IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004562

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	MG (also known as BX)
Date of birth:	1985
Date of death:	7 August 2024
Cause of death:	1(a) Sharp force injuries to the right forearm
Place of death:	Creswick-Newstead Road, Sandon, Victoria 3462
Keywords:	Suicide; Family Violence Allegations

INTRODUCTION

1. On 7 August 2024, MG was 38 years old when he was found deceased next to his vehicle in rugged bushland in Sandon. At the time of his death, MG lived at his workplace which was a factory in Campbellfield.

2. MG had a troubled upbringing and grew up in out-of-home care before he was adopted by a family in his early teenage years. At the time of his death, MG was estranged from both his biological and adoptive families. MG had one child, but he separated from the child's mother in or around 2009 when the child was a few months old and he had no known contact with his child since.

3. In 2006 or 2007, MG met CJ online via a computer game. MG and CJ met in person in 2009 and moved in together until their relationship ended in 2018. MG and CJ remained friends and would confide in and support each other. CJ also continued to work with MG until May 2023. The Court had the benefit of a very detailed statement from CJ.

4. In April or May 2024, MG formally changed his name from BX to MG.

THE CORONIAL INVESTIGATION

5. MG's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (Vic) (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. 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.

8. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of MG's death. The Coronial Investigator conducted inquiries on behalf of the Court, including

taking statements from witnesses – such as family, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. In July 2025, I assumed carriage of the investigation into MG's death upon the retirement of then Coroner John Olle for the purpose of finalising the investigation and making findings.

10. This finding draws on the totality of the coronial investigation into the death of MG 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

Circumstances in which the death occurred

11. In January 2024, CJ saw MG in person for the last time. She noted that MG was in a better place following the breakdown of a relationship and was working hard on creating a better life for himself. He was also optimistic about his new partner, EA, who lived in Scotland. EA travelled to Melbourne on a working holiday visa to be with MG sometime in early 2024.[2]

12. On 5 August 2024, MG attended the Fawkner Police Station and spoke with a police officer regarding an incident that occurred in May 2024. He alleged that EA smashed a glass bottle over her face and then told friends that MG had assaulted her which resulted in police conducting a welfare check on her. MG also stated that EA had borderline personality disorder and would threaten to make up rumours about him and tell his boss. He informed the officer that EA had moved to a friend's place and that she had plans to return to Scotland. MG was not supportive of any application for a family violence intervention order because MG and the police expressed the view there were no immediate threats to MG's safety as EA was no longer residing with MG and she was due to leave the country.[3] A family violence report was made which listed MG as the affected family member and EA as the respondent.

13. Around 10.40am on 6 August 2024, an ex-partner of MG contacted police requesting a welfare check on EA at MG's workplace in Campbellfield. When police attended at approximately

[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.
[2] Coronial Brief, Statement of CJ.
[3] Coronial Brief, Statement of First Constable Olivia-Grace Vernino.

11.15am, they located EA alone and passed out in an office area that had been converted into a living area. EA was emotionally distressed when police raised her. She informed police that she was working for MG without pay and alleged that he did not allow her to leave the factory. EA further disclosed a range of other offences undertaken at the direction of MG. She mentioned that she was attempting to leave Australia but had been unable to. Police made multiple attempts to contact MG via phone, but he could not be reached. A search warrant was then executed by police at the Campbellfield factory.[4]

14. EA showed police text messages she had received from MG threatening to take his own life due to her disclosing such matters to police including that he was *"going to find a beautiful place to end it".* At this point, MG was listed as a missing person as he had not been seen and there were concerns for his welfare.

15. EA advised police that she was tracking the whereabouts of MG's phone via the Life360 app which showed that it was in the vicinity of Creswick-Newstead Road in Newstead. Around 11.40pm on 6 August 2024, a police unit was sent to search the area including the police airwing.

16. Around 12.30am on 7 August 2024, police located a vehicle registered to MG in bushland approximately 750 metres from Creswick-Newstead Road in Sandon. MG was located deceased near the rear driver's side door of the vehicle with large lacerations to his arm and a large amount of blood in the vehicle and on his person. A Stanley knife was found on the ground next to MG.[5]

17. Investigating Victoria Police members did not identify any suspicious circumstances surrounding MG's death. At the time of MG's death, police were investigating admissions made by EA in text messages to MG that she was going to tell police she had made up the allegations against him.

Identity of the deceased

18. On 9 August 2024, MG (also known as BX), born 1985, was visually identified by his partner, EA.

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

[4] Coronial Brief, Summary of Circumstances.
[5] Coronial Brief, Statements of Senior Constable Raymond Hender and Detective Senior Constable Joel Peters.

Medical cause of death

20. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 8 August 2024 and provided a written report of his findings dated 22 August 2024.

21. The post-mortem examination revealed extensive deep sharp force injuries to the right forearm, resulting in transection of major blood vessels. Extensive sharp force injuries were also seen on the left forearm, although less major blood vessels were transected. A superficial sharp force injury was seen on the neck but did not result in injury to any blood vessels.

22. Toxicological analysis of post-mortem samples identified the presence of ethanol (0.08 g/100mL).[6]

23. Dr Young provided an opinion that the medical cause of death was '1(a) *Sharp force injuries to the right forearm*'.

24. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was MG (also known as BX), born 1985;

    b) the death occurred on 7 August 2024 at Creswick-Newstead Road, Sandon, Victoria 3462, from *sharp force injuries to the right forearm*; and

    c) the death occurred in the circumstances described above.

26. Having considered the location where MG was found, the text exchanges found on his mobile phone between him and EA, the lack of any other person at the scene or any evidence of others being present, and the totality of the circumstances, I am satisfied that MG intentionally took his own life.

I convey my sincere condolences to CJ for her loss.

[6] Alcohol.

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:

CJ, Senior Next of Kin

Senior Constable Nathan Marsh, Coronial Investigator

Signature:

Coroner Therese McCarthy

Date: 03 August 2026

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.