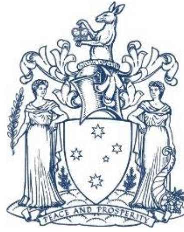

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 001089

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF PJQ

Findings of:	Coroner David Ryan
Delivered on:	14 May 2024
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria
Inquest hearing dates:	24 & 26 April 2024
Counsel Assisting the Coroner:	Rose Singleton of counsel
Ms V:	Zoe Broughton of counsel
Department of Families, Fairness and Housing:	Raph Ajzensztat of counsel
Berry Street:	Naomi Hodgson of counsel
Keywords:	Children in State care – Transition to independent living – Accommodation

INTRODUCTION

1. On 25 February 2022, PJQ was 18 years old when she was located deceased at a house in Dandenong.

2. PJQ was a resourceful and engaging young woman who was loved by her family. She is warmly remembered and mourned by her maternal grandmother, Ms V who described her in a coronial impact statement as a "*kind, beautiful, big hearted girl*".

BACKGROUND

3. Between 9 December 2003 and 18 January 2019, PJQ was the subject of seven reports to Child Protection, which is part of the Department of Families, Fairness and Housing (**DFFH**). The early protective concerns for PJQ related to her exposure to family violence, as well as her parents' capacity to adequately care for her prior to their separation, in the context of a history of substance abuse.

4. On 30 October 2009, a Permanent Care Order under the *Children, Youth and Families Act 2005* (**CYFA**) was made for PJQ to reside with Ms V, until her 18th birthday.

5. In the years that followed, PJQ experienced a period of stability in her placement with Ms V and engaged well with schooling. When she commenced high school, however, PJQ began to struggle socially and academically and her behaviour became increasingly challenging. In July and August 2018, Child Protection received its fifth and sixth reports which included concerns of ongoing conflict between PJQ and her grandmother and her disengagement from school.

6. On 18 January 2019, Child Protection received its seventh report for PJQ which raised concerns she had not returned to Ms V and was being sexually exploited.[1]

[1] CB275.

7. On 13 February 2019, Ms V advised Child Protection that she was no longer in a position to be responsible for PJQ's guardianship due to her challenging behaviours. Child Protection issued a Protection Application by Emergency Care[2] due to PJQ's increased risk of harm and after making a referral for out-of-home care,[3] PJQ commenced a placement with Anglicare Victoria. The following day, PJQ was placed on an Interim Accommodation Order[4] with conditions relating to school attendance and breach of curfew without permission.

8. On 7 April 2019, due to a breakdown in her residential out-of-home care placement, PJQ was accepted into the "Keep Embracing Your Success" (**KEYS**) program,[5] a residential service offered by Anglicare Victoria and overseen by Child Protection, with clinical input from Monash Health. Following an initial psychiatric review, clinicians formed the view that PJQ relied heavily on substances to regulate her emotions and distress, and that her symptoms were consistent with diagnoses of post-traumatic stress disorder (**PTSD**) and polysubstance abuse.

9. After this initial assessment, PJQ's ongoing engagement with clinicians in the KEYS Program was impacted by her absconding from the placement, chemically withdrawing from non-prescribed substances, and periods of stay at Secure Care Services.[6] Throughout this period, PJQ resided in a number of different residential care houses due to her challenging behaviour and increased risk.

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[2] A Protection Application by Care is made to the Children's Court of Victoria in the most serious circumstances where a child has suffered significant harm or is at risk of significant harm and the child's parent/s are unable or unwilling to protect them.

[3] Out-of-home care is a temporary, medium or long-term living arrangement for children and young people who cannot live in their family home.

[4] An Interim Accommodation Order is an order that provides for where a child who is subject to a protection application will reside (or be placed) until the protection application has been determined by the Court.

[5] The KEYS program is a therapeutic model of care for highly vulnerable young people, with a specific focus on transitioning young people to appropriate future care arrangements.

[6] Secure Care Services is a community service that has "lock-up facilities" that is established under the CYFA. A young person may be placed in Secure Welfare Services by the Children's Court or by the Secretary of DFFH if they have parental responsibility and are satisfied there is a substantial and immediate risk of harm and it is the only suitable option for ensuring the young person's protection.

10. On 30 October 2019, PJQ commenced receiving support from the Youth Support and Advocacy Service (**YSAS**). YSAS is one of Australia's largest, youth-specific community service organisations. It provides practical support and evidence-based clinical services for young people experiencing serious problems.

11. Ms Natalie Hands was the Alcohol and Drug Youth Consultant employed with YSAS. She had been working with PJQ since late October 2019 and had established a good rapport with her through the provision of outreach support and consultation with the broader Care team. Warren Eames, YSAS Regional Manager South East, noted in his statement to the Court that, "*It was difficult to establish the type of relationship continuity that would be considered ideal for Natalie to be in a position to exert the sort of influence that may have affected positive changes on [PJQ]'s outlook and decision making*".[7]

12. On 23 January 2020, PJQ's Protective Care Order was revoked and she was made the subject of a Care by Secretary Order[8] which was due to expire on 9 December 2021 when she turned 18.

13. On 25 January 2021, PJQ relocated to a Transitional Housing Management (**THM**) property and received daily support via a Targeted Care Package (**TCP**).[9] This placement came to an end after an accidental fire at the property in February 2021.

14. On 21 May 2021, PJQ's case management was transferred to Berry Street. Ms Celeste Carbonaro was PJQ's Berry Street Case Manager and she also established a good rapport with PJQ.

15. On 1 June 2021, PJQ relocated to a therapeutic care property managed by the Lighthouse Foundation.[10] This placement was potentially available to transition PJQ to her 18th birthday and up until the age of 21.

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[7] CB381.

[8] A Care by Secretary Order gives parental responsibility for a child's care to the Secretary or delegate to the exclusion of all other persons.

[9] A Targeted Care Package is an allocation of funding that is tailored specifically to meet individual needs of a particular child or young person and is aimed at providing an alternative to residential care.

[10] The Lighthouse Foundation's leaving care model allowed PJQ to reside in a property with a live-in mentor and up to four other young people until 21 years of age.

16. On 13 September 2021, PJQ's placement with the Lighthouse Foundation broke down due to her lack of engagement and substance use. She was then placed in a residential care unit managed by Anglicare Victoria.

17. Between and January 2020 and December 2021 , PJQ presented to hospital on around 20 occasions to receive treatment primarily in the context of substance abuse.

18. Between February 2019 and December 2021, PJQ was reported as a missing person by her carers on 231 occasions. In this period, 142 warrants were granted by the Children's Court of Victoria on the application of Child Protection to locate PJQ and return her to her accommodation or the Secure Care Services.

19. Fortnightly meetings were held with PJQ's Care team (which included Ms Carbonaro, Ms Hands and representatives from DFFH) to discuss her progress and plan for how she could best be supported. Ms Carbonaro and Ms Hands collaborated diligently in their efforts to best support PJQ in the context of her ambivalent engagement and high-risk behaviours.

20. On 8 December 2021, a Care team meeting was held to discuss PJQ's arrangements for leaving the care of the State. They had been unable to secure the leasing of a property through Trusted Care Partners (an external agency funded by DFFH) and were experiencing challenges in sourcing accommodation given PJQ's complex risk profile, which included drug-taking behaviour, mental health vulnerabilities and susceptibility to sexual exploitation. Accommodation options were discussed which included youth accommodation services, high rise public housing and private rentals. The option of short-term Airbnb accommodation was discussed but ultimately not approved by DFFH on the basis that it was "*too risky and potentially undermines other options for [PJQ]*".[11]

[11] CB404.

21. PJQ turned 18 years old on 9 December 2021 and she was no longer able to remain in residential care. DFFH remained involved in her care through the Better Futures program.[12] Berry Street is not funded to provide support to clients after they turn 18 years of age; however, they had agreed to remain involved in PJQ's case management for a further three months to assist as she transitioned to independent living. They arranged for PJQ to reside with Ms V for a period while Haven Home Safe (funded by DFFH) attempted to secure a property for PJQ to lease.[13]

CORONIAL INVESTIGATION

Jurisdiction

22. PJQ'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.

23. The Coroners Court of Victoria (**Coroners Court**) is an inquisitorial court.[14] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

24. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

25. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

26. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation

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[12] Better Futures supports young people who are making the transition from care to adulthood until the reach the age of 21. It is funded by DFFH and the service is provided by community organisations. In PJQ's case, it was provided by South East Community Services (SECL).
[13] Haven Home Safe is a non-profit organisation that provides accommodation services to the vulnerable and homeless.
[14] Section 89(4) of the *Act*.

findings and by the making of recommendations by coroners. This is generally referred to as the prevention role.

27. Section 7 of the Act provides that a coroner should liaise with other investigative authorities, official bodies or statutory officers to avoid unnecessary duplication of inquiries and investigations and expedite the investigation of deaths.

28. Coroners are empowered to:

    (a) report to the Attorney-General on a death;[15]

    (b) comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[16] and

    (c) make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.[17]

29. These powers are the vehicles by which the prevention role may be advanced.

30. It is important to stress that coroners are not empowered to determine civil or criminal liability arising from the investigation of a reportable death. Further, they are specifically prohibited from including a finding or comment, or any statement that a person is, or may be, guilty of an offence.[18] It is also not the role of the coroner to lay or apportion blame, but to establish the facts.[19]

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[15] Section 72(1) of the Act.
[16] Section 67(2) of the Act.
[17] Section 72(2) of the Act.
[18] Section 69(1) of the Act. However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the Act.
[19] *Keown v Khan* (1999) 1 VR 69.

31. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles enunciated in *Briginshaw v Briginshaw*.[20]

32. It was not mandatory under the Act for an inquest to be held into PJQ's death. On 18 May 2023, Ms V submitted a request pursuant to section 52(3) of the Act seeking that an inquest be held into PJQ's death. At a mention hearing on 17 November 2023, I advised the interested parties that I had determined to hold an inquest in the exercise of my discretion pursuant to section 52(1) of the Act. The inquest occurred on 24 and 26 April 2024.

IDENTITY OF THE DECEASED

33. On 28 February 2022, PJQ was visually identified by her grandmother, Ms V.

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

MEDICAL CAUSE OF DEATH

35. On 2 March 2022, Dr Hans de Boer, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an autopsy. In a report dated 3 May 2022, Dr de Boer noted that there was no evidence of disease, violence or any injuries which could have contributed to death.

36. Toxicological analysis of post-mortem blood samples identified the presence of gamma hydroxybutyrate (**GHB**),[21] amphetamines,[22] etizolam,[23] flualprazolam[24] and diazepam.[25]

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[20] (1938) 60 CLR 336.

[21] GHB is a colourless, odourless and slightly salty tasting liquid freely soluble in water. It has no therapeutic use in Australia. Adverse effects can include bradycardia, coma, hallucinations, hypersomnolence, hypothermia, hypotension, respiratory depression and seizures.

[22] Amphetamines is a collective word to describe central nervous system (CNS) stimulants structurally related to dexamphetamine. One of these, methamphetamine, is often known as speed or ice. Adverse effects include agitation, fever, elevated heart rate and blood pressures, aggression and violence.

[23] Etizolam is a thienotriazolodiazepine derivative with amnesic, anxiolytic, anticonvulsant, hypnotic, sedative and skeletal muscle relaxant effects.

[24] Flualprazolam is a benzodiazepine derivative and has no established therapeutic use. It is considered a novel psychoactive substance.

[25] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.

37. Dr de Boer expressed the opinion that the cause of death was "*1(a) Multidrug toxicity (GHB, Amphetamines, Benzodiazepines)*".

38. I accept Dr de Boer's opinion.

CIRCUMSTANCES IN WHICH DEATH OCCURRED

39. On 5 January 2022, PJQ commenced a withdrawal program at Williams House in Coburg, relating to her use of alcohol, marijuana, amphetamines and benzodiazepines. She successfully completed the Williams House program on 11 January 2022. Ms Carbonaro transported her that day to the Gippsland Youth Residential Rehabilitation Program (**GYRRP**) in Traralgon.

40. On 31 January 2022, PJQ was advised by Ms Carbonaro that Haven Home Safe had secured a unit for her in Traralgon, which would be available from 11 March 2022.[26]

41. Soon after commencing at GYRRP, PJQ accepted an offer of employment at Hungry Jacks and as a result, missed multiple program activities. She advised staff that she would continue to prioritise her employment over therapeutic engagement in order to afford housing after completing the program.

42. Ms Carbonaro was on annual leave from 14 February to 18 February 2022. It was the expectation that PJQ would remain at GYRRP during this period and until shortly prior to her unit becoming available. Ms Carbonaro had made a plan for PJQ while she was on leave which included access to case management through the Berry Street Duty system, with oversight by her Team Leader.

43. On 15 February 2022, PJQ was discharged early from the program at GYRRP due to her non-engagement with therapeutic activities and non-compliance with its rules. PJQ's Care team were advised by GYRRP staff of her discharge that day and canvassed options for short-term accommodation. Better Futures did not support the funding of motel options as it was previously decided that "*the risk was too high*" and "*none of these risks have*

[26] CB392.

been negated".[27] She was offered emergency accommodation in Morwell, however she expressed a preference to stay with her sister Ms E in Cranbourne until she could sign a rental agreement. Ms Hands contacted Ms V as a possible source of short-term accommodation but she was unavailable to assist.

44. PJQ was transported by a Berry Street worker to her sister's place where she stayed for a few days after which she began staying overnight at a house in Dandenong. The house in Dandenong was associated with Ms E's ex-boyfriend.

45. On 22 February 2022, PJQ spoke with a Better Futures worker over the phone, who formed the view that PJQ was substance affected.[28]

46. On the morning of 24 February 2022, PJQ contacted Ms Carbonaro and they arranged to meet face-to-face. Ms Carbonaro collected PJQ from the Dandenong house and observed that she appeared substance affected. PJQ subsequently reported methylamphetamine and GHB use but did not confirm the quantities. Ms Carbonaro drove to the YSAS office which was nearby and was supported and assisted by Ms Hands. PJQ's condition deteriorated and they contacted emergency services. By the time Ambulance Victoria arrived, PJQ's condition had improved and she absconded as she did not want to be taken to hospital. Ambulance Victoria and Victoria Police were unsuccessful in attempts to contact PJQ following the incident. Ms Hands and Ms Carbonaro remained very concerned for PJQ's welfare.

47. That evening, PJQ and her friend used multiple prescription and illicit drugs at the Dandenong house (methylamphetamine, GHB, and benzodiazepines). Her friend returned to her residential care facility later that evening and PJQ continued taking GHB. Also present at the address were Anthony Ricciuti, who observed PJQ unsteady on her feet before she retired to bed, and Peter Mark, who was already asleep at this time.

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[27] CB442.
[28] CB283.

48. At approximately 4.00am the following morning, Anthony woke and noticed PJQ behaving in a severely drug-affected manner and observed her using GHB, before they returned to their respective bedrooms.

49. When Peter woke at approximately 10.30am, he believed PJQ was sleeping. Anthony worked on a trailer in the front yard throughout the day while smoking methylamphetamine, while PJQ remained in bed.

50. When Peter returned home at approximately 3.00pm, he observed PJQ still in bed. Anthony remained in the front yard of the property until approximately 8.00pm and at 8.50pm, he took some GHB before checking on PJQ. As he entered the bedroom, Anthony observed that PJQ's feet and legs appeared discoloured and in a state of panic, he consumed further GHB before calling emergency services at approximately 9.07pm.

51. Ambulance Victoria arrived at approximately 9.16pm. Responding paramedics were unable to find signs of life and pronounced PJQ deceased at 9.20pm.

52. Police examined the scene and located several items of drug paraphernalia throughout the house. Police did not identify any suspicious circumstances or third-party involvement in connection with PJQ's death, nor any evidence to suggest that her overdose was anything other than accidental.

SOURCES OF EVIDENCE

Coronial brief

53. Victoria Police assigned Detective Senior Constable Derek Gardam to be the Coroner's Investigator for the investigation into PJQ's death. The Coroner's Investigator conducted inquiries on my behalf and prepared a Coronial Brief including statements from PJQ's family and friends, the forensic pathologist and some of her support workers. The Court also obtained statements from the DFFH, Berry Street and YSAS.

Report of the Commission for Children and Young People

54. In December 2020, the Commission for Children and Young People published a report entitled "*Keep caring*", after conducting a systemic inquiry into services for young people transitioning from out-of-home-care.

55. Some of the key themes that emerged from the inquiry were a lack of considered and coordinated planning for the process of transition from out-of-home care to independent living, a dire shortage of post-care accommodation, and that outcomes tended to be poorer for young people who had lived in residential care. One of the Commission's recommendations (Recommendation 12) was for the Victorian Government to increase investment in post-care housing. This recommendation has been accepted in principle and in his statement to the Court, David Atkinson of DFFH stated that substantial action had been taken to develop post-care housing options for care leavers following government investment.[29]

56. Another recommendation (Recommendation 15) was for the Victorian Government to amend the CYFA to include an enforceable right for young people who leave care between the ages of 16 and 18 to receive services and supports to transition to independence until at least the age of 21. It was also recommended that there be sufficient investment to support the right, which is responsive to current and growing future demand for post-care services and supports. This recommendation has been accepted by DFFH and opportunities for legislative change are being progressed.

Inquest

57. The inquest ran over 2 days and concurrent evidence was given by the following witnesses:

    (a) Kristina Laycock (DFFH, Acting Principal Practitioner), Bayside Peninsula Area);

[29] CB343.

(b) Timothy Pedlow (Berry Street, Regional Director, South East Victoria); and

(c) Daniel Alcock (YSAS, Community Drug and Alcohol Manager, Dandenong & Frankston).

58. This finding is based on the evidence heard at the inquest, as well as the material in the Coronial Brief, and the submissions made by counsel assisting and counsel for the interested parties following the conclusion of the evidence. I will refer only to so much of the evidence as is relevant to comply with my statutory obligations and for narrative clarity.

SCOPE OF THE INQUEST

59. The scope of the inquest was limited to the supports provided to PJQ as she transitioned from the care of DFFH to independent living, in particular, in relation to accommodation.

TRANSITION TO INDEPENDENT LIVING

60. Under section 174(1)(b) of the CYFA, when the Secretary of DFFH places a child or young person in care, they "*must make provision for the physical, intellectual, emotional and spiritual development of the child in the same way as a good parent would*".

61. The evidence demonstrates that there was a coordinated process in place to plan for PJQ's transition from out-of-home care to independent living. The process was supported by a Care team that was acutely aware of PJQ's trauma history and the challenges presented by her complex risk profile. In particular, Ms Carbonaro and Ms Hands had worked collaboratively together to establish a therapeutic relationship with PJQ which was based on trust and confidence. Ms Carbonaro worked tirelessly to map out a schedule for PJQ that was designed to ensure as much as possible that she maintained stable accommodation.

62. A consistent challenge in PJQ's case in the lead up to her Care by Secretary Order lapsing was the difficulty in sourcing and maintaining long-term accommodation. The panel stated in evidence that there was lack of affordable and appropriate housing for children with complex presentations and risk-taking behaviours. Long-term accommodation was

not able to be secured for PJQ before she turned 18 years of age and her Care team had to rely upon short-term bridging options.

63. It was a reasonable plan for PJQ to complete residential drug withdrawal and rehabilitation programs before transitioning to private rental accommodation. However, given her history of non-engagement in the past, the plan should have included a contingency for the possibility that PJQ may not be able to complete those programs.

64. The policies and processes of drug rehabilitation facilities were not the focus of this inquest and I am not critical of the decision by GYRRP to exit PJQ from the program early given that she was not participating in the therapeutic activities and was not complying with the rules. I consider that it is reasonable for places in these programs to be available to those who are prepared to be actively engaged in the process.

65. I accept the evidence of Mr Alcock who stated that:

> "*A sudden exit from services is common. I think the model that a lot of drug rehab programs operate in is what they call a therapeutic model…so they have the community of other residents to consider, and sometimes if there's behaviour that might have an impact on that therapeutic community, they make a decision in the best interests of the community rather than the individual*".[30]

66. I accept the evidence of the panel that as much notice as possible being provided to the Care team when a young person is to be exited early from a drug rehabilitation program is beneficial to contingency planning. However, there may be security and safety reasons which require an early exit from a program and which prevent the provision of advanced notice. Further, in PJQ's case, I am not satisfied that further notice would have made a difference in being able to source any other short-term bridging accommodation, particularly when a decision had been made that a motel or Airbnb accommodation were not supported.

[30] T65, [7]-[14].

67. The period after PJQ's early discharge from GYRRP on 15 February 2023 was critical in terms of her transition. She had just turned 18 years old and was no longer in the care of the State, but she remained in a particularly vulnerable position given her complex history and lowered tolerance to illicit drugs after a period of abstinence. There was a delicate path to be negotiated over a period of several weeks to give PJQ the best chance of successfully commencing new living arrangements in Traralgon on 11 March 2022, particularly in circumstances where she had secured ongoing employment in the area.

68. As it turned out, PJQ was not able to stay on a path that would lead her to the tenancy secured for her. The Dandenong house was a very unsafe environment for PJQ. The prospect of a child or young woman spending time in such an environment while in a vulnerable state is disturbing.

69. In the circumstances, with the benefit of hindsight, there should have been greater consideration and effort to securing flexible short-term bridging accommodation for PJQ, such as an Airbnb or motel, so that she could continue to reside in Traralgon and maintain her employment until her rental property became available on 11 March 2022.

70. I accept the evidence of the panel that there are significant challenges in sourcing accommodation for young people. Further, there was a process of risk assessment that was required to be undertaken by DFFH in December 2021, and then Better Futures in February 2022, which took into account PJQ's complex and challenging history. However, in my view, many of the risks associated with placing PJQ in short-term accommodation would have remained when she transitioned to independent living in her leased property. Any risk assessment process is nuanced and depends upon the circumstances, but in PJQ's case, perhaps greater flexibility could have been applied in considering accommodation options and some level of risk could have been accepted in order to bridge a critical accommodation gap during a particularly vulnerable period.

CONCESSIONS AND NEW INITIATIVES

71. In his statement to the Court, Mr Pedlow noted that Ms Hands and GYRRP staff maintained contact with PJQ in the period after she was transported to her sister's place on 15 February 2022. However, with the benefit of hindsight, he acknowledged that somebody from the Berry Street Duty Team ought to have attempted to contact PJQ in that period, rather than relying on the broader Care team.

72. In his evidence, Mr Pedlow also advised that Berry Street had reviewed its staff leaving plan procedures since PJQ's death with the outcome that all high-risk young people will be allocated a specific team member to cover a case manager who is on leave.

73. In her statement to the Court, Ms Laycock acknowledged that, given PJQ's traumatic history and exposure to substance abuse, Child Protection could have arranged a Neuropsychological Assessment when she was 16 years old, which would have helped inform leave care planning and may have led to additional supports through the National Disability Insurance Scheme (**NDIS**) being available.

74. Given PJQ's high-risk taking behaviours and trauma history, Ms Laycock also considered that she could have been referred by Child Protection to the Multiple and Complex Needs Initiative (**MANCI**) when she was 16 years old. This specialist statutory service is funded to facilitate better coordination of supports, including accommodation, and may have provided Child Protection with more information about PJQ's needs when making arrangements for her transition.

75. In her evidence, Ms Laycock referred to the Housing First for Young People Leaving Residential Care (**Housing First**) initiative which is currently being implemented by DFFH. It provides assertive outreach, personalised case work, tenancy support and oversight for young people leaving residential care or who are at risk of homelessness. The initiative sources housing directly from DFFH and aims to provide stable accommodation as a young person prepares for transition out of State care to independent living.

76. Ms Laycock stated in evidence that, had it been available at the time, PJQ would have been eligible for Housing First.[31] If the initiative had have been available in PJQ's case, DFFH housing could have been secured after her residential care arrangement broke down with the Lighthouse Foundation. She would then have had that accommodation to return to after participating in any withdrawal and rehabilitation programs, which would have avoided the problems associated with securing short-term bridging accommodation upon her early discharge from GYRRP.

77. Ms Laycock also referred in evidence to the Leaving Care Panel (**LCP**) established in the Bayside Peninsula Child Protection Program in September 2022. The LCP is aimed at providing advice and support to case managers in identifying the complex care needs of vulnerable young people at the earliest opportunity and ensuring that strong leaving care plans are developed and executed. Ms Laycock referred to a recent review of cases involving the LCP which demonstrated its effectiveness in providing focussed planning for young people leaving State care and its success in securing accommodation options.

FINDINGS AND CONCLUSION

78. PJQ's story is incredibly sad and distressing. She was a complex and engaging young woman who struggled to cope with the trauma she had experienced, and she presented challenges to her case workers who were invested in supporting her. Although I am satisfied that the immediate cause of PJQ's death was the unintended result of her deliberate use of illicit and prescription drugs, it is clear that the broader circumstances in which her death occurred can be traced back to her complex trauma history.

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[31] T40.

79. Having held an inquest into PJQ's death, I make the following findings, pursuant to section 67(1) of the Act:

    a) the identity of the deceased was PJQ, born on 9 December 2003;

    b) the death occurred on 25 February 2022 at 30 Tarene Street, Dandenong, Victoria, from multidrug toxicity (GHB, amphetamines, benzodiazepines); and

    c) the death occurred in the circumstances described above.

COMMENTS

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

80. PJQ had to confront and negotiate enormous challenges when she was a child and experienced significant trauma in a period when she was learning and developing, and during a time when she required care, guidance and supervision. PJQ had to learn to cope with her trauma history, which led to high-risk behaviours and a corresponding lack of engagement with education and therapeutic services.

81. Despite the care and support provided to PJQ by her case managers and her grandmother, it was inevitable that PJQ's transition to independent living would be a difficult and challenging time. However, despite the complexity of PJQ's case, her lack of engagement and challenging behaviour, her death at such a vulnerable and critical time following her recent departure from State care is not something that this community can accept.

82. PJQ's case underscores the importance of secure and safe accommodation for young people as they transition from State care to independent living. Australian research has consistently found that care leavers with stable housing are more likely to experience successful transitions to independence, including improved employment, better

education and training outcomes, more secure relationships and increased social connectedness.[32]

83. The Victorian Government has responded positively to the *Keep caring* report of the Commission for Children and Young People, and the Housing First initiative in particular is designed to ensure that vulnerable children with complex needs are more likely to secure stable accommodation as they transition from out-of-home care to independent living.

RECOMMENDATIONS

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

84. That the Department of Families, Fairness and Housing incorporate a guideline in its risk assessment framework which is directed toward the risk assessment process to be applied when considering the suitability of short-term accommodation options for children whose Care by Secretary Order is shortly due to expire, which:

    (a) promotes flexibility; and

    (b) recognises the importance of safe and stable accommodation during this critical transition period.

I convey my sincerest sympathy to PJQ's family.

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

[32] Commission report, 92.

I direct that a copy of this finding be provided to the following:

Ms Y, Senior Next of Kin

Mr K, Senior Next of Kin

Ms V, c/- Doogue & George Lawyers

Berry Street, c/- Lander & Rogers

Liana Buchanan, Commission for Children and Young People

Department of Families, Fairness and Housing, c/- MinterEllison

Peter Ryan, Monash Health

Youth Support and Advocacy Service

Detective Senior Constable Derek Gardam, Coroner's Investigator

Signature:

Coroner David Ryan

Date: 14 May 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 inquest. 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.