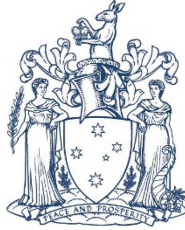

IN THE CORONERS COURT	**COR 2020 0958**
OF VICTORIA	**COR 2020 1106**
AT MELBOURNE	**COR 2020 2250**
	COR 2020 2877
	COR 2020 3158

CLUSTER FINDING INTO DEATHS WITHOUT INQUEST

Findings of: Coroner Leveasque Peterson

Delivered on: 24 November 2023

Keywords: Youth suicide; Cluster; Mental health; Stressors; COVID-19 Lockdown; Social media

Pursuant to section 55(2)(e) of the Coroners Act 2008, a pseudonym replaces the names of all deceased.

Introduction

1. Suicide is the leading cause of death among young people in Australia and the incidence of youth suicide has only increased in recent years.

2. It is critical that as a community we consider every death as a chance to learn more about youth suicide in an effort to identify every possible prevention opportunity and stem the current tide.

3. The Coroners Court of Victoria (**CCOV**) in particular is in a unique position to be able to draw on evidence and information at both a micro and a macro level, and undertake a broader examination of these tragedies with a view to gaining insights that could help save young lives in the future.

4. The report contains an examination of data and draws some factual conclusions. It also contains extracts of observations from young people who have either been directly affected by suicide or who have simply shared their feelings about the challenges they face as young people and the feelings they have experienced in the wake of these tragedies.

5. The identities of all the young people in this report have been deidentified to protect their privacy.

Background

6. Between February and June 2020 five suicides occurred among young males aged under 18 years who resided in the Greater Geelong local government area (**LGA**). These five deaths were identified as a potential suicide cluster and were grouped for coronial investigation.

7. In the context of the rise in youth suicide and the need to identify prevention opportunities these cases were brought together in order to collate and assess

the collective evidence as to whether the five deaths comprise a suicide cluster and, if so, in what sense.

8. The four elements of suicide clustering that were examined here included:

    - Temporal clustering. A temporal cluster comprises suicides among a group of people (usually defined by sex and/or age and/or occupation and/or other socio-demographic characteristics) which occur closer together in time than might be expected by chance.

    - Spatial clustering. A spatial cluster comprises suicides among a group of people which occur closer together in space than might be expected by chance.

    - Social clustering. Suicides are said to be socially clustered if the deceased know - or know of - one another.

    - Thematic clustering. A thematic cluster is a group of suicides where the deceased share common stressors or other experiences proximal to death.

Evidence of temporal and spatial clustering

9. The five deceased shared several characteristics that strongly indicated they might comprise a spatial and/or temporal cluster: they were all males aged under 18 years who resided in Greater Geelong and died within a six-month period.

10. To test for temporal and spatial clustering, the analysis commenced with the identification of all suicides reported to CCOV during the period January 2009 to May 2021 where the deceased was a male aged under 18 years who resided in Greater Geelong. Analysis of this data showed that the five

suicides identified clearly stood out as occurring closer together in time than previous or subsequent suicides.

11. To test whether clusters of similar magnitude may have occurred in other Victorian LGAs during the period, all suicides among young males aged under 18 that occurred in Victoria between 2019 and 2020 were examined and collated by LGA of usual residence.

12. The LGA with the next highest suicide frequency after Greater Geelong experienced three suicides of usual residents occurred between August 2019 and March 2020. There was no other LGA associated with more than two suicides in the young male cohort during the period.

13. The same analysis as described above was used to identify whether there may have been clusters involving young females, however the results revealed that the only cases were those already linked in a previous cluster analysis. Across 2019 and 2020 there was no LGA of usual residence associated with more than one suicide.

14. On this basis, the five suicides clearly represented a cluster defined by socio-demographics (males aged under 18), space (usual residence in Greater Geelong) and time (February to June 2020).

Evidence of social clustering

15. To investigate social clustering among the five deaths, the individual briefs of evidence were reviewed for evidence that any deceased knew any other deceased, 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.

16. Connections were identified between four of the deceased, although there was no single social linkage which connected all of the deaths:

- In three deaths the deceased attended the same school in Geelong. Two of the deceased were known to have formed a close friendship at the school and continued to maintain this after one of them moved to another local school in 2020. The third deceased was in another year level but may have known both of the other deceased.
- In two deaths there was evidence the deceased shared a mutual friend who died also by suicide in January 2020[1].
- In two deaths the deceased were undertaking educational courses at the same TAFE.
- In three deaths the deceased played football for the local or school team, however there was no direct evidence any of the deceased knew the others through football.
- In two deaths the deceased were engaged with Barwon Health Child and Adolescent Mental Health Service (**CAMHS**).

17. One of the deceased was not clearly linked to any of the other cases.

Evidence of thematic clustering

18. To ascertain whether there was any evidence of thematic clustering, it was necessary to examine a chronological overview of the events leading up to each suicide, focusing particularly on any apparent stressors or triggers.

19. In considering the events leading up to each death, the purpose is not to lay blame but rather to identify common stressors which may present an opportunity for increased supports.

[1] This case was not part of the cluster investigation.

20. One common factor between the five deaths was the role of breakdowns or disruptions in social life (friendships and relationships). In particular:

- CA's suicide occurred in a context of deteriorating mental health after separating from his girlfriend.

- CB experienced a period of online bullying and loss of friendships after a problematic social media post.

- CF was grieving the deaths of two friends, one of whom had also died by suicide and is included in this cluster. The third deceased also suffered a notable mental health decline due to the social isolation brought about by COVID-19 restrictions.

- CD was significantly impacted following COVID-19 restrictions which impacted his ability to play sports.

- CG experienced increasing suicidality following a relationship breakdown with his girlfriend.

21. Another common theme was evidence of mental health issues across a number of the deaths, where the deceased were engaged with one or more mental health services. These ranged from school-based psychological support to counselling, General Practitioners, psychologists and psychiatrists.

22. The remaining themes that featured across multiple deaths are summarised below including:

- In four deaths there was evidence of family-related stressors, including parental separation, exposure to parental use of alcohol, and disagreements. In most cases, it appeared that the breakdown of family relationship may have negatively impacted the deceased's

mental health to some extent, although family relationships may also have acted simultaneously as a protective factor.

- In four deaths, there was direct or indirect evidence of educational stressors in relation to behaviour and/or academic performance.
- In three deaths there was evidence of substance use, mainly alcohol and cannabis.

Conclusions on clustering

23. Based on the analysis of the available evidence in the five suicides I find the deaths were a genuine cluster in that:

- the deaths were clearly clustered in time, space and sociodemographics;
- the same method was used in all deaths;
- all five were secondary school students at the time of their deaths;
- there were direct and indirect social links between most of the deceased; and
- there was evidence of breakdowns occurring in important social relationships, mental health deterioration and engagement with mental health services were present across all deaths.

Other investigations

24. As part of the cluster investigation the Court commissioned a report from the Centre for Innovative Justice at RMIT.

25. The report: *Young People living in Geelong: Reflections, actions and ideas in response to youth suicide*, was produced as a means of elevating the

voices and experiences of young people living in Geelong and the surrounding area who were impacted by the deaths of six young men including the five identified in this cluster.

26. I would like to thank the Centre for Innovative Justice for the work that was undertaken. The report was an invaluable resource for my investigations and the observations extracted in this Report were often poignant and always informative.

27. I have extracted selected observations here that I consider provide insight into the challenges faced by our youth, and I commend them for their candour and for giving their time to such an important exercise.

28. I propose to liaise with Centre for Innovative Justice regarding the possibility of a broader publication of the Report.

Key themes from the Report

29. Being a teenager is one of the hardest stages of life, noting it is a time for questioning one's place and value in the world. The participants reported that an unfortunate but natural progression to those thoughts is "*Do I even deserve to be here?*"

30. ***On being a young person***

Today I could probably name 10 people that say they're tackling some sort of eating disorder. Same goes with depression. I'd had three or four friends that were depressed and now it seems like all of them are…

31. ***On Social media***

I'd say social media is one of the biggest contributors to low mental health. I know I see a pretty strong correlation between my overall mental health and my screen time on social media.

Social media links to everything. Social media ties into the struggles that people have in their teenage years where they are trying to fit in, trying to figure themselves out. And alongside trying to figure themselves out they've got this device that's pushing their worst fears and revealing them to be true.

Snapchat has the feature that you can see the time when someone has opened your text – and that obviously means that you can see the exact time that you were ignored.

There's like an analytics tab on Instagram and I used to check that all the time where you can see how many people have viewed it and how many people have liked it and you kind of compare that to your self-worth; that ratio kind of determines how you feel that day, your self-worth.

32. ***On lockdowns***

The lockdowns just increased screen time…The increased "me" time could be bad for people who are having self worth issues.

33. ***On social and cultural issues***

The classic Australian doesn't say 'G'day mate I'm here to talk about my feelings'. That doesn't happen.

In my school there's a very big sort of toughen up mentality. No one talks about their problems. There's definitely a stigma.

34. ***On the impact of the suicides***

People cared about each other after the suicides. There was a lot less bullying. You wouldn't see it so much on social media.

Everyone knew someone who died, or at least they knew a friend of a friend who died. It hit close to home for everyone.

My group of mates started telling each other that we love each other

The school has changed in the last six months. I remember the months after…I didn't hear a single negative thing said…

After,…organised this session…to come together and talk about mental health…The room was packed. The room was packed.

35. ***On what helps***

Having friends to talk to.

Having the psychologist, talking to the school.

When you trust your family and friends you know that its not always dark times. You know there's a light at the end of the tunnel.

There's something I really believe that we should do, refer people to the right place where they can get the right treatment, the right help. You can help them as a friend, you can offer them support but you can't fix their problem.

36. ***On what might help***

More education. More scenarios about how to respond in difficult situations. If we could somehow integrate that in our learning that would be a massive plus I reckon.

…there's not a lot of how. How do you be resilient? You cant just tell a kid to be resilient and they'll go Oh Okay I'll be resilient then…

I think kids need to be taught how to speak and how to listen…

Communication is so important but we're not taught how to do it…

I had to tell my dad to just listen, because whenever I'd talk to him he would, with good intentions, constantly ask questions…I just want to be heard…

CONCLUSION

37. The suicides of these five young men represent an immeasurable tragedy for their family and friends and a failing for society more broadly. Having met with family members, I am conscious of the urgent and critical need to implement measures to avoid the recurrence of such tragic outcomes.

38. As was recently stated by the State Coroner:

    The health and wellbeing of young Victorians is a community responsibility. While we work with state and federal government to provide data that informs targeted suicide prevention programs, I urge parents and friends to help our young people stay connected and supported.[2]

39. While recognising the commonalities which existed between these five deaths, I have not identified any specific prevention opportunities arising from the particular circumstances of the cluster.

40. However, I am hopeful that broadscale reforms emerging from the Royal Commission into Victoria's Mental Health System (**the Commission**) will improve supports available to young people in the future.

41. The issue of youth suicide and suicidal behaviour was considered thoroughly in Chapter 13 of the Commission's Final Report which

---

[2] Coroners Court of Victoria, Media release titled 'Increase in youth suicide observed in first three months of 2023', 26 April 2023, https://www.coronerscourt.vic.gov.au/increase-youth-suicide-observed-first-three-months-2023#:~:text=The%20health%20and%20wellbeing%20of,people%20stay%20connected%20and%20supported..

recommended substantial reform and investment in services targeted at young people. This was in addition to the interim report's recommendation to establish an aftercare service for children and young people who have self-harmed or who are at risk of suicide.

42. I commend the Victorian Government on its commitment to implementing all of the Commissions' recommendations and urge continued focus in this area. In this respect, I propose to provide a copy of this report and the Centre for Innovative Justice Report to the Department of Health and the Department of Education for information and consideration in the context of current and planned future youth suicide prevention strategies.

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.

Signature:

CORONER LEVEASQUE PETERSON

Date: 24 November 2023

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.