



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006801

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of: Coroner Ingrid Giles

Deceased: [REDACTED]

Date of birth: [REDACTED]

Date of death: 20 December 2021

Cause of death: *Neck compression; Hanging*

Place of death: Goulburn Valley Health, Shepparton Public
Hospital, 2-48 Graham Street, Shepparton,
Victoria, 3630

Aboriginal and Torres Strait Islander readers are advised that this content contains the name of a deceased person. Readers are warned that this finding may contain words and descriptions that may be culturally distressing.

INTRODUCTION

1. [REDACTED] [REDACTED] was a [REDACTED] Aboriginal woman who passed in hospital from self-inflicted injuries on 20 December 2021. At the time of her passing,² [REDACTED] lived with her mother and siblings in Mooroopna.
2. [REDACTED]'s mother described her as an intelligent young woman who had worked hard to obtain qualifications at TAFE and secure casual employment. She was not known to have any history of suicidality or mental illness. Her treating General Practitioner (GP) saw her regularly and never noted any depressive symptoms or mental health concerns.
3. [REDACTED] had been in a relationship with her boyfriend [REDACTED] since she was approximately [REDACTED] years old. The relationship was reportedly tumultuous, with conflicts often arising between them in the context of increasing recreational drug use (believed to be cannabis). The couple predominantly resided together, moving between their respective parents' houses until shortly before [REDACTED]'s passing, when she relocated to the family home after the relationship ended.

THE CORONIAL INVESTIGATION

4. [REDACTED]'s passing 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.

¹ Referred to throughout my finding as '[REDACTED]', unless more formality is required.

² The term 'passing' is generally more accepted and sensitive terminology to use when discussing the death of Aboriginal and Torres Strait Islander people due to the spiritual belief around the life cycle (*see* 'Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying', Queensland Government, December 2015, available [here](#)). On the advice of the Coroners Aboriginal Engagement Unit, the term 'passing' will be used instead of 'death' in this finding, save where required by the words of relevant statutes.

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. Coroner Leveasque Peterson initially held carriage of this investigation. Victoria Police assigned Senior Constable David Basham (**SC Basham**) to be the Coroner's Investigator for the investigation of ██████'s passing. SC Basham conducted inquiries on the Court's 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. I took carriage of this matter in July 2023 for the purposes of obtaining further statements, seeking further advice from the Coroners Prevention Unit (**CPU**),³ finalising the investigation and making findings.
9. This finding draws on the totality of the coronial investigation into the passing of ██████ 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.⁴

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

Circumstances in which the death occurred

10. In early December 2021, ██████ and ██████ separated in reportedly traumatic circumstances in which she alleged that she had been sexually assaulted by another man but was not believed. Her mother ██████ observed that ██████ had *not been herself* following the break-up, and was struggling to come to terms with the separation and the circumstances in which it had occurred.

³ The CPU was established in 2008 to strengthen the prevention role of the coroner. The CPU assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. CPU staff include health professionals with training in a range of areas including medicine, nursing, and mental health; as well as staff who support coroners through research, data and policy analysis.

⁴ 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.

11. A few days before her passing, [REDACTED] was walking her dog on a lead in Mooroopna when the dog was struck by a vehicle and died. Her brother reported that this event deeply impacted [REDACTED], and that she seemed to be in a daze the entire week.
12. [REDACTED] 2021 was [REDACTED]'s [REDACTED] birthday. She spent the morning at home with her mother and her siblings, with plans to have a cake later that evening. The family turned on a movie in the lounge room and watched it together.
13. At some point, [REDACTED] left the living room to take a shower. Her mother remained dozing on the couch and was woken by her younger daughter's screams from the ensuite in the master bedroom. She raced into the ensuite and observed [REDACTED] hanging from the shower screen door, having used [REDACTED] as a ligature.
14. The family took [REDACTED] down and her brother commenced cardiopulmonary resuscitation (CPR) while her mother arranged for emergency services to be called.
15. Victoria Police officers and Ambulance Victoria paramedics arrived soon after and took over CPR. [REDACTED] was field intubated before being transported to Shepparton Hospital. Clinical investigations confirmed that she had developed a global hypoxic brain injury and she was declared brain dead. [REDACTED] passed away in hospital on 20 December 2021 with her mother present.
16. Victoria Police did not locate any suicide note during their investigations. After a thorough investigation, they concluded that there were no suspicious circumstances surrounding the passing.

Identity of the deceased

17. On 19 December 2021, [REDACTED], born [REDACTED], was visually identified by her brother, [REDACTED], who made a formal statement of identification.
18. Identity was not in dispute and required no further investigation.

Medical cause of death

19. Forensic Pathologist Dr Paul Bedford from the Victorian Institute of Forensic Medicine conducted an examination on 23 December 2021 and provided a written report of his findings dated 31 December 2021.

20. The post-mortem examination revealed findings in keeping with the clinical history. Toxicological analysis of post-mortem samples identified trace amounts of midazolam and cannabinoids. Alcohol was not detected.
21. Dr Bedford provided an opinion that the medical cause of death was *neck compression; hanging*.
22. I accept Dr Bedford's opinion as to medical cause of death.

CORONER'S PREVENTION UNIT REVIEW

23. During the coronial investigation, I referred this case to the CPU for review, due to concerns that were raised with the Coroners Court of Victoria (**Coroners Court**) about the prevalence of suicide among young people in the Greater Shepparton region and, relevantly, Aboriginal young people linked to the Greater Shepparton community.
24. The CPU advised that [REDACTED]'s passing occurred during a period of heightened concern in the Greater Shepparton community about deaths among young people.
25. In the months preceding and following [REDACTED]'s passing, there were several other deaths among young people between 10 and 24 years of age in the Greater Shepparton region in circumstances consistent with suicide.
26. The CPU conducted analysis showing these deaths most likely comprised a statistical cluster: since 2011 there has been no other comparable period during which so many non-natural deaths of young people occurred in the region. Furthermore, this statistical clustering was also overlaid with a cohort of Aboriginal people who passed by suicide and who either resided in or were otherwise linked with the Aboriginal community in Shepparton.
27. The Coroners Court was first alerted to the Shepparton community's concerns by the Victorian Department of Health (**DOH**) on 26 November 2021. Over the next few months, the CPU stayed in regular contact with the Suicide Prevention and Response Office (**SPARO**) at the DOH to support and assist their suicide postvention efforts.
28. The SPARO provided the CPU with an update in October 2023 which outlined the activities and initiatives taken as part of the DOH postvention response. They included:
 - a) DOH worked with StandBy Support After Suicide (the national suicide postvention program) to coordinate the community response during this period;

- b) stakeholder meetings and consultation took place with a wide range of organisations, to identify immediate risks and community support needs, longer-term needs, and what actions would be taken by what services to deliver the postvention response;
 - c) a Shepparton Rapid Response Group was formed and met weekly through to late January 2022;
 - d) funding was provided for StandBy to create a culturally inclusive community connections hub where impacted community members could attend without appointment to seek support;
 - e) a specific postvention strategy meeting was facilitated to consider the needs of the Aboriginal community in Shepparton, which was attended by local Aboriginal organisations and community representatives;
 - f) the Office of the Chief Psychiatrist engaged with local mental health services to ensure enhanced mental health support was delivered over the holiday period; and
 - g) other activities were conducted including targeted social media messaging, Koorie Youth Gatherings, and collaboration between local stakeholders on developing postvention protocols.
29. The DOH's active involvement in this strengthened postvention response ended in late January 2022 however they have continued to monitor suicides in the local area and have also delivered a community gatekeeper training pilot to assist with ongoing postvention efforts.

FINDINGS AND CONCLUSION

30. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was [REDACTED], born [REDACTED];
 - b) the passing occurred on 20 December 2021 at Goulburn Valley Health, Shepparton Public Hospital, 2-48 Graham Street, Shepparton, Victoria, 3630, from *neck compression; hanging*; and
 - c) the passing occurred in the circumstances described above.
31. Having considered all of the circumstances, including the means chosen, I am satisfied that [REDACTED] intentionally ended her own life. While I cannot determine the particular stressors that

motivated her to take her decision, it is apparent that she had recently experienced a situational crisis⁵ in response to circumstances surrounding a relationship breakdown. A significant proportion of Victorian suicides in young people are impulsive acts precipitated by personal stressors and situational factors. ██████'s passing highlights the difficulty in predicting when a person may be at risk of crossing the suicide threshold, particularly where they have given no indication to those around them or to their treating medical practitioners that they are considering self-harm.

32. The loss of a young person to suicide is a tragedy which can have lasting effects on the lives of those who loved them. I convey my sincere condolences to ██████'s family, friends, and community for their loss, and I acknowledge the sudden and traumatic circumstances in which her passing occurred.

COMMENTS

33. Pursuant to section 67(3) of the Act, I make the following comments connected with the passing:
- a) The Victorian Suicide Register (**VSR**) reveals a general increasing trend over time in the number of Aboriginal and Torres Strait Islander people who have passed by suicide since 2018. In several instances, a suicide in a particular area was closely followed by another suicide in the same or a neighbouring community. This intensified the impact of the passings on the affected communities and created rolling anxieties across Victoria about the possibility of suicide clusters. Social factors present in regional Aboriginal communities are common across many of the reported passings, including difficulties accessing culturally appropriate support services, relationship breakdowns, and the availability of appropriate crisis services and housing.
 - b) As outlined above, I am satisfied that the Victorian Department of Health (hereinafter '**DOH**'), in conjunction with the Coroners Court of Victoria, is continuing to monitor the issue of suicide amongst young people in the Greater Shepparton region. These efforts are to be commended. Since early 2022, the VSR has not revealed further or subsequent statistical clustering of suicides in this region in particular, and I am

⁵ A situational crisis is not a mental health diagnosis, but a term used when a person's coping mechanisms are adversely affected by a particular stressor or circumstance in the absence of mental illness. Situational crises are often associated with acute distress and sometimes increased risk of self-harm and suicide.

therefore of the view that, while the incidence of suicide in Aboriginal communities across the state remains deeply concerning, no coronial recommendations are required to address strengthened postvention supports or to address further prevention opportunities in the Greater Shepparton region itself.

- c) On a statewide level, I am advised by the CPU that the Victorian Government (led by the DOH) is currently finalising the Victorian Suicide Prevention and Response Strategy 2024-2034. The strategy was developed through extensive consultation and engagement including consideration of *‘Aboriginal-led suicide prevention and response approaches based on cultural knowledge and expertise, needs and aspirations’*.⁶ Relevant parts of the strategy have been co-designed with Aboriginal communities and the strategy will soon be publicly available. I also note that the State’s most recent suicide prevention framework (2016-2025) includes a commitment to *‘halving the suicide rate over the next ten years’*,⁷ which will continue to be monitored through collection and interrogation of VSR data to inform future prevention efforts in this space.

ORDERS

34. Pursuant to section 73(1A) of the Act, I order that this finding be published (in redacted form) on the Coroners Court of Victoria website in accordance with the Rules.
35. I direct that an unredacted copy of this finding be provided to the following:

██████████, Senior Next of Kin

Senior Constable David Basham, Coroner’s Investigator

Bailey Nation-Ingle and the Office of the Chief Psychiatrist, Victorian Department of Health

Victorian Institute of Forensic Medicine

⁶ Available: <https://www.health.vic.gov.au/mental-health-wellbeing-reform/victorian-suicide-prevention-and-response-strategy>

⁷ Available: <https://www.health.vic.gov.au/prevention-and-promotion/suicide-prevention-in-victoria#halving-victorias-suicide-rate-by-2025>

Signature:



Coroner Ingrid Giles

Date : 18 January 2024

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.
