example, recognising and including this behaviour, and associated psychological harms, in existing assessment and treatment protocols – particularly for adolescents and young adults seeking assistance with mental health issues.

80. The APS also noted it was keen to support the advancement of the above recommendations and to work with the Victorian and federal governments to address these issues and those identified in Dr King's report. Dr Burgess noted that governments need to commit to investing funds for further research to identify the prevalence and incidence of gaming disorders, and to promote prevention and evidence-based treatment for such disorders to minimise the psychological harms resulting from this behaviour.

Office of the Chief Psychiatrist

81. I also provided Dr King's expert report and my proposed recommendations to the Office of the Chief Psychiatrist for comment.

82. Dr Dom Baetens, Deputy Chief Psychiatrist, did not comment on the recommendations but recognised Dr King's expert opinion regarding the potential roles of primary, secondary, and tertiary prevention strategies as well as potential public policy and government interventions.

FINDINGS AND CONCLUSION

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

(a) The identity of the deceased was Oliver Vincent Paul Cronin, born 11 August 2006.

(b) The death occurred on 25 October 2019 at Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria 3052.

(c) The cause of Oliver's death was hanging.

(d) The death occurred in the circumstances described above.

(e) There is insufficient unambiguous evidence before me that Oliver intended to take his life that tragic evening. Given his relative youth, I find it unlikely that he considered and clearly understood the ramifications or finality of his actions.

COMMENTS

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

84. Oliver was a school student in Victoria. However, based on available information, neither the school nor his parents were sufficiently aware of the risks posed by the extent of his gaming, nor did they recognise that the changes in Oliver's behaviours were associated with his increased use and reliance on online gaming platforms. Oliver was not diagnosed with a gaming disorder; however, his behaviours suggest that he met the WHO description of a gaming disorder.

85. It is clear that current understanding the prevention of gaming disorders and the diagnosis and treatment of gaming disorders is neither extensive nor rigorous. The prevalence and incidence within the Australian population and especially adolescent and young adult population is also not reliably understood. This places parents, families, and schools in the position of being unaware and unsure of what is the best thing to do to prevent gaming disorder and promote healthy online behaviours or how to react in situations where there are indications of problem behaviours associated with gaming.

86. Comparatively, Australia has not acted as proactively as other nations and actions and policy are not informed by local information or standardised. Most education and information for intervention in preventing unsafe adolescent and young adult gaming use is aimed at parents and is focused on privacy and security and not psychological harms.

87. Furthermore, there are no specially public funded services specific to gaming disorder and/or its prevention in Australia. Professional help is also not standardised and much of it is linked to gambling or addiction services or is promoted by private practitioners as a speciality area of practice.

88. Research to date by the Office of the eSafety Commissioner into gaming was in the '2018 State of Play – Youth and Online Gaming in Australia'[13] which found online multiplayer gaming is a very popular activity for young Australians, with 6 in 10 young people aged 8 to 17 years having played these games, nearly 1 in 2 young people have played eSport video games, and an estimated 17% of multiplayer gamers have experienced in-game bullying. The report concluded that it would be useful to explore further research relating to the intensity with which young people play video games and the impact that this can have on themselves and their relationships with others.

89. There is therefore a need to increase the commitment to research to establish the prevalence and incidence of gaming disorders and unhealthy internet use and to expand current advice and intervention information to include a standardised approach to the prevention of behaviours that may contribute to the development of psychological harms and a gaming disorder.

90. The Office of the eSafety Commissioner's remit includes safeguarding Australians at risk from online harms and to promoting safer, more positive online experiences, as well as leading and coordinating the online safety efforts of government, industry, and the not-for-profit community in Australia.[14] The Office of the eSafety Commissioner also funds research projects through the Online Safety Grants. I am therefore persuaded that the Office of the eSafety Commissioner is the appropriate body to which I direct the following recommendations.

[13] eSafety Commissioner, Youth and online gaming - state of play, https://www.esafety.gov.au/sites/default/files/2019-07/Youth-and-online-gaming-report-2018.pdf, accessed 10 October 2022.
[14] eSafety Commissioner, What we do, www.esafety.gov.au/about-us/what-we-do, accessed10 October 2022.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. To help prevent psychological harms to adolescents and young adults from gaming platforms and online gaming, I **recommend** the **Office of the eSafety Commissioner** raises awareness in adolescents and young adults of the risks of gaming on their psychological wellbeing and promote the inclusion of information about gaming and psychological wellbeing in school-based digital health programs.

2. To help develop a reliable evidence-base about gaming and adolescents and young adults in Australia, which will inform strategic and local policies, the standardisation of advice on the risks of psychological harms and online gaming, prevention strategies, and the development of contemporary and evidence-based interventions, I **recommend** the **Office of the eSafety Commissioner** promote research that establishes the incidence and prevalence of psychological harms to adolescents and young adults from online gaming.

I convey my sincere condolences to Oliver's family and his community 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:

Helen and Christopher Cronin, Senior Next of Kin
eSafety Commissioner
Australian Psychological Society
Office of the Chief Psychiatrist
Royal Children's Hospital
Commission for Children and Young People
Department of Education and Training Victoria
Royal Australian and New Zealand College of Psychiatrists
Royal Australian College of General Practitioners
National Health and Medical Research Council
Detective Senior Constable Liza Burrows, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 10 October 2022

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.