IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 4288

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: MARIA LIORDOS

Findings of:	**AUDREY JAMIESON, CORONER**
Delivered on:	1 August 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	25 to 29 July 2016, 22 to 25 August 2016 and 4 October 2016
Police Coronial Support Unit:	Leading Senior Constable Tracey Ramsey, Assisting the Coroner
Appearances:	Ms Christine Willshire of Counsel, on behalf of Sue Liordos (instructed by Shine Lawyers) Mr Andre Halse of Counsel. on behalf of the Salvation Army Westcare (instructed by Nevitt Ford Lawyers) Ms Judy Benson of Counsel. on behalf of the Department of Health and Human Services

I, AUDREY JAMIESON, Coroner having investigated the death of **MARIA LIORDOS**

AND having held an inquest in relation to this death on 25 to 29 July 2016, 22 to 25 August 2016 and 4 October 2016

at Southbank

find that the identity of the deceased was **MARIA LIORDOS**

born on 22 September 1997

and the death occurred on 24 September 2013

at 15 Dowling Street, Kealba in the State of Victoria

from:

1 (a) MIXED DRUG TOXICITY

in the following summary of circumstances:

At the time of her death, Maria Liordos[1] was a 16 year old child in the care of the Department of Health and Human Services (**DHHS**),[2] and subject to a Custody to Secretary Order. Maria resided at 106 Fox Street, St Albans; a residential care unit (**the Unit**) managed by the Salvation Army, Westcare.

On the night of 23 September 2013, Maria returned to the Unit with a friend in a drug affected state. Soon after, Maria and her friend took a taxi to the home of another friend in Kealba, where they intended to stay the night, contrary to the conditions of Maria's Order. Maria was discovered deceased the next morning. Illicit drug use has been implicated in the cause of Maria's death.

BACKGROUND CIRCUMSTANCES

1. Maria was born on 22 September 1997, the first child to Sue and Tom Liordos. Her only sibling, a brother, was born two years later.
2. In July and October 2010, at the age of 13 years, the DHHS received reports about Maria in relation to her mental health, sexualised behaviours and substance misuse. The family's involvement in community services, such as a Child and Adolescent Mental Health Service, was thought to be sufficient to support Maria and her family at these times.

[1] Maria Liordos was referred to as "Maria" only during the course of the Inquest at the request of her mother, Sue Liordos. For consistency, I have also used only her first name throughout the Finding save where I have deemed it necessary for formal purpose, to use her full name.

[2] Known as the Department of Human Services during Maria's engagement with Child Protection.

3. On 5 November 2010, a third report was received by the DHHS and proceeded to a full investigation surrounding concerns about Maria's cannabis use, flirtatious behaviour and parental inability to manage her behaviours.

4. In December 2010 Maria was diagnosed with a major depressive episode and substance abuse disorder. She was admitted for a period to the Royal Children's Hospital Banksia Unit. She reported having used "ice", "speed", petrol, cocaine and heroin and that she regularly consumed alcohol. Other high risk behaviours identified at this time included indiscriminate sexual promiscuity, violence and threatening behaviours towards her family, chronic absconding, self-harm, attempted suicide and engagement with her father during periods of absconding.

5. In May 2011, during a counselling session at the Royal Children's Hospital (RCH) Gatehouse Centre, Maria disclosed/alleged that her father had been sexually abusing her since the age of nine years, and that it was ongoing. A report was made to police but Maria retracted her statement and no further action was taken. On 4 May 2011 and 6 June 2011 the DHHS sought Protection Applications in the Children's Court of Victoria. [redacted] On 2 March 2012, Mr Liordos pleaded guilty to 10 counts of breach of an IVO, two counts of failure to appear whilst on bail, and one count of supply substances to a minor, for which he was placed on a Community Based Order and directed to attend a Men's Behavioural Change program.

6. [redacted]

[3] [redacted]

[4] [redacted]

7. On 12 September 2011, Maria was placed in a Salvation Army Westcare residential care unit in Spence Street, Keilor Park where she met "T"[5] who later became her intimate partner.

8. On 21 October 2011, the Children's Court of Victoria made Maria subject to a Custody to Secretary Order (**CTSO**), which remained in force at the time of her death. The CTSO meant that the Secretary had the 'daily care and control' of Maria and the right and responsibility to make decisions concerning that daily care and control, including making decisions regarding placement and returning Maria to the care of her parents if it was assessed to be in her best interests. Guardianship remained with Maria's parents.[6]

9. In December 2011, Child Protection placed Maria on the High Risk Youth Schedule, a schedule of young people identified as being at the highest risk of harm and requiring the most intensive and vigilant case management and programmatic oversight. On 7 December 2011, Maria's case management was contracted to the Salvation Army Westcare Intensive Case Management Service (**Westcare ICMS**). These services are reserved for the highest risk youth who have multiple and complex behaviours and emotional difficulties, necessitating long term substantial support.[7] The Westcare ICMS were a multidisciplinary team that had available in-house mental health clinicians and alcohol and other drug workers.[8]

10. On 24 September 2012, Maria's residential placement was changed to 106 Fox Street, St Albans. She continued to exhibit high risk behaviours, including committing criminal offences, absconding, sexual promiscuity, as well as continued contact with her father and the use of illicit substances.

11. Between 2011 and July 2013 Maria was placed in Secure Welfare Services (**SWS**) on five occasions. SWS provide short term accommodation in situations of immediate and significant risk of harm; they are considered *'beneficial in arresting a pattern of chronic or escalating at risk behaviour by a young person and as a means to provide contact and*

---

[5] The name of Maria's intimate partner has been redacted from the Finding with the aim of protecting her identity. Exhibit 6 – a DVD from the Taxi Directorate depicting Maria and "T" after leaving the Unit was released to the ABC following a Form 45 Application and Mrs Liordos' request that the material be released to them was done so on an undertaking that "T's" name not be used and her face pixilated (T @ p 299).

[6] Statement of Maria Tulloch dated 30 June 2016.

[7] Outline of Submissions on behalf of the DHHS – Judy Benson, Counsel for DHHS, dated 15 September 2016.

[8] T @ p 1015.

engagement opportunities for treatment and case management services'.[9] Maria had a period of eight days in SWS at the beginning of May 2013, after attending at an Emergency Department with acute abdominal pain and being diagnosed with acute hepatitis C. Maria's last period in SWS was between 15 and 24 July 2013. She had been located in Tocumwal and there were concerns regarding substance misuse and a need to assess her emotional wellbeing.[10]

12. In the period of time Maria had been in the care of Westcare she was subject to 22 warrants due to absconding.[11]

13. On 3 September 2013, Maria's CTSO was extended. There were 15 conditions attached to the Order.

SURROUNDING CIRCUMSTANCES

14. In the week leading up to Maria's death she spent four nights at the Unit and three nights away.

15. On Friday 20 September 2013, Maria stayed the night at the home of her Aunt Joanna Panagoulopoulos (**Aunt Joanna**). On Saturday 21 September 2013, Maria stayed at her mother, Sue Liordos' (**Ms Liordos**) home, as it was her birthday the next day. That evening, Maria went out to dinner in Lygon Street with her mother, brother, Aunt Joanna and her maternal grandmother. Aunt Joanna recalled:

16. *At this time I observed Maria to be happy to be turning 16; she was taking photos and was in good spirits.*[12]

17. On 22 September 2013 at approximately 12.45pm, Aunt Joanna collected Maria from Ms Liordos' house to take her to lunch in Williamstown, for a birthday lunch with her friends.[13] That night, Maria and her intimate partner, "T" who was also a client of Westcare,[14] stayed at the Unit. During the early hours of 23 September 2013, Maria had a lengthy telephone

---

[9] Exhibit 26 – Statement of Monica Tulloch dated 10 December 2013.

[10] *Ibid.*

[11] The legislative basis for obtaining a warrant for the return of an absconding child in the care of the State is found at s.598 *Children, Youth and Families Act* 2005 – Part 8.3 Placing a child in emergency care.

[12] Exhibit 27 – Statement of Joanna Panagoulopoulos dated 11 February 2014.

[13] *Ibid.*

[14] Maria and "T" met at the Spence Street residential unit. Aunt Joanna said: *In her relationship with "T" I believe Maria for the first time found love, loyalty and what it means to be loved, give love and be appreciated at least for a 15 year old* - Exhibit 27 – Statement of Joanna Panagoulopoulos dated 11 February 2014.

conversation with Aunt Joanna. She was talking positively about her future but *'she was talking quickly and her speech was racy.'*[15] Maria denied having used drugs when questioned by Aunt Joanna. At approximately 6.30am, Maria and "T" left the Unit. She did not disclose to the residential unit workers where she was going.

18. On 23 September 2013 at approximately 8.00pm, Maria telephoned the Unit and advised staff that she would not be returning that night but would return the following day.[16] At 8.45pm, Maria and "T" returned to Fox Street. Curfew is 9.00pm. Residential worker, Alanna O'Brien (**Ms O'Brien**) was working on her own at the Unit. No other clients were present. Ms O'Brien observed that both Maria and "T" appeared substance affected. Maria was slurring her words, talking fast and appeared agitated. She looked pale and her pupils were dilated. After having something to eat and drink, Maria went to the bathroom. She seemed to take some time in the bathroom and when she emerged, she appeared to be more substance affected and was described by Ms O'Brien as stumbling and slurring her words more. Maria and "T" left the Unit soon after, advising Ms O'Brien that they were going to the bus stop to take a bus to 'Angelo's', where they were going to stay the night. Ms O'Brien declined their request to walk them to the bus stop, as she did not want to leave the Unit unattended in case any of the other clients returned. Afterwards, Ms O'Brien checked in the bathroom for any drug paraphernalia but did not locate anything.

19. At approximately 9.00pm, Ms O'Brien telephoned Lisa Cadman (**Ms Cadman**), another residential worker attached to Fox Street, for advice about the situation she had just experienced with Maria and "T". Ms Cadman advised Ms O'Brien to complete an Incident Report and to inform the Westcare ICMS on-call. Ms O'Brien was, however, unsure as to what this was and instead waited until the residential care relieving night shift worker, Kym Studley (**Ms Studley)** came on duty.

20. At 10.05pm Maria telephoned Angelo to inform him that she and "T" were in a taxi on their way to his house in Kealba.

21. At 10.10pm Ms Studley telephoned the Westcare ICMS on-call worker Michelle Hines (**Ms Hines**) to advise her of the situation as conveyed to her by Ms O'Brien.

---

[15] Exhibit 27 – Statement of Joanna Panagoulopoulos dated 11 February 2014.

[16] Exhibit 4 – Notes/Extracts from the Fox Street Communications Book.

22. At approximately 10.17pm, Ms Studley telephoned Angelo to inform him that Maria was on her way and that she was likely drug affected. She asked Angelo if she could telephone him back in approximately one hour to confirm that Maria had safely arrived.

23. At 10.30pm Maria and "T" arrived at Angelo's in Kealba. At around the same time, Ms Studley spoke to Maria's mother on the telephone and provided her with an update.

24. At approximately 10.45pm, Ms Studley telephoned Angelo and received confirmation that Maria and "T" had arrived.

25. At approximately 10.50pm, Ms Studley telephoned Ms Hines to provide an update.

26. At approximately 11.07pm, Maria had a telephone conversation with Aunt Joanna, who suspected that she had taken drugs, because of the way she was slurring her words. Maria only admitted to having taken *'a tiny bit of weed'*.[17] Joanna spoke briefly with Angelo, who denied any knowledge of Maria having taken any drugs. Between approximately 11.30pm and 12 midnight,[18] Aunt Joanna telephoned Ms Liordos to tell her of her concerns.

27. At 7.40am on 24 September 2013, Maria was discovered deceased by "T" and Angelo.

28. Police attended at the Fox Street Unit on 24 September 2013, and located drug paraphernalia in the rubbish bin in the girls' bathroom.[19]

JURISDICTION

29. Maria's death was a reportable death under section 4 of the *Coroners Act 2008* ('the Act'), because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury. In addition, immediately before her death, Maria was subject to a Custody to Secretary Order, and therefore was a person placed in custody or care, as defined in section 3 of the Act. An Inquest was thus mandated by virtue of her 'in care' status.[20]

---

[17] Exhibit 27 – Statement of Joanna Panagoulopoulos dated 11 February 2014, T @ p 1006.

[18] Exhibit 28 – Statement of Athanasia (Sue) Liordos dated 21 June 2016.

[19] Ms Studley gave evidence that it was her usual practice to empty the rubbish bins in the bathrooms during the night shift after the residents had settled. She stated that she had done this that evening and had not located any drug paraphernalia – T @ p 234. Later in her *viva voce* evidence she conceded that as the Police located drug paraphernalia in the rubbish bin the next morning she must not have emptied the bins the previous night – T @ pp 280 - 281.

[20] Section 52(2)(b) *Coroners Act* 2008.

PURPOSE OF THE CORONIAL INVESTIGATION

30. The Coroners Court of Victoria is an inquisitorial jurisdiction.[21] 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 death occurred.[22] 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 merely all circumstances which might form part of a narrative culminating in death.[23]

31. The broader purpose of 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.[24] Coroners are also empowered to report to the Attorney-General on 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.[25] These are effectively the vehicles by which the prevention role may be advanced.[26]

32. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

33. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death

---

[21] Section 89(4) *Coroners Act 2008*.

[22] Section 67(1) of the *Coroners Act 2008*.

[23] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[24] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

[25] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[26] See also sections 73(1) and 72(5) of the Act 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.

was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

STANDARD OF PROOF

34. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[27] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    - the nature and consequence of the facts to be proved;
    - the seriousness of any allegations made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

35. The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

INVESTIGATIONS PRECEDING THE INQUEST

Identity

36. The identity of Maria was confirmed through visual identification by Ms Kym Studley, Youth Worker, and required no additional investigation.

Medical Cause of Death

Post mortem examination

37. On 27 September 2013 Dr Linda Iles (**Dr Iles**), Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**), performed a full post mortem examination on the body of Maria. Information available to Dr Iles prior to performing the post mortem examination was contained within the Police Report of Death for the Coroner, Form 83.

---

[27] (1938) 60 CLR 336.

Anatomical findings at the post mortem included non-specific pulmonary oedema, fresh haemorrhage and evidence of peri venous subacute inflammation in the right antecubital fossa, an anatomically normal cardiovascular system and a simple cystic change of the left ovary. Dr Iles reported that no anatomical cause of death was identified at the post mortem examination.

Toxicology

38. Post mortem toxicological analysis of blood and other bodily fluids demonstrated evidence of the use of heroin and methylamphetamine prior to Maria's death. There was also evidence of the use of the antidepressant fluoxetine, the adrenergic agonist modafinil and the antihistamine diphenhydramine. Dr Iles commented in her report that although fluoxetine and diphenhydramine were not considered to be present in blood at excessive levels, they were both central nervous system depressants so their contribution to Maria's death could not be excluded.

Forensic pathology opinion

39. Dr Iles ascribed the cause of Maria's death to mixed drug toxicity.

Conduct of my investigation

40. The investigation and the preparation of the Inquest Brief was undertaken by Detective Senior Constable (DSC) Sarah Kendall on my behalf.

INQUEST

Direction Hearings

41. Direction Hearings were held on 7 March 2016 and 26 April 2016.

42. The scope of the Inquest was determined to focus on the management and supervision related to Maria's drug taking and absconding behaviour, proximal to the time of her death. There was a view to identify any shortcomings and/or improvements in how Maria, a vulnerable young person, was supervised and managed on the night prior to her death.

Suppression Orders

43. On 25 July 2016, at the outset of the Inquest, a Proceeding Suppression Order pursuant to section 18(2) of the *Open Courts Act 2013* in relation to the contents of the Commission for Children and Young People's Child Death Inquiry Report, prepared in response to Maria's death, was made following submissions made on behalf of the Commissioner for Children

and Young People by Ms J. Davidson of Counsel. This Suppression Order remains in place until 25 July 2021.[28]

44. On 23 August 2016, a Proceeding Suppression Order pursuant to section 18(2) of the *Open Courts Act 2013*, was made in relation to the name of an employee of Westcare, who was mentioned in the course of the evidence. This Suppression Order remains in place until 23 August 2021.

***Viva voce* evidence at the Inquest**

45. *Viva voce* evidence was obtained from the following witnesses:

- Alice Barnacle, Psychologist, Gatehouse, Royal Children's Hospital
- Alannah O'Brien, Residential Care Worker, Westcare
- Kym Studley, Residential Care Worker, Westcare
- Michelle Hines, Maria's Case Manager, Westcare
- Maria Powers, Acting Team Leader (at the time) Intensive and Case Management Services
- Daniella Pajic - Alcohol & Other Drugs Worker (AODW)
- Andrea Clements – Senior Manager, Practice, Planning and Training, the Salvation Army, Westcare
- Peter Annesley – Senior Manager Residential and Support Services, Westcare
- Beth Allen, Assistant Director Child Protection, Department of Health and Human Services
- Monica Tulloch – DHHS, Secure Welfare Services
- Joanna Panagoulopoulos – Maria's Aunt
- Athanasia (Sue) Liordos – Maria's mother

[28] T @ pp 12-14.

ISSUES INVESTIGATED AT THE INQUEST

46. A number of issues were investigated in the course of the Inquest, including but not limited to: Maria's case plan; care team meetings; High Risk Youth Panel meetings; impediments to engagement with Maria; management of Maria's substance misuse; and access to the After-Hours Child Protection Emergency Service.

Maria's case plan

47. The case plan, common to DHHS' Child Protection and Westcare, included the ultimate goal of the reunification of Maria with her family. In August 2013 there was some advancement in realising the case plan, as Maria spent an extended period of time with her family.

48. A crisis plan was also in place, which included instructions relevant to Maria's absconding behaviours and specifically stated that if Maria was missing for six or more hours, a warrant could be sought.[29]

Care team meetings

49. The co-ordination of Maria's complex needs were the subject of discussion and planning at care team meetings approximately every fortnight. These meetings were the responsibility of Westcare's ICMS team.

50. Evidence was given that the generation and dissemination of the minutes of the meetings relevant to Maria were either not done at all, were not done in a timely or contemporaneous manner to the meeting and/or were not disseminated to all of the relevant people.[30] Maria's Case Manager, Michelle (Shelley) Hines (**Ms Hines**) was responsible for the minutes.

High Risk Youth Panel meetings

51. The High Risk Youth Panel meetings were convened monthly and chaired by senior Child Protection staff from the DHHS. Minutes of these meetings were generated and disseminated to participants and there was evidence[31] that matters relevant to Maria including her absconding behaviour, substance misuse and matters related to Maria and "T"'s relationship were known and considered by the panel.

---

[29] Exhibit 19 – Statement of Andrea Clements dated 22 August 2016.

[30] For example, see evidence of Alice Barnacle – T @ p 67.

[31] Exhibit 24 -

52. There was an interconnection between the High Risk Youth Panel and the ICMS team.

Impediments to engagement with Maria

53. Alice Barnacle (**Ms Barnacle**), Psychologist, Gatehouse, Royal Children's Hospital had been Maria's mental health worker during the period November 2012 to June 2013, through the Intensive Mobile Youth Outreach Support Service (IMYOS).[32] From July 2013, Ms Barnacle was again Maria's mental health worker, through Gatehouse. At this time, Maria sought counselling in relation to a recently disclosed incident of sexual assault, allegedly perpetrated by a residential care worker in the Unit.[33] In the latter period, Ms Barnacle saw Maria on only two occasions in August 2013. Maria had absconded at the time of the scheduled third session. There were three other scheduled sessions that Maria was not brought to, for reasons that were not communicated to Ms Barnacle. At another scheduled session, Maria was instead taken shopping by her Case Manager. Ms Barnacle also had two sessions with Ms Liordos, and attended Maria's care team meetings on 13 August 2013 and 27 August 2013. At the care team meetings, Ms Barnacle would provide an update on Maria's mental health, advising of discussions with Ms Liordos and on strategies she was implementing with Maria, as well as discussing how such strategies could be implemented in the Unit.[34] Maria's absconding behaviour was also discussed at the care team meetings. Ms Barnacle said that she was aware that Maria was continuing to exhibit absconding behaviour.[35] However, she believed that it had lessened overall during her second and most recent period of engagement, and attributed this to Maria spending more time with her mother, including overnight stays at Ms Liordos' house.[36]

54. The situation was not, however, straightforward as Ms Barnacle also reported that Maria's relationship with her mother presented ongoing challenges.

> *While Sue demonstrated protective intent with relation to the prevention of Maria's alleged contact with Tom, it appeared challenging for Sue to consistently keep Maria's childhood trauma in mind as being connected to Maria's high-risk behaviours. The idea of consequences for Maria's acting out behaviour appeared to*

---

[32] IMOYS is within the Child and Adolescent Mental Health Services (CAMHS), a division of the Victorian Mental Health Services.

[33] Exhibit 1 – Statement of Alice Barnacle dated 5 March 2014.

[34] T @ p 22.

[35] T @ p 24.

[36] T @ p 23.

trigger a sense of rejection in her, enraging her to the point that she would become verbally and sometimes physically abusive towards Sue.[37]

55. According to Ms Barnacle, a significant impediment to progress the therapeutic interventions she was trialling with Maria was related to her reported ongoing contact with her father. She stated:

> *Perpetuating Maria's core belief systems and problematic high-risk behaviours was her reported ongoing contact with Tom Liordos (evidenced by witnesses to their contact),* [redacted] *.....Furthermore, Tom's reported supply of drugs and money to Maria, alongside alleged continued sexual abuse (all disclosed by others witnessing their contact), likely provided Maria with a sense of acceptance and even love, thus maintaining her distorted belief with regard to the association of sexually abusive behaviours with a maladaptive sense of gratification.*[38]

56. But overall, since the commencement of her second period of engagement with Maria at Gatehouse, Ms Barnacle felt that there was reduced absconding; reduced persistent drug abuse so that it seemed more opportunistic than addictive; and an improved relationship with her mother, including communication, contact and positive connection.[39] Ms Barnacle said that in that period – the last two sessions, Maria was quite insightful and quite positive about how far things had come with her mother.[40]

57. In the two weeks prior to Maria's death, Ms Barnacle *felt very out of the loop* in respect of the matters related to Maria's risk, because Maria had not been brought to scheduled sessions. In addition, Ms Barnacle had not received a response from Ms Hines to her email and phone messages as to why this had occurred.[41] Ms Barnacle said that had Maria:

> *..been able to continue to attend her appointments consistently then (sic) she would have been able to continue to process her feelings and her disappointments and I would have been able to advocate around what they were to the care team.*[42]

---

[37] Exhibit 1 – Statement of Alice Barnacle dated 5 March 2014.

[38] Exhibit 1 – Statement of Alice Barnacle dated 5 March 2014.

[39] T @ p 32.

[40] T @ p 71.

[41] T @ p 43, 65, 72.

[42] T @ p 43.

Management of Maria's substance misuse

58. It was generally believed by those involved in Maria's care that she had not used heroin for approximately three months.[43]

59. Alcohol & Other Drugs Worker (AODW) Daniella Pajic (**Ms Pajic**) also stated that in her opinion, the triggers for Maria resorting back to substance misuse centred on her history of sexual abuse, arguments with her mother, and ongoing contact with her father.[44]

60. Ms Pajic created the Alcohol and Other Drugs Crisis Plan dated 11 July 2013,[45] which was in place at the time of Maria's death. The plan specifically stated that an ambulance was to be called if Maria was at risk or required medical attention. The plan was not, however, followed on the evening of 23 September 2013, either at the time Maria and "T" returned to the unit in a drug affected manner, or during the hour that they remained there. Maria's initial presentation was one of being substance affected. However, when Maria came out of the toilet, according to Ms O'Brien she was more substance affected; Maria *was stumbling and slurring her words more.*[46]

61. There appeared to be little appreciation of the existence of the Alcohol and Other Drugs Crisis Plan by the relevant workers. Ms Beth Allen, Assistant Director Child Protection (**Ms Allen**) said that it was concerning that the Crisis Management Plan was not implemented.[47] Ms Monica Tulloch, General Manager of SWS also agreed that it was concerning that an ambulance was not called.[48]

Access to After-Hours Child Protection Emergency Service

62. Ms Hines was Maria's Case Manager and also the Westcare ICMS on-call worker on the night of 23 September 2013. She received a telephone call from Ms Studley at 10.10pm,[49] who relayed the information that Ms O'Brien had conveyed to her about Maria's presentation and departure from the Unit. Ms Studley recalled that Ms O'Brien had told her

---

[43] T @ p 194, 242.

[44] T @ p 561.

[45] Exhibit 5 – ICMS Alcohol and other Drugs Crisis Management Plan dated 11 July 2013.

[46] T @ p 90.

[47] T @ p 891.

[48] T @ p 967.

[49] Exhibit 4 – Extracts/notes from Communication Book (also referred to as Fox Street Comms Book)

that after Maria came out of the bathroom, she was demonstrating slurring of speech and being uncoordinated; she was staggering.[50]

63. Ms Hines' evidence varied somewhat from Ms Studley's about the extent of the information conveyed and what was specifically said, implied or assumed in the conversation. In relation to the extent of the effects of substances on Maria when she was leaving the Unit, Ms Hines stated that Ms Studley had told her that Maria's eyes were "rolling in the back of her head".[51] Ms Hines said that she had also asked Ms Studley if an ambulance had been called and she recalled *suggesting that paramedics be called if staff had concerns for Maria's (sic) presentation....at least then medical professionals could make an assessment (sic) and take it from there.*[52]

64. Ms Studley had only been in the position for six weeks[53] at the time of these events and stated that she *was listening to Shelley and taking her advice. She was a senior staff member.*[54] Ms Studley was a compelling witness who appeared to have genuine regard for her charges. She had no recollection about a conversation with Ms Hines that there was any further action that she was encouraged to follow,[55] including about calling for an ambulance.[56] She had made contemporaneous notes following her conversation with Ms Hines, such that these notes acted as an *aide memoir* during her *viva voce* evidence. In respect of whose responsibility it was to seek appropriate means to return Maria to her residence, Ms Studley did not recall having had a specific conversation with Ms Hines about this but assumed that it was the responsibility of the Westcare ICMS on-call to seek a warrant.[57] Ms Studley was correct in this assumption. I accept that Ms Studley followed up on the matters she understood that she had been asked to do. Ms Studley stated *I took the advice of someone I trusted and I followed her direction and I would not have gone against her direction.*[58] In particular, Ms Studley telephoned Angelo to advise him that there were

---

[50] T @ p 193.

[51] T @ p 304.

[52] T @ p 306.

[53] Ms Studley later agreed with Ms Benson that she had been working as a casual employee for approximately 4 months in the residential care sector – T @ pp 243 – 244.

[54] T @ p 228.

[55] T @ p 203.

[56] T @ p 207, 228.

[57] T @ p 212.

[58] T @ p 234.

concerns for Maria's welfare and informed him that Maria was believed to be on her way to his house. In the second telephone call to Angelo, Ms Studley merely sought to confirm with him that Maria had in fact safely arrived at his home. It was Ms Studley's evidence that Ms Hines had provided her with Angelo's contact details.[59] Ms Studley's contemporaneous notes also reflect that Angelo's address and telephone number were provided to her during her conversation with Ms Hines.[60]

65. On the other hand, Ms Hines made no contemporaneous notes about the conversation she had with Ms Studley, she was evasive throughout the provision of her *viva voce* evidence and appeared to have no independent recall of the events despite prompting from members of the bar table. The significance of the events of that night, including that she was informed the next morning that Maria had died, similarly appeared to have no bearing on Ms Hines' recall. She stated in her evidence that she did have a diary at home that she may have made some notes in, but these notes were never forthcoming, despite her undertaking to the Court to attempt to locate them. Ms Hines initially denied providing Ms Studley with Angelo's details, stating she did not know them and subsequently that she might have just guessed the street name in the Keilor-Kealba area because she had once dropped Maria off in that street.[61] Ms Hines appeared to struggle to clarify what specific actions she took in response to the information Ms Studley had conveyed to her that evening. The evidence that she did telephone the DHHS' After-Hours Child Protection Emergency Service (AHCPES) number on the night of 23 September 2013 prompted her response that she would have been seeking a warrant. Evidence obtained through Telstra indicated that the telephone call Ms Hines made lasted for two minutes and 25 seconds.[62] The length of the call suggests only that the call occurred. After taking into account the time taken to listen to the after hours pre-recorded message, only one minute would have remained for communication about Maria's situation.[63] There is no evidence that Ms Hines spoke to anyone specifically about Maria to seek advice or a warrant for her apprehension. Otherwise, I am told and I accept that the CRIS file[64] would have been accessed/opened and a note of the contact would have occurred

---

[59] T @ pp 226-27, 249.

[60] Exhibit 4 – Fox Street Communications (Comms) Book entry for 23 September 2013.

[61] T @ p 307.

[62] Exhibit 11.

[63] Exhibit 30 – Statement of Lisa Hema dated 19 August 2016.

[64] CRIS is the DHHS' Client Relationship Information System.

on the file.[65] Even in the absence of a note being made, the file would reflect that it had been opened at a particular time.[66] Evidence from the CRIS file reflects that it was accessed by Westcare on only one occasion in the relevant month, being on 19 September 2013.

66. Ms Studley also gave evidence about the DHHS' After-Hours Child Protection Emergency Service (AHCPES) and in particular, about the difficulty of getting through to the service. She said that when she had attempted to contact AHCPES about a child who had absconded or was exhibiting other behaviours on that child's crisis management plan, the longest that she had been kept on hold waiting to speak to someone was three hours. Ms Studley further stated that even after a long wait on hold, it was not unusual to then be told that the call taker would ring back, but in her experience, they would consistently not do so.[67] Furthermore, Ms Studley confirmed that there was not a dedicated number for the residential workers to ring AHCPES.[68] She had no knowledge of the DHHS' collated data which indicates the average response time by the after hours service is only eight minutes. Ms Studley responded that it was her impression and memory, and she had no recollection of *the phone being picked up in eight minutes, ever.*[69]

67. Nevertheless, the evidence of Ms Hines in regard to knowledge and response to the information conveyed to her by Ms Studley on the evening of 23 September 2013, and in particular her evidence regarding her contact with AHCPES, was also cast into doubt by the evidence of Ms Liordos, who said that Ms Hines had told her that she did not request a warrant.[70]

68. Ultimately, I was unable to reconcile the evidence of Ms Hines with that of other witnesses. Her interpretation of the events appeared self-serving, could not be substantiated and did not stand up to scrutiny such that I was prompted to remind her of the requirement to tell the truth under oath. Her evidence in relation to a lack of knowledge of Angelo's address and other details, was implausible. Consequently, I attached little weight to the evidence of Ms Hines.

---

[65] T @ p 881, 929.

[66] T @ p 894.

[67] T @ pp 256 - 258.

[68] T @ p 291.

[69] T @ p 290.

[70] T @ p 1056-1057.

Developing alternative models of care

69. During the course of the Inquest, I raised the question about alternative models of residential care adopted or considered by the DHHS that may have been more conducive to Maria's circumstances. I was informed that since Maria's death, the DHHS has taken steps to enhance the service delivery in therapeutic residential care and residential care generally, with a focus on how residential care for children can best be managed to make their stay as short as possible with a view to reunification back with families.[71] I was provided with a number of publications in support, including two dated April 2015 and entitled "*Program requirements for residential care in Victoria*" and "*Program requirements for the delivery of therapeutic residential care in Victoria*". In the latter publication "therapeutic residential care" is defined:

> *Therapeutic residential care is intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs.*[72]

70. I have also had the opportunity to read the 2014 Churchill Fellowship study of Magistrate Jennifer Bowles titled: *"What Can be Done? – Residential therapeutic treatment options for young people suffering substance abuse/mental illness"*. Magistrate Bowles, who sits in the Children's Court of Victoria, undertook her study by visiting secure homes and therapeutic residences in Sweden, Scotland, England and New Zealand. She concluded *inter alia* that the current system is not working for large numbers of children and young people with drug/alcohol/mental health issues and that opportunities were being missed to help those who are volunteering to access services. In addition, Her Honour said that although the provision of secure residential therapeutic facilities will not deliver perfect results, her study showed that they would provide an opportunity for young people to access treatment and turn their lives around. Her Honour has proposed a model which provides for the establishment of secure therapeutic residential treatment facilities. The model requires, amongst other things, legislative change to enable Youth Therapeutic Orders to be made in

[71] T @ p 1012 (Closing submissions on behalf of the DHHS)

[72] The source of the definition is stated as to be from a National Child Protection Clearing House Issues paper No 35 2011, Australian Institute of Family Studies – for the full reference see p 9 of the DHHS publication.

the Children's Court of Victoria and where participation has occurred, the Court would have regard to the progress of the young person for sentencing and child protection order purposes. Her Honour made a number of Recommendations to enable the establishment of secure therapeutic residential treatment facilities for young people with significant drug/alcohol/mental health issues, including the establishment of a multidisciplinary Steering Committee to advise on and plan for the implementation of the same. I understand that the Committee has been established and meets every six weeks and that Her Honour has appeared before the Parliamentary Inquiry into Youth Justice Centres in Victoria and the Northern Territory Royal Commission into the Protection and Detention of Children in the Northern Territory to speak about her research findings.

71. Had a model such as that proposed by Magistrate Bowles been available to Maria, she would have likely been a suitable candidate, given her multitude of problems including her drug misuse, mental ill health and criminality. Therapeutic models of residential care, including the secure facilities recommended by Her Honour, will, if adopted, provide additional options for the DHHS and its agencies. These models will assist the DHHS in its pursuit of the delivery of appropriately tailored care and services to the children and young people it has become responsible for. As Her Honour stated, these models of care provide an opportunity for these children and young people to turn their lives around. However, it is impossible to make a definitive statement that had Maria been afforded the opportunity to participate in any model of therapeutic residential care, her tragic trajectory would have been altered.

Information sharing between agencies

72. Communication breakdowns between government agencies are a recurring theme in coronial investigations. The Finding following the Inquest into the death of Luke Batty,[73] delivered by His Honour Judge Ian Gray on 28 September 2015, identified a number of issues relating to the sharing of information between different agencies. His Honour recommended, *inter alia*, that the State of Victoria identify and remove legislative or policy impediments to the sharing of relevant information between agencies operating within the integrated family violence system, so they are able to share relevant information in relation to a person at risk. The Inquest into the death of Luke Batty illustrated the importance of information sharing to protect vulnerable people, and while not entirely factually on foot with Maria's case, the

[73] COR 2014 0855.

investigation has illuminated a number of shortcomings with the sharing of information between the DHHS and Westcare.

73. The Victorian Royal Commission into Family Violence[74] also identified that sharing information about risk within and between organisations is crucial to keeping victims safe. It was identified that a number of barriers impede organisations from sharing information, among them the complex legislation that governs privacy and information sharing, current information-sharing practices, and outdated information technology systems. The Commission recommended the introduction of a specific family violence information-sharing regime under the Family Violence Protection Act, to provide clear authority for relevant prescribed organisations to share information. The Commission also recommended that a Central Information Point be established to facilitate the sharing of information.

74. By way of letter dated 29 June 2017, the Hon. Gavin Jennings, Special Minister of State, informed His Honour Chief Magistrate Lauritsen that the Family Violence Protection Amendment (Information Sharing) Bill 2017 had passed. The Bill included introducing a specific family violence information sharing legislative regime and enabling the operation of the Central Information Point. These legislative forms were anticipated to commence in the second half of 2017. It is anticipated that legislative change will improve the standard of communication between agencies in the family violence domain. As such, I am hopeful that this will equate to improved communication between DHHS Child Protection and the contracted agencies responsible for vulnerable children, who like Maria, often present in the context of family violence.

Closing submissions

75. At the conclusion of the Inquest, I received written outlines of submissions from Counsel Assisting, and legal representatives for Ms Liordos, Westcare and the DHHS. On 4 October 2016, Counsel Assisting and Counsel acting on behalf of the interested parties, made oral submissions in accordance with their respective outlines. I have considered all of this material for the purpose of this Finding.

---

[74] See: Royal Commission into Family Violence, 'Summary and Recommendations', March 2016, 20.

76. Counsel Assisting submitted that the evidence obtained during the course of the Inquest had identified deficiencies in procedures specific to:

- The standards of education and training required by new staff employed by Westcare;
- The induction process for new staff of Westcare appeared lax and shifted responsibility to the individual employee to acquaint themselves with numerous guidelines, procedures and individual client plans at times when they were expected to be supervising clients;
- Education and training pertaining to the assessment and management of clients who are substance affected;
- Lack of consistency on minimum standards of training/education/work experience prior to new staff being rostered on alone to supervise clients;
- Staff not remaining on duty during allocated rostered shifts and an apparent need for a formalised procedure to be followed if staff leave a residential unit before the completion of their shift;
- Quality control of the production and dissemination of administrational documents such as care team meetings minutes to the relevant people; and
- A lack of adherence by Westcare staff to follow Crisis Management Plans prepared specifically for Maria in relation to absconding and substance use.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. Maria was a high risk adolescent with issues associated with, or arising from, sexual abuse believed to have been commenced by her biological father, absconding behaviours and drug abuse. Maria's vulnerabilities necessitated the intervention, protection and care by the State, and DHHS Child Protection, Westcare and Sue Liordos were all fully aware of Maria's propensities.
2. Ms Allen stated that as a statutory service system, the DHHS' Child Protection is very challenged by how best to care for and manage high risk adolescents.[75] I agree. The death of

[75] T @ p 916.

one such adolescent, Maria, has had a significant impact not only on her family but for all those who engaged with her in their endeavours to support her journey to address her complex array of problems.

3. Maria's substance misuse varied in intensity over time but in the month preceding her death there is evidence to suggest that Maria was metaphorically 'in a better place' - there is nothing noted to suggest that she was presenting as substance affected. Ms Pajic agreed that from about 16 July 2013, it appeared that Maria had not engaged in substance use or suffered from withdrawal symptomology.[76] However, in the day prior to her death there appears to have been a change. Whether this change was merely part of the general lability of her complex issues or whether there was a specific precipitating event(s) was not elucidated by the evidence.

4. The array of trauma experienced by Maria was complex. She experienced trauma that undoubtedly led to high risk behaviours and her high risk behaviours added to her trauma. There was one consistent reference to the trauma caused to Maria; the alleged prolonged sexual abuse of her by her father. Whether or not Maria continued to have contact with her father and whether or not this constituted ongoing abuse of her is impossible to discern when regard is had to other significant events that occurred to her while she was in the care of the State. All the matters brought to my attention by Sue Liordos were important and significant in Maria's very short life. I do not dismiss that each event had a cumulative effect on Maria, but similarly, I am not able to definitively determine they did and if so, to what extent. I determined that many of those matters were not within the scope of my investigation because they had either been addressed by DHHS and/or Westcare, were remote, or were not apparently causative to the immediate surrounding circumstances to Maria's death. Such matters include the letters from Ben Lucien, Maria's allegations of sexual assault by a residential care worker[77] and that an employee of Westcare was selling her drugs, as well as the evidence that Ms Hines made a Facebook friend of Maria - a matter specifically denied by her under oath[78] but which was specifically conceded by Westcare.[79]

---

[76] T @ p 525, Exhibit 16 – Statement of Danielle Pajic dated 13 march 2013..

[77] The alleged assault was not reported to Westcare until some months after the incident. Westcare commenced a quality of care investigation once it was brought to their attention and the said worker was stood down as a result of the complaint – T @ pp 51-52.

[78] T @ p 374.

[79] T @ p 1029.

5. The investigation into Maria's death identified a litany of adverse incidents which occurred while she was in the care of the State, and in particular, Westcare. Ms Liordos was justifiably concerned about these incidents, and the possible impact that they had on Maria's wellbeing. Similarly, within the confined scope of this Inquest, a number of shortcomings have been identified that would warrant recommendations for change. However, I acknowledge that the evidence, in particular through Ms Clements, indicates that Westcare has reviewed its systems and procedures, and initiated a number of risk prevention strategies. In addition, Westcare have informed me they have implemented ongoing quality improvement assessments, including but not limited to: the Westcare High Risk Practice Panel; Therapeutic Behaviour Intervention Plans; and relevantly, the reintroduction of the liaison meetings between Child Protection, Westcare and the Local Engagement Officer. In the circumstances, I have refrained from replicating recommendations to this effect.

FINDINGS

1. I find that the identity of the deceased is Maria Liordos, who was born on 22 September 1997 and who died on 24 September 2013 at Dowling Street, Kealba in the State of Victoria.
2. I find no causal connection between the poor administrative practices of employees of Westcare, in particular related to the generation of and dissemination of minutes of care team meetings, and the cause of her death, as there is no evidence that the contents of the minutes of those meetings would have contained information directly related to the circumstances surrounding Maria's death.
3. A duality of responsibility was held towards Maria; by the State for its overall responsibility towards high risk youth in Victoria and by Westcare through the day to day intensive case management. However, both organisations failed to achieve any of the significant goals for Maria, including reunification with her family, reform and rehabilitation of her substance misuse, and significantly to keep her safe from her own behaviours. The DHHS failed to properly monitor Westcare's delivery of services to Maria, including failing to ensure that required and expected reporting systems were being adhered to. The evidence in this regard reflects badly on the DHHS. The Department cannot totally divest itself of its responsibilities to the State's most vulnerable children merely by contracting the delivery of intensive case management to another agency. However, I find that these issues are not directly causative to Maria's death or causative of the immediate surrounding circumstances of her death.

4. I find that there was a significant loss of opportunity to intervene to keep Maria, a child in the care of the State – delegated to the Salvation Army Westcare, as safe as possible by ensuring that she was given the opportunity to be attended on by medically trained personnel or taken to a medical facility where her level of substance intoxication could have been monitored. There was an Action Plan in place to provide guidance to the staff of the residential unit specific to the circumstances but it was not acted upon and its existence was unknown to the staff on duty. However, I make no specific adverse comment against Ms O'Brien; she was in an invidious position having been left to manage the residential unit on her own. I accept that she engaged with Maria in conversation and assisted her with obtaining something to eat and it would have been difficult for her to initiate the Action Plan and call for an ambulance whilst on her own at the Unit even if she had known that such a plan existed. Furthermore, it is not possible to definitively find that Maria would have consented to engage and participate with ambulance paramedics or other medical personnel at that time of the evening. There is evidence that she would have rejected that offer of assistance and departed the Unit in any event.

5. Mr Halse submitted that it is unreasonable to suggest that another worker should have been found to support Ms O'Brien for one hour[80] when there were no residents in the Unit at the time her colleague went home. I do not accept this submission for reasons that it is the unpredictable nature of the residents in these units and thus in the care of Westcare, and as demonstrated by the events of 23 September 2013, that makes it reasonable for a sick and/or early departing employee to be replaced and why I suspect the practice of the Unit rostering two staff members on for this shift was in place. Another ground for rejecting Mr Halse's submission in this regard is that at the time, Ms O'Brien was inexperienced in the role and thus deserving of a co-worker for the whole of her shift. Furthermore, I note that Westcare receive sufficient funding from the DHHS that would enable two employees to remain at the Unit up to 11.00pm.[81] As Mr Peter Annesley, Senior Manager Residential and Support Services stated in his *viva voce* evidence, it was neither best practice nor ideal[82] that Ms O'Brien was left on her own at the Unit.

---

[80] As pointed out by Ms Willshire in closing submissions – Ms Cadman left the Unit at 8.00pm but was in fact rostered on until 10.00pm equating to a 2 hour period that Ms O'Brien was left on her own – T @ p 1063.

[81] T @ p 889.

[82] T @ p 850.

6. I find that Westcare failed to ensure that their staff were properly trained, cognisant of client based documents and supported. Relevant to the circumstances, Westcare let Ms O'Brien down and consequentially let Maria down.

7. However, I am unable to definitively find that the death of Maria Liordos would have been prevented merely by her remaining at the Fox Street residential unit on 23 September 2013. She returned to Fox Street drug affected and appears to have injected further illicit substances when she went to the bathroom. It is not possible to unequivocally state that she would have been monitored/supervised such that the fatal event could have been prevented if she had simply gone to her room and been left unattended or presumed to be sleeping for the remainder of the night. Remaining at the Unit would have, however, afforded her a better opportunity than the situation she was ultimately in – in bed at Angelo's home in Kealba with "T", who was also drug affected.

8. I find that Ms Studley's response to the circumstances as conveyed to her by Ms O'Brien when she came on duty, was both supportive of Ms O'Brien and appropriate. She reported to the Westcare ICMS on-call worker and telephoned Angelo on two occasions. I agree with the submission of Mr Halse that her actions demonstrated both initiative and care on her part. I do not accept that Ms Studley's care should have extended to travelling to Angelo's home in an attempt to retrieve Maria. It was not an option open to the residential workers at the time[83] and would have constituted an unsafe work practice to have attempted to retrieve Maria either on their own or together, in the middle of the night.

9. I find that Ms Hines was aware of Maria's association with Angelo, had his personal details and never made any checks or enquiries about the suitability of Maria's association and contact with him.[84]

10. AND I further find that there was a dereliction of care by the Westcare ICMS on-call worker Ms Hines, in that she failed to exercise all due care and diligence in in her position as Maria's Case Manager but more specifically in her overarching role as the Westcare ICMS on-call worker that night. There is a dearth of evidence that she took any meaningful action to keep Maria safe on the night of 23 September 2013. Ms Hines was employed by

---

[83] I was informed that since Maria's death an outreach service similar to Streetworks (an outreach program that services the Central Business District and St Kilda); has since been implemented by Westcare. The outreach service, AH (After Hours) ROAST, enables workers in some circumstances to retrieve a child/young person and return them to their residential placement. See: Exhibit 19 – Statement of Andrea Clements, dated 22 August 2016.

[84] Ms Andrea Clements agreed with the proposition that she would have expected Maria's Case Manager to have undertaken checks/enquiries on Angelo to assess the suitability of Maria's contact with him – T @ p 767.

Westcare. I do not suggest that they condone the behaviours or inactions of their employee on the night of 23 September 2013 however, they cannot divest themselves of responsibility for ensuring that the person they placed in this position of responsibility had the necessary experience, training and attributes to hold such a position. The Westcare ICMS on-call worker was, after all, responsible for the vulnerable children and young people under her charge as well as for the supervision and support to the other workers who had varied levels of skills and experience. Unfortunately, it is not apparent on the evidence, that Westcare discharged their responsibilities in this regard.

11. With the purpose of keeping Maria, a child in the care of the State – delegated to Salvation Army Westcare, as safe as possible on the evening of 23 September 2013, I find that there was a significant loss of opportunity to intervene in the events. Apart from the proactive actions of Ms Studley no other remedial action was taken to check on Maria's welfare and/or have her returned to the Unit – no police assistance was sought either through a request for a warrant or by a direct request to Police to attend Angelo's house. I cannot predict what the outcome of police involvement may have been but as Maria's location was actually known, the information could have possibly been effectively used in an attempt to retrieve Maria.

12. AND in the absence of any evidence that Maria was provided with any and/or additional illicit substances at Angelo's house or any evidence that she ingested or injected any additional substances on her arrival at Angelo's house on the evening of 23 September 2013, I find that there is no direct causal connection between her attendance at Angelo's house in Kealba and the cause of Maria's death. The direct connection is geographical only in that she died at this house.

13. I accept and adopt the cause of death as identified by Dr Linda Iles and find that Maria Liordos died from mixed drug toxicity in circumstances that I find that her death was the unintentional consequence of her intentional use of illicit drugs.

14. AND the evidence overwhelmingly supports findings that Maria's personal, social, medical, mental health and substance misuse issues were vast and complex. Her death at the age of a mere 16 years is nevertheless, a tragedy.

RECOMMENDATIONS

Pursuant to section 72(2) of the ***Coroners Act 2008***, I make the following recommendation(s) connected with the death:

1. With the aim of preventing like circumstances where children/adolescents at high risk require urgent detection and apprehension, but the process for accessing the DHHS After-Hours Child Protection Emergency Service in fact impedes the contract care workers from seeking an urgent warrant, **I recommend that** this system be reviewed.

2. With the aim of preventing like circumstances where children/adolescents at high risk require urgent detection and apprehension but the process for accessing the DHHS After-Hours Child Protection Emergency Service in fact impedes the contract care workers from seeking an urgent warrant, **I recommend that** contracted agencies such as Westcare ICMS be provided with a dedicated direct telephone line to access DHHS After Hours Child Protection.

3. With the aim of preventing like circumstances where children/adolescents at high risk require urgent detection and apprehension, **I recommend that** the DHHS review the efficacy of the range of means of detection/apprehension tools that are available to Child Protection and its Agents such as but not necessarily limited to, the use of the Missing Persons reports to Victoria Police and the use of a "Red Flag" system on the Police LEAP[85] system as was the subject of a Recommendation made following an Inquest into the Death of Krisinda Smart.[86]

---

[85] Law Enforcement Assistance Program.

[86] COR 2008 0297.

To enable compliance with sections 72(5) and 73(1) of the *Coroners Act 2008* (Vic), I direct that the Findings will be published on the internet.

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

Ms Sue Liordos

Ms Joanna Panagoulopoulos

Shine Lawyers, on behalf of Ms Liordos

Mr Phillip Brewin, Director, Nevett Ford Lawyers, on behalf of Westcare

Ms Kym Peake, Secretary, Department of Health and Human Services

Senior Constable Sarah Kendall, Victoria Police

Professor Jeremy Oats, CCOPMM

Ms Liana Buchanan, Principal Commissioner, Commission for Children and Young People

Ms Danielle Wooltorton, Director, Office of the Deputy Secretary, Children, Families, Disability and Operations Division, Department of Health and Human Services

Ms Annabelle Mann, Legal Counsel Royal Children's Hospital

Signature:

AUDREY JAMIESON
CORONER
Date: **1 August 2017**