IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2935

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	Jane*
Delivered on:	31 May 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing dates:	Inquest: 17 November 2020
Findings of:	Coroner Paresa Antoniadis Spanos
Counsel assisting the Coroner:	Leading Senior Constable Jo Allen from the Police Coronial Support Unit
Representation:	Jane's parents GK and FM appeared in person
	*This finding is published in its totality but under a pseudonym, in accordance with the family's wishes.

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INTRODUCTION

1. Jane, born on 7 August 2003, was the daughter of GK and FM. Jane had no significant medical history or current medical problems, but she did have a past episode of drug induced psychosis and was considered to suffer from social anxiety and/or depression. When she died on 21 June 2017 from the consequences of illicit drug use, Jane was only thirteen years of age, a few weeks short of her 14th birthday.

2. Although a troubled young woman in many respects, who was proving a challenge to parent at that stage of her life, Jane also had an engaging personality and a lot of potential which she did not live to fulfill. Her death has left her parents and aunt devastated, as well as affecting other family members and her friends, and the child protection workers and other support workers involved in her life.

INVESTIGATION AND SOURCES OF EVIDENCE

3. This finding is based on the totality of the material the product of the coronial investigation of Jane's death. That is, the brief of evidence compiled by Senior Constable Stephanie Watkins, as re-compiled by Leading Senior Constable Jo Allen from the Police Coronial Support Unit, including statements from family members, Jane's friends, others who were with Jane on the evening of 19 June 2017, Child Protection workers and managers, workers from other support services, members of Victoria Police and forensic officers involved in the investigation of her death, and autopsy and toxicology reports from the Victorian Institute of Forensic Medicine (**VIFM**).

4. All of this material, together with the inquest transcript, will remain on the coronial file.[1] In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

5. The purpose of a coronial investigation of a *reportable death*[2] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death

[1] From the commencement of the ***Coroners Act 2008*** (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

[2] The term is exhaustively defined in section 4 of the ***Coroners Act 2008*** [the Act]. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

occurred.[3] Jane's death clearly falls within the definition of reportable death, specifically section 4(2)(a) of the Act which includes (relevantly) a death that appears to have been unexpected and unnatural.

6. The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[4]

7. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[5]

8. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[6] These are effectively the vehicles by which the coroner's prevention role can be advanced.[7]

9. Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[8]

IDENTIFICATION

10. Jane was identified by her mother GK who signed a formal Statement of Identification on 21 June 2017 before a member of the clinical staff at Monash Medical Centre.

11. Identification was not in issue and required no further investigation.

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[3] Section 67(1).

[4] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[5] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[6] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[7] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[8] Section 69(1). 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).

MEDICAL CAUSE OF DEATH

12. Jane's body was brought to the Coronial Services Centre where Forensic Pathologist Dr Joanna Glengarry from VIFM performed a full post-mortem examination or autopsy on 28 June 2017 and provided a written report of her findings and opinion as to the cause of death dated 11 September 2017.[9]

13. In terms of evidence of traumatic injury, Dr Glengarry found bruises to the right arm, right shin and beneath the scalp of the right side of the head but no pathologic or radiologic evidence that any injury caused death. Examination of the genitalia and anus showed petechial haemorrhages (pinpoint bleedings) and bruising that were non-specific and of uncertain significance.

14. Dr Glengarry found no evidence at autopsy of any natural disease process which could have caused or contributed to death. There was a swollen brain with microscopic evidence of widespread neuronal (brain cell) death, confirming the clinical diagnosis of hypoxic ischaemic encephalopathy or brain death due to a lack of blood and oxygen. Examination of the liver showed microvesicular steatosis, a change of a type seen in severe drug toxicity.

15. Routine toxicological analysis was undertaken on antemortem blood and urine samples taken from Jane on admission to Monash Medical Centre (**Monash**) in order to detect any drugs in her system closer to the time she went into cardiac arrest. Extended toxicology was also undertaken on hair samples taken post-mortem.[10]

16. The results showed an elevated level of gamma hydroxybutyrate[11] in antemortem blood (~136mg/L) and urine (~679mg/L), and 11-nor-delta-9-carboxytetrahydrocannabinol (**THC-COOH**) in urine. The latter may indicate the use of a single dose of cannabis within a few days before death but can persist for weeks following repeated or binge use.

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[9] Dr Glengarry's 14-page report is at pages 263-275 of the inquest brief, Exhibit E.

[10] One hair segment designated Z1 was tested for drug use between approximately 21 February and 21 June 2017, the other designated Z2 was tested for drug use between approximately 21 October 2016 and 21 February 2017. Without exception, while the levels differed, the same drugs were detected over both periods of time suggesting consistent use of those drugs during the six months leading to Jane's death.

[11] An illegal drug known as GHB, GBH, Fantasy, liquid ecstasy among other names. It is a white, colourless liquid, freely soluble in water with a short half-life (20-60 minutes). Oral or intravenous doses of 10mg/kg may cause amnesia and hypotonia leading to anaesthesia at 50mg/kg. Post-mortem concentrations in fatalities attributed to GHB abuse showed an average concentration of approximately 329mg/L. See page 281 of the inquest brief. Exhibit H. See also statement of Dr Joanne Tully at page 120 of the inquest brief, especially page 127 where she states that *"GHB is an illicit substance that acts as a depressant on the central nervous system. It is used as a recreational drug because it induces euphoria (a feeling of happiness and wellbeing) and is an aphrodisiac in non-toxic doses. GHB has been colloquially named the 'date-rape' drug because of its association with drug-facilitated sexual assault. In higher doses GHB causes respiratory depression (reduced breathing), bradycardia (a slow heart rate) and coma. Low blood pressure and body temperature can also be observed. Fatality associated with GHB may occur due to its depressant effect on breathing. GHB is rapidly absorbed into the body with a quick onset of action. Peak blood concentrations are reached rapidly – usually within 30 to 60 minutes. The drug is then rapidly excreted from the body."*

17. Extended toxicological analysis done on hair samples support a finding that in the past Jane had used cannabis, methylenedioxymethamphetamine (**MDMA** or ecstasy),[12] methylenedioxyamphetamine (**MDA**), ethylone (**MDEC**),[13] methylamphetamine (ice) and dextromethorphan.

18. Based on those results and Jane's clinical course at Monash Medical Centre, Dr Glengarry formulated the medical cause of her death as *1(a) hypoxic ischaemic encephalopathy (secondary to) 1(b) gamma hydroxybutyrate toxicity.*[14]

CIRCUMSTANCES IMMEDIATELY PROXIMATE TO DEATH

19. During the evening of 19 June 2017, Jane's 15-year-old friend Mollie had been messaging Liam, a 17-year-old friend of hers. As a result, Jane and Mollie agreed to meet Liam and one of his friends and were picked up around 9.00pm from Oaklands Primary School, near Jane's home. In the vehicle were Liam and his 19-year-old friend Luke.

20. After driving around for some time, Luke stopped at an address in Narre Warren where he purchased 20mls of GHB for $50 before driving back to his home, a unit on Princes Highway, Dandenong. Between midnight and 1.00am, all four used cannabis supplied by Luke. Then, Luke drew up a quantity of GHB into a plunger and passed it around to the others who took the offered plunger and ingested an estimated 1.00-1.5mls of the substance directly into their own mouths.

21. In the early hours of the morning of 20 June 2017, Luke offered GHB to Jane on at least six occasions and she accepted, ingesting about the same amount each time by placing the plunger directly into her mouth. As a result, Jane is estimated to have ingested at least 6-9mls of GHB. According to Mollie, she and Jane had only used GHB on one previous occasion in the week before. Based on this evidence, Jane would have been relatively naive to the effects of the drug.

22. At the same time, Luke made sexually suggestive remarks and advances towards Jane and the group took several selfies which were uploaded to the "Snapchat Story" of Jane and Mollie and

[12] A designer amphetamine, in part metabolised in the body to another designer amphetamine MDMA. According to the toxicologist's report, long term use of amphetamines can lead to permanent damage to myocardial muscle including myocarditis, as well as vasospasm and loss of peripheral nerve function as well as behavioural changes including paranoia, psychosis, delirium and aggression. See page 283 of the inquest brief, Exhibit E.

[13] A synthetic stimulant drug of the phenethylamine class. These compounds are chemically similar to, and have central nervous system stimulant properties like MDMD, cocaine and amphetamines. See page 284 of the inquest brief, Exhibit E.

[14] See also statement of Dr Joanne Tully, Monash Children's Hospital, page 128 of the inquest brief, Exhibit H, where she states *"The presence of GHB in Jane's blood and urine supports the statement made that she consumed GHB shortly before she was found unresponsive and not breathing. Jane's presentation with cardiorespiratory arrest, hypothermia and hypotension in combination with the statement made by her friend of recent GHB ingestion and the toxicology results obtained, indicates that Jane's clinical presentation almost certainly occurred as a result of GHB ingestion."*

accessed by numerous people. At about 4.00am, Jane and Luke lay down on an air mattress in the lounge room and fell asleep. Mollie and Liam shared a couch in the lounge room.

23. One of the people who saw the Snapchat post was Jane and Mollie's friend Alyssa who became concerned for their welfare and, having walked about half an hour to get there and then waited about an hour until they responded to her messages/calls, finally entered the unit at around 6.00am on 20 June 2017. Alyssa and Mollie checked on Jane and found her lying face down on the air mattress with Luke's arm and leg lying across her. Alyssa pushed Luke off and turned Jane over to find her pale, unresponsive and unconscious with purple lips.

24. Alyssa called emergency services (000) and Jane's mother GK. Liam commenced cardiopulmonary resuscitation (**CPR**) under the direction of the emergency call taker until members of the Metropolitan Fire Brigade arrived a short time later and took over. Ambulance Victoria (**AV**) paramedics and a Mobile Intensive Care Ambulance (**MICA** 16) arrived at 6.12am and assume responsibility for Jane's care. Their combined efforts saw a spontaneous return of circulation at 6.28am. Jane was then stabilised, extricated from the unit with some difficulty and taken by ambulance to Monash, Clayton. According to the attending MICA paramedic, Jane did not display any neurological improvement and her pupils remained dilated and non-reactive to light.[15]

25. Jane was admitted to Monash with an initial diagnosis of 'out of hospital cardiac arrest following GHB and THC intake'. A CT brain angiogram undertaken on 20 June 2017 was in keeping with diffuse cerebral oedema with preservation of normal enhancement of the intracranial arteries. Jane remained haemodynamically unstable, with persisting fixed and dilated pupils, metabolic acidosis and the development of diabetes insipidus.

26. A nuclear cerebral perfusion scan undertaken on 21 June 2017 confirmed brain death. Jane's dire prognosis was discussed with her family and she was kept comfortable until pronounced deceased at 5.10pm on 21 June 2017.[16]

THE FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

27. As noted above, the determination of criminal liability is entirely beyond the scope of a coronial investigation. However, in accordance with the general practice in this jurisdiction, since criminal charges arising from the events of 19-20 June 2017 were laid against Luke, the inquest was delayed pending finalisation of that prosecution in October 2018.[17]

[15] Statement of Frank van der Stam, MICA paramedic, at page 118 of the inquest brief, Exhibit E.

[17] Luke pleaded guilty to two charges of supplying a drug of dependence to a child (cannabis and GHB supplied to Jane), two charges of possession of a drug of dependence and theft of a motor vehicle, burglary and other offences relating to his conduct immediately following Jane's death. He was sentenced in the County Court to a total effective

28. The primary focus of the coronial investigation and inquest into Jane's death was on the Child Protection response to reports regarding Jane and the adequacy of the supports offered to her and her family in the period immediately preceding her death and whether more could have been done to prevent her death.

CHILD PROTECTION HISTORY

29. In total, the then Department of Health and Human Services (**the Department**),[18] in its Child Protection iteration, received four notifications in respect of Jane. The last notification on 20 June 2017 related to the overdose to which she ultimately succumbed, is not relevant to the provision of services that may have assisted her in the period immediately preceding her death and will therefore not be examined in this finding.

30. The Department received the first report concerning Jane on 19 November 2013[19] when she was ten years old. The report raised concerns that Jane was having contact with a Registered Sex Offender who was known to the family. The report proceeded past intake for investigation and assessment. A safety plan was developed with Jane and her family and the case was closed on 11 December 2013 on the basis that there was no ongoing role for the Department at the time.

31. A second report was received on 10 July 2014[20] and raised concerns about Jane residing with her father FM. Previously, Jane had been in the full-time care of her mother GK, but her parents had separated, and she had moved in with her father. The reporter raised concerns that associates of Mr FM were reportedly engaged in substance use and Mr FM was involved in criminal activity.

32. The matter proceeded for further investigation and assessment. Ms GK initiated proceedings in the Federal Circuit Court for formal parenting orders and Jane returned to the care of her mother. An interim order was made placing Jane in the full-time care of her mother with a condition providing for visitation with Mr FM. The Department closed its file on 24 September 2014 on the basis that there was no ongoing role for the Department at the time.

THIRD REPORT TO THE DEPARTMENT AND PROTECTIVE INTERVENTION

33. The third and most pertinent report made to the Department concerning Jane was on 19 May 2016.[21] The reporter raised concerns about conflict between Jane and her mother; that Jane was seeking to reside with Mr FM; that Jane was displaying defiant behaviour and was reported to have been engaging in substance use involving cannabis and pills of an unknown description.

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sentence of three years and six months imprisonment with a non-parole period of two years. The sentencing judge indicated that but for the guilty plea, Luke would have been sentenced to a total effective sentence of five years.

[18] The department now responsible for Child Protection Services is the Department of Families, Fairness and Housing.

[19] Statement of Karen Woolsey dated 25 September 2017, at page 129 of the inquest brief, Exhibit E.

[20] Ibid at pages 129-130 of the inquest brief, Exhibit E.

[21] Ibid at page 130-132 of the inquest brief, Exhibit E.

34. The Department investigated and assessed the report and concluded that Jane was indeed a young person in need of protection due to concerns she was engaging in high-risk behaviour including absconding from home, disengaging from education, using substances and associating with older males raising concerns for her being at risk of sexual exploitation.

35. The Department made a protection application to the Children's Court of Victoria on 13 June 2016. The Court subsequently made a protection order placing Jane in the full-time care of Ms GK under a family preservation order which remained in place from 5 July 2016 to 4 April 2017.

36. The Department remained involved with Jane and her family for the duration of the family preservation order with a number of community support services engaged during this period to address the protective concerns and to ensure Jane's ongoing safety, stability, development and well-being, for example Windermere counselling; Connections Stronger Families, an intensive family support service; and Youth Support and Advocacy Service (YSAS), a youth alcohol and drug support service.

37. The Department's file was closed on 8 May 2017, some six weeks before Jane's death, with some community service providers remaining engaged with Ms GK and Jane beyond the end of the family preservation order.

SUPPORT SERVICES WITH WHICH JANE HAD ENGAGED

38. Amanda Heaton-Harris was employed by Windermere Child & Family Services (**Windermere**) and provided counselling to Jane between 5 August and 11 November 2016 when she was twelve to thirteen years of age.

39. Counselling sessions were usually fortnightly and care team meetings were also held. Ms Heaton-Harris also met with Ms GK in a joint session with Jane in an effort to strengthen the parent-child relationship where Ms GK spoke openly about her fears and concerns for Jane's safety when she went out. At an individual session with Ms GK, she wanted to find strategies that encouraged Jane to reduce her risk-taking/drug-taking behaviours and strategies to help her parent Jane and create a better connection with her.[22]

40. The main focus of counselling with Jane was on her engagement and harm minimisation around her risk-taking behaviours.[23] Jane presented as older than her age of twelve at the beginning of

[22] Exhibit A, statement of Amanda Heaton-Harris dated 17 April 2019 at page 155.1 of the inquest brief. See also transcript pages 12-13, 15, 23, and 25-26.

[23] Exhibit A and transcript pages 14-15. I note that Jane did not mention using GHB to Ms Heaton-Harris, consistent with other evidence that suggests she was naïve to that particular drug.

counselling and she was aware of this and felt it was an asset to look older.[24] She spoke about her experience of social anxiety and found psychoeducation around anxiety helpful including the problems associated with using drugs and alcohol to numb her experience of anxiety.

41. Jane engaged well with counselling and her demeanour was fairly consistent, her level of engagement only declining when attending sessions with little or no sleep. Ms Heaton-Harris described her as bubbly, charismatic and an incredibly likeable young woman except when she had not slept much.[25]

42. Jane spoke to Ms Heaton-Harris about her use of drugs and alcohol in social settings and, although she did not disclose how much she used, she did refer to being 'so wasted' she could not remember large parts of an evening.[26] Ms Heaton-Harris felt Jane had little insight around her choices, at times finding her actions funny.[27] While Jane seemed to hear and understand what was being discussed during counselling, she still continued to make the same choices to go out late at night and to use drugs in the company of relative strangers, including older males.[28] However, she remained consistent in her resolve that she was not going to continue with her current drug and alcohol habits and that she had goals and aspirations of achieving things as she got older.[29]

43. A significant factor in Jane's life was her relationship with her friend Mollie. From Ms GK's perspective this was a problematic relationship as Mollie was two years or so older than Jane and the proverbial bad influence in whose company Jane tended to engage in all her risk-taking behaviours.

44. Ms Heaton-Harris was of the view that the relationship was a 'very, very intense kind of friendship;' that there was a complex dynamic between them; that they relied on each other a lot; and that Jane found it difficult to socialise with Mollie being there.[30] Ms Heaton-Harris also

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[24] Ms Heaton-Harris testified that Jane looked older than twelve physically and, although street-smart about some things, once you spoke to her you realised that developmentally she was a young twelve-year old. Transcript page 17.

[25] Transcript page 16.

[26] The drugs documented by Ms Heaton-Harris were LSD, pills and cannabis. Exhibit A.

[27] Transcript page 18.

[28] Apart from the obvious concerns about a young person using illicit substances and the risks associated with the substances themselves, in Jane's case there was a further concern that she would be vulnerable if drug affected away from home and in the company of relative strangers who might take advantage of her. See transcript page 16 and following.

[29] Exhibit A and transcript page 32 where Ms Heaton-Harris gave evidence that *"…she would speak to me that this isn't a life that she's going to have forever, you know, she's not – she's going to do something with her life. She didn't know what it was, she was very confident in that, you, she'd sort of say, 'I'm not going to end up on the dole and doing nothing with my life.' She – yes – she didn't know what she wanted but she knew that she wasn't – didn't want to keep doing what she was doing forever."*

[30] Exhibit A and transcript pages 18 and following. Although appointments were generally set to a fortnightly rotation, occasionally Jane was seen weekly and occasionally after a three to four-week gap, due to her inability to attend because of her 'partying.'

gave credence to the idea that Mollie was a 'bad influence' on Jane stating in evidence that her perception was that Jane's behaviours were less out of control when Mollie was not around and that theirs' was *"quite a complex and almost I guess toxic connection, although Jane loved Molly [sic], absolutely loved her."*[31] Relevantly, Ms Heaton-Harris felt that Jane's drug use had decreased in October 2016 and increased in November 2016, corresponding to Mollie's absence.[32]

45. Kate Alexandra Perry was also employed by Windemere and provided counselling to Jane from 23 January to 19 June 2017, generally on a fortnightly basis.[33] Ms Perry has a Masters in Creative Arts Therapy which included a counselling component. Jane's counselling sessions involved creative arts therapy, psychoeducation around human relationships, drug/alcohol use, reflective practice and solution-focused conversation. Ms Perry would also keep in touch with Ms GK to check how Jane was tracking from her perspective.[34]

46. Like Ms Heaton-Harris, Ms Perry felt that Jane looked older than the thirteen-year-old that she was and that she revelled in looking older which she saw as a real positive rather than a negative. Ms Perry likened it to playing the game of being grown-up.[35]

47. According to Ms Perry, Jane said she had trouble saying "no" when friends asked her to go out and to use alcohol and illicit substances with them. She reported drinking alcohol to differing levels of intoxication, using pills (ecstasy), cannabis and using inhalants on one occasion which led to a psychotic episode and hospitalisation. Jane told Ms Perry that the experience was frightening and that she would not use an inhalants or hallucinogen again. She also exercised critical thinking around her choices for drug use and was very critical of the 'highly addictive drugs such as heroin and ice' based on her observations of others.[36]

48. Consistent with Ms Heaton-Harris's views, Ms Perry also made the connection between Jane's underlying social anxiety and her risk-taking behaviours and the negative aspects of her relationship with Mollie.[37] Over the course of their engagement, Ms Perry described Jane as actively forming healthier relationships, making better choices for herself and setting up a

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[31] Transcript page 24.
[32] Exhibit A.
[33] Exhibit B is the statement of Ms Kate Alexandra Perry dated 10 April 2019 at page 155.4 of the inquest brief.
[34] Transcript page 42, 49-51. While Ms Perry spoke with Ms GK about Jane, she stressed that she was not undertaking family therapy in a formal sense.
[35] Transcript pages 47-48 – *"... she didn't look like a small 13-year old, but, um, definitely presented, you know, she would – the nails, the make-up and her hair was done and you know, she was quite developed physically."*
[36] Exhibit B and transcript page 44, 48, 52. Ms Perry mentioned Jane's reported use of alcohol and pills, namely ecstasy in her statement.
[37] Transcript page 44, 56-57.

healthier future for herself over the course of her engagement with her but in an evolving stepwise process in the style of two steps forward and one step back.[38]

49. At inquest, Ms Perry described a "duality" in Jane who could within the space of one counselling session vacillate back and forth between being fully prepared to return to school and refusing, this having become a source of anxiety for her; or might say that she was absolutely not going out this weekend, to going out regardless when the time came.

50. Another example of what Ms Perry described as Jane's duality was framed in respect of her alcohol use – *"... like we never ever discussed GHB but ... she knew, even alcohol she realised drinking to a blackout state wasn't okay but she still did it occasionally but ... you know it was that sort of growing awareness that she did learn from her experiences and she did learn from what people said to her but she didn't always make good choices when the moment came ..."*[39] The same concept of duality was evident in her friendships, with friends playing a bad conscience role and leading her towards the partying 'let's get ourselves obliterated party lifestyle' versus others being the voice of reason telling her she was a person who was worthwhile without being off her face.[40]

51. When invited to reflect on what more could have been done by for Jane and her family, Ms Perry agreed that the family were concerned for Jane, sought assistance from Child Protection, in a 'cry for help' and actively engaged with services provided to them. This was not a situation of a family only minimally complying so as to avoid Child Protection oversight. Nor was it a situation of a lack of supports or difficulties accessing appropriate support services. Ms Perry expressed the 'personal opinion' that that was absolutely not the case, and that Jane had a good multi-disciplinary care team wrapped around her with evidence of good progress on her part.[41]

52. Ms Perry agreed with my suggestion that Jane's death was more about the unpredictability of the drugs and the situation in which she found herself in than any lack of availability of appropriate supports or real engagement with services.[42]

53. Ms Robyn Glover from the Multi Lit education program run by Uniting Connections Stronger Families also provided a statement and gave evidence at the inquest. Ms Glover has a teaching qualification and an Arts degree majoring in psychology, three years as a probationary psychologist with the Victorian Education Department and 30 years' experience with the same department. Jane was referred to the program in October 2016 and engaged with Ms Glover in

[38] Exhibit B and transcript pages 59 and following.
[39] Transcript page 55.
[40] Transcript page 56.
[41] Transcript pages 63-66.
[42] Transcript page 64.

weekly sessions of an hour's duration more of less continuously from 19 October 2016 until her death in June 2017.[43]

54. Ms Glover explained that Multi Lit (presumably short for literacy) was a program from Macquarie University supported by a solid research base that has been used in a number of settings with different cohorts of children always with 'brilliant results.' Initially, Jane underwent a standard reading and comprehension test which indicated she was an independent reader but had a significant gap of several years in her comprehension of what she read. Ms Glover suggested that Jane's initial comments that she was 'dumb and can't do' schoolwork likely arose from this gap. Ms Glover testified that from Grade 3 onwards all subjects involve reading and without comprehension, students struggle across all areas of the curriculum. The fact that Jane could read well probably gave her teachers the false impression that she was coping well.[44]

55. Ms Glover stressed that her role was purely around Jane's education and not her drug use or other risk-taking behaviours. All she noticed was that Jane was sometimes a bit tired. On the other hand, Jane loved the program and really wanted to do it. Ms Glover's aim was to improve Jane's literacy and numeracy and to support her return to school if that was what she wanted, or alternatively to prepare her for some sort of vocational training through a TAFE. As with other children who had been through the same program, Jane's confidence improved, and she could apply herself well for the whole hour which was a challenge initially.[45]

56. When lessons resumed for Jane in late March 2017, they were scheduled on days when her mother was not working, and Ms Glover would discuss Jane's progress with Ms GK opportunistically when she came to pick Jane up. Given the nature of her role, she did not see the need to engage separately with Ms GK.[46]

57. Madeline Giumarra was an Alcohol and Drug Liaison Outreach Worker with the Youth Support and Advocacy Service, Dandenong (YSAS). Jane was referred to that service on 14 March 2017 by a Child Protection worker from Dandenong, in the aftermath of the inhalant/psychosis episode in March 2017.[47]

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[43] Exhibit C is Ms Glover's statement appearing at page 155.5 of the inquest brief. There was a break in classes between 14 December 2016 and 14 February 2017. In March 2017, Jane cancelled for two consecutive weeks but resumed classes from 29 March 2017 after a discussion between Ms Glover, Jane and Ms GK. This gap corresponds to Jane's use of an inhalant and ensuing psychotic episode referred by above.

[44] Transcript pages 69-70.

[45] Transcript page 73-75, 77.

[46] Transcript page 75.

[47] Exhibit D is the statement of Ms Madeline Giumarra dated 22 April 2019 at pages 155.2-155.3 of the inquest brief and transcript pages 81-84 where she explains the referral process. Ms Giumarra was unable to recollect the inhalant episode in early March 2017 but allowed of the possibility that she may have known at the time and had forgotten since.

58. Jane's first and only appointment with Ms Giumarra was on 19 April 2017 at her home and in the company of her mother. While Jane was open to engaging, she also acknowledged that she did not think she needed alcohol or drug support due to significant reduction in her substance use. Jane presented as open and talkative, and she and her mother appeared to have a close relationship. They were both optimistic when discussing Jane's improved behaviours and reduced use of substances.[48]

59. In her statement, Ms Giumarra described Jane as "pre-contemplative" with regards to substance use at this appointment. While she did not disclose the extent of her current use, she reported that her primary substances were ecstasy and alcohol. Jane reflected on "historic" high use behaviours including using multiple pills per occasion, "double dropping", combining pills with alcohol, being out late/all night, offending and being in the company of older peers (Mollie) and older males. While Jane spoke in detail about her friend Mollie, her mother spoke of Mollie as a negative influence. Jane recounted incidents jokingly, but her mother appeared shocked by her disclosures and indicated she had been unaware of the extent of her daughter's previous substance use behaviours.[49]

60. Both Jane and Ms GK confirmed that Jane had been doing a lot better, had reduced her substance use, was staying home more often and had not recently absconded. Jane said she was open to engaging and another outreach appointment was scheduled for 28 April 2017 to discuss further reduction, harm minimisation and prosocial activity inclusion.[50]

61. Significant efforts made by Ms Giumarra to engage with Jane thereafter were unsuccessful, but Ms Giumarra persisted until 31 May 2017 when Ms GK advised her in a phone call that she felt they had no need of YSAS outreach services as Jane 'really opens up to her counsellor and has heaps of support at the moment'. Ms GK noted Jane's plans to return to education and improved behaviour and was provided with details if future re-engagement was required. Ms Giumarra notified Jane's care team accordingly and offered to provide secondary consultation for the care team should they have concerns about her substance use.[51]

FINDINGS/CONCLUSIONS

62. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications. [52]

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[48] Exhibit D at page 155.2.
[49] Exhibit D at page 155.3 and transcript page 85. Ms Giumarra explains what she means by "pre-contemplative" at transcript page 86-87, 89.
[50] Ibid. Details of those efforts which involved phone calls to Jane and/or her mother are set out in Exhibit D.
[51] Exhibit D and transcript page 86.
[52] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 especially at 362-363. "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a*

63. Adverse findings or comments against individuals or institutions are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and in so doing caused or contributed to the death under investigation.

64. Having applied the applicable standard of proof to the available evidence, I find that:

    a. The identity of the deceased is Jane born 7 August 2008, aged 13.

    b. Jane died at Monash Medical Centre, Clayton, on 21 June 2017.

    c. The medical cause of Jane's death is hypoxic ischaemic encephalopathy secondary to gamma hydroxybutyrate toxicity.

    d. Jane died from an accidental or inadvertent overdose in the circumstances outlined above.

    e. The available evidence does not support a finding that there was any want of clinical management or care on the part of the emergency responders who tended to Jane on 20 June 2017 or the clinical staff at Monash Medical Centre on 20-21 June 2017.

    f. The available evidence does not support a finding that there was any want of response on the part of the Department of Health and Human Services/Child Protection to the last notification made in respect of Jane, or any inadequacy in the provision of support services to Jane and her family, that caused or contributed to her death.

    g. For all her much older appearance and the way she chose to present herself to the world, the weight of available evidence supports a finding that Jane's was the tragic death of a thirteen-year-old girl who was living a lifestyle entirely inappropriate for her age that involved drinking alcohol and using illicit substances when the opportunity arose.

    h. That said, Jane had engaged well and with reasonable consistency with a number of support services in the two years before her death, and was making good progress towards re-engaging in education, seeking part-time employment and living a meaningful and productive life with good relationships.

    i. I wish to convey my sincere condolences to Ms GK, Mr FM and other family members as well as to the Child Protection and other support services involved with Jane.

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particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"

PUBLICATION OF FINDING

65. Pursuant to section 73(1) of the Act, unless otherwise ordered by the coroner, the findings, comments and recommendations made following an inquest must be published on the internet in accordance with the rules. I make no such order. The finding has bee written and is to be published under a pseudonym, in accordance with the family's wishes.

DISTRIBUTION OF FINDING

66. I direct that a copy of this finding be provided to:

GK and FM

The Manger, Child Protection, Department of Families Fairness and Housing

Ms Liana Buchanan, Child Safety Commission

Ms Sue Beattie-Johnson, Windermere

The Manager, Youth Support and Advocacy, 155 Lonsdale Street, Dandenong

Consultative Council on Obstetric and Paediatric Mortality and Morbidity

Senior Constable Stephanie Watkins (#38397) c/o O.I.C. Greater Dandenong C.I.U.

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 29 July 2021

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.