IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 2544

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**Coroner Darren J. Bracken**
Deceased:	**Janet Foster**
Date of birth:	21 November 1960
Date of death:	Between 6 June 2016 and 7 June 2016
Cause of death:	I(a) Mixed drug toxicity in a woman with cardiomegaly and chronic obstructive airway disease
Place of death:	Unit 1, 3 Gerbera Avenue, Norlane, Victoria

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HIS HONOUR:

BACKGROUND

1. On 7 June 2016, Ms Foster was 55 years old when she was found deceased in her own home. At the time of her death, Ms Foster was admitted as a voluntary patient to Alan David Lodge (**'the Lodge'**), a residential aged care facility operated by Barwon Health, for palliative care.[1] Ms Foster also had her own home at Unit 1/3 Gerbera Avenue Norlane. Effectively she lived in her home and at the Lodge. The Lodge was aware of Ms Foster having her own home and of her staying there regularly.

2. Ms Foster had end stage chronic obstructive pulmonary disorder, congestive cardiac failure and a medical history of alcohol and opioid dependence, osteoporosis, intravenous drug use, hepatitis C, depression, anxiety, hypertension and right leg pain with avascular necrosis of her right femur.[2]

THE CORONIAL INVESTIGATION

Coroners Act 2008

3. Ms Foster's death constituted a "*reportable death*" pursuant to section 4 of the *Coroners Act 2008* (Vic) (the **Act**) as his death occurred in Victoria, was unexpected and was not from natural causes.[3]

4. The Act requires a Coroner to investigate reportable deaths such as Ms Foster's and, if possible, to find:

   (a) The identity of the deceased;

   (b) The cause of death; and

   (c) The circumstances in which death occurred.[4]

5. For coronial purposes, "*circumstances in which death occurred*"[5] refers to the context and background to the death including the surrounding circumstances, rather than being a consideration of all circumstances which might form part of a narrative which culminated in

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1 Statement of Dr Alexander Sossin dated 9 March 2017.
2 Statement of Dr Bianca Angelica dated 2 March 2017; Statement of Dr Kenneth Lindstedt dated 22 March 2017; Statement of Dr Christopher Powers dated 3 March 2017; Statement of Dr Alexander Sossin dated 9 March 2017.
3 Coroners Act 2008 (Vic) s 4.
4 *Coroners Act 2008* (Vic) preamble and s 67.
5 *Coroners Act 2008* (Vic) s 67(1)(c).

the death. Required findings in relation to circumstances are limited to those circumstances which are sufficiently proximate to be considered relevant to the death.

6. The Coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[6] It is not the Coroner's role to determine criminal or civil liability,[7] nor to determine disciplinary matters.

7. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by making recommendations.

8. Coroners are also empowered to:

   (a) Report to the Attorney-General on a death;[8]

   (b) Comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[9] and

   (c) 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.[10]

Standard of Proof

9. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities, giving effect to the principles explained by the Chief Justice in *Briginshaw* v *Briginshaw*.[11] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[12] The principles enunciated by the Chief Justice in *Briginshaw* do not create a new standard of

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6 *Keown v Khan* [1999] 1 VR 69.
7 *Coroners Act 2008* (Vic) s 69 (1).
8 *Coroners Act 2008* (Vic) s 72(1).
9 *Coroners Act 2008* (Vic) s 67(3).
10 *Coroners Act 2008* (Vic) s 72(2).
11 (1938) 60 CLR 336, 362-363. See *Domaszewicz v State Coroner* (2004) 11 VR 237, *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152 [21]; *Anderson v Blashki* [1993] 2 VR 89, 95.
12 *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but bear in mind His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

proof; there is no such thing as a "Briginshaw Standard" or "Briginshaw Test" and use of such terms may mislead.[13]

10. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved and the finding to be based on those facts.[14] Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[15] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[16]

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

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

11. On 7 June 2016, Neville Foster identified the deceased as his sister, Janet Foster, born 21 November 1960.

12. Ms Foster's identity is not in dispute and requires no further investigation.

Cause of death, pursuant to section 67(1)(b) of the Act

13. On 10 June 2016, Dr Ajith Rathnaweera, a Medical Practitioner practising as a Registrar in Forensic Pathology at the Victorian Institute of Forensic Medicine, conducted an autopsy upon Ms Foster's body and provided a written report, dated 13 September 2016, in which he opined that Ms Foster died from *'mixed drug toxicity in a woman with cardiomegaly and chronic obstructive airway disease'*.

14. At autopsy, Dr Rathnaweera found Ms Foster had cardiomegaly (an enlarged heart), chronic obstructive airway disease, pulmonary hypertension (high blood pressure) and patchy pulmonary oedema (excess fluid in the lungs). Dr Rathnaweera commented that people with an increased heart weight are at an increased risk of sudden death, usually due to a cardiac arrhythmia (irregular heartbeat).

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13 *Qantas Airways Ltd v Gama* (2008) 167 FCR 537, [123]-[132].

14 Anderson v Blashki [1993] 2 VR 89, following Briginshaw v Briginshaw (1938) 60 CLR 336, referring to Barten v Williams (1978) 20 ACTR 10; Cuming Smith & Co Ltd v Western Farmers' Co-operative Ltd [1979] VR 129; Mahon v Air New Zealand Ltd [1984] AC 808 and Annetts v McCann (1990) 170 CLR 596.

15 *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.

16 Briginshaw v Briginshaw (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd [1979] VR 129, at p. 147; Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd (1992) 67 ALJR 170 at pp170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

15. Toxicological analysis of post mortem samples taken from Ms Foster identified the presence of free morphine at a blood concentration of approximately 0.2 mg/L, as well as codeine, diazepam, nordiazepam, temazepam, oxazepam, demethylvenlafaxine, metoclopramide and paracetamol at therapeutic concentrations.

16. Heroin is an illegal drug produced from morphine obtained from the opium poppy. Heroin and morphine are depressants of the central nervous system causing reduced rate and depth of breathing and eventually cessation of the breathing reflex. Multiple use of drugs that also depress the central nervous system, such as benzodiazepines and opioids, will increase the risk of death. There is no clearly defined safe or toxic concentration of morphine in blood, or any other tissue. Any concentration has the potential to be fatal, depending on the circumstance and the tolerance to the drug. The concentration of free morphine in deaths attributed to heroin have ranged from 0.01 to well over 1 mg/L, with a mean of about 0.2 – 0.3 mg/L.

17. I accept the cause of death nominated by Dr Rathnaweera.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

18. Ms Foster was admitted to the Lodge on 11 May 2016 and was assessed by General Practitioner Dr Alexander Sossin. He noted that Ms Foster had recently been discharged from hospital with a large dose[17] of oral opioids. Medical records from the Lodge indicate she was most recently discharged from the Transition Care Program on 10 March 2016 but do not specify the prescriptions with which she was provided on departure.[18] Dr Sossin consulted Dr Rodger Brough, a substance dependence and addiction specialist, and ordered three random urine tests for alcohol and opioids. He noted that Ms Foster was drinking alcohol daily during her stay. Dr Sossin suspected drugs diversion as all three tests came back negative for opioids. With agreement from Dr Brough, Dr Sossin ceased oral opioid analgesics and prescribed a mild dose Norspan[19] patch as a replacement for chronic pain. Ms Foster was unhappy with the change to her medication regime and constantly requested opioid analgesia to relieve her chronic pain.[20]

19. On 29 May 2016, Ms Foster was taken by ambulance to the Emergency Department at the University Hospital Geelong, Barwon Health, with a history of vomiting, loose bowel

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17 Dr Sossin recollected the dosage was 400mg/day.
18 Barwon Health Patient Care Plan Progress Notes 01/01/2016 – 10/05/2016, Coronial Brief.
19 Norspan is the proprietary form of buprenorphine, an opioid analgesic used for management of moderate to severe pain.
20 Statement of Dr Alexander Sossin dated 9 March 2017, Coronial Brief.

motions and mild abdominal pain which she later rated in severity as 10 out of 10. Ms Foster reported that she had severe pain, disclosed that her General Practitioner had reduced her regular medication and requested opiate medication. She was examined by Emergency Registrar Dr Conor Kelly who found that Ms Foster had soft mild epigastric tenderness. Dr Kelly formed the view that Ms Foster was likely in acute opiate withdrawal rather than suffering from gastroenteritis given the cessation of her regular opiates by her General Practitioner and administered an antiemetic, antacid, analgesic pain relief comprising paracetamol 1g and two doses of Endone 5mg, potassium replacement and an oral fluid replacement. Ms Foster was discharged back to the Lodge later that day.[21]

20. On 6 June 2016 at about 2.00pm Ms Foster was reviewed by Dr Sossin at the Lodge. During this review registered nurse Wendy Davies saw Ms Foster was *'verbally abusing'* Dr Sossin because he had *'seized her supply of opioids'*.[22] Dr Sossin left the Lodge and Ms Foster asked for an oxygen cylinder, which was provided to her by nursing staff.[23] At approximately 2.30pm, nursing staff were unable to locate Ms Foster and the ward clerk, Mary Sifri, informed nursing staff that she had, earlier in the day, organised a taxi for Ms Foster to take her to her home in Norlane. Nursing staff did not have any immediate concerns for Ms Foster's safety. According to Ms Davies, no particular limits were placed upon the movement of residents in and out of the Lodge and they were *'free to come and go as they like'*.[24]

21. When Ms Foster had not returned to the Lodge by 9.30pm, Ms Davies filled out a risk form. At approximately 9.50pm, Ms Davies called the After-Hours Nursing Coordinator Sharon Clearwater and advised that Ms Foster had not returned. Ms Davies unsuccessfully attempted to contact Ms Foster's brother, Neville Foster, before her shift concluded at 10.30pm.[25]

22. Around this time and pursuant to a missing patient protocol, the nurse in charge Lois Thom contacted Ms Clearwater.[26] Ms Clearwater then contacted the Lodge's On Call Director, Debbie Prestwich, to inform her of the situation.

23. On the advice of Ms Prestwich, Ms Clearwater agreed to telephone Corio Police Station and make a missing resident report on behalf of Ms Thom and the Lodge.[27]

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21 Statement of Dr Conor Kelly dated 2 March 2017, Coronial Brief.
22 Statement of Wendy Davies dated 7 June 2016, Coronial Brief.
23 Statement of Wendy Davies dated 7 June 2016, Coronial Brief.
24 Statement of Wendy Davies dated 7 June 2016, Coronial Brief.
25 Statement of Wendy Davies dated 7 June 2016, Coronial Brief; Statement of Irene Sady dated 8 December 2016, Coronial Brief; SWARH – Barwon Health – McKellar Centre Progress Notes, Coronial Brief.
26 Statement of SC Jessica Johnston dated 24 January 2017, Coronial Brief.

24. Staff at the Lodge attempted to telephone Ms Foster at 11.01pm on 6 June 2016, but there was no answer and they left a voicemail message.[28]

25. At 11.08pm Ms Clearwater telephoned the Corio Police Station and spoke to Senior Constable (SC) Jessica Johnston, the Watch-House Keeper. Ms Clearwater told SC Johnston that Ms Foster was a voluntary patient who had not returned to the Lodge after a dispute with the General Practitioner on duty at approximately 2.00pm. Ms Clearwater informed SC Johnston that Ms Foster suffered from chronic obstructive airway disease that required oxygen, suffered from drug and alcohol dependency issues and had addictions to heroin and morphine. Ms Clearwater asked to list Ms Foster as a missing person as she had not returned to the Lodge and attempts to contact her brother Mr Foster had been unsuccessful. Ms Clearwater provided SC Johnston with a description of Ms Foster and two possible addresses which Ms Foster may have retreated to, her home at Unit 1/3 Gerbera Avenue in Norlane and her brother's address in St Albans Park.

26. At approximately 11.21pm, SC Johnston contacted the Emergency Services Telecommunications Authority (**ESTA**) and requested a patrol unit go to the Lodge and speak directly with Ms Thom to take an appropriate missing person report. SC Johnston relayed Ms Foster's medical conditions, including her need for oxygen and mobility issues. She requested a Geelong unit and a Corio unit check Ms Foster's home in Norlane and Mr Foster's home in St Albans Park. SC Johnston noted that, in accordance with Victoria Police Policy, *'it is a preference that missing person reports are taken in person as opposed to over the phone*'. SC Johnston twice unsuccessfully attempted to contact Mr Foster by telephone; both phone calls diverted to voicemail.[29]

27. At approximately 11.31pm, the ESTA operator dispatched a request to Police Unit Waurn Ponds 310 to attend the Lodge to take a missing persons report. At approximately 11.33pm, the ESTA operator dispatched Police Unit Geelong 311 to attend Mr Foster's address in St Albans Park to conduct a welfare check.

28. At approximately 11.35pm, Sergeant (**S**) Gregory Taylor was the divisional nightshift patrol supervisor responsible for actively supervising and managing all patrol units across the Geelong Police Service Area as a part of which he monitored the 'jobs' dispatched by ESTA

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27 Statement of Wendy Davies dated 7 June 2016, Coronial Brief; SWARH – Barwon Health – McKellar Centre Progress Notes, Coronial Brief.

28 Phone records of Ms Foster's telephone dated 6 June 2016 and 7 June 2016; Email correspondence from Detective Sergeant Adam Forehan dated 20 November 2018.

29 Statement of Senior Constable Jessica Johnston dated 24 January 2017, Coronial Brief; Police Notes of Senior Constable Jessica Johnston dated 6 June 2016.

in relation to Ms Foster. S Taylor was aware at the time the *'job'* was dispatched in relation to Ms Foster that of the five divisional Van crews available in the Geelong police service area, two were assisting Ambulance Victoria with violent psychiatric patients. S Taylor asked the ESTA operator to standby, to hold the *'jobs'* in relation to Ms Taylor while he telephoned SC Johnston to clarify information about the *'jobs'*.[30]

29. In his statement on the coronial brief S Taylor stated that he *'formed the opinion that the matter did not require immediate police attendance'*. He considered that, based on the information available to him, it was not appropriate to take a missing persons report or commence a missing persons investigation.[31] He informed SC Johnston that she needed to contact the Lodge to *'advise that [Ms Foster's] absence [did] not meet the criteria for missing person reports to be taken as [Ms Foster] is a voluntary patient within Alan David Lodge'*.[32] S Taylor also informed SC Johnston that the staff at the Lodge would need to contact the immediate family of Ms Foster and notify them of her absence from the Lodge, and should they have further concerns in relation to her welfare, then the family should again contact police.[33]

30. At 11.37pm, SC Johnston contacted Ms Clearwater and notified her that the appropriate avenue was to inform Ms Foster's family, and for her family to report her missing if appropriate.[34] Ms Clearwater relayed this information to Ms Prestwich.[35]

31. At approximately 11.40pm, S Taylor spoke to the ESTA operator by telephone. In that conversation, he stated that the request did not meet their criteria as Ms Foster was a voluntary patient and had decided to walk out of the Lodge. He referred to the missing persons report as an *'arse covering thing'* and lamented why it is a *'police problem'*. He queried why they did *'these things'*, in reference to missing persons reports, but confirmed that it was appropriate to conduct a separate welfare check on a person who had made threats of suicide and left a hospital before being assessed under the *Mental Health Act 2014*. S Taylor directed the missing person report of Ms Foster go back to the watchhouse keeper and stated that he did not think it required the immediate attention of the police. S Taylor did not

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30 Statement of Sergeant Gregory Taylor dated 16 December 2016, Coronial Brief; ESTA Radio Communications dated 6 June 2016, Coronial Brief.
31 Statement of Sergeant Gregory Taylor dated 16 December 2016, Coronial Brief.
32 Statement of Senior Constable Jessica Johnston dated 24 January 2017, Coronial Brief; Police Notes of Senior Constable Jessica Johnston dated 6 June 2016.
33 Statement of Senior Constable Jessica Johnston dated 24 January 2017, Coronial Brief; Statement of Sergeant Gregory Taylor dated 16 December 2016, Coronial Brief; Police Notes of Senior Constable Jessica Johnston dated 6 June 2016.
34 Statement of Senior Constable Jessica Johnston dated 24 January 2017, Coronial Brief.
35 SWARH – Barwon Health – McKellar Centre Progress Notes, Coronial Brief.

raise concerns regarding the availability of police resources in the telephone call and there was no reference to Ms Foster's medical issues.[36]

32. At 11.42pm, the requested dispatch of units to attend the Lodge and attend the nominated addresses to check on Ms Foster were closed on request of S Taylor.[37]

33. At approximately 11.55pm, Ms Clearwater spoke to Mr Foster and informed him that Ms Foster had left the Lodge after having an argument with a doctor over her medication. Mr Foster was on his way home from Darwin and told Ms Clearwater that he would check Ms Foster's home in Norlane the following morning.[38]

34. At 11.57pm, Ms Clearwater contacted SC Johnston to advise that Mr Foster had recently come off a plane from Darwin and he would attend his sister's address in Norlane the following day to check on her.[39]

35. On the morning of 7 June 2016, Ms Davies returned to work and observed that Ms Foster had not returned to the Lodge. At approximately 8.40am, Ms Davies rang Corio Police Station and was told *'that the job had been received by police but was unsure of the result'*.[40] Staff at the Lodge told Ms Davies that *'police were called during the night but were told she couldn't be reported missing by anyone other than family'*.[41]

36. Victoria Police attempted to contact Ms Foster at 10.02am on 7 June 2016, but there was no response.[42]

37. At approximately 10.45am, Mr Foster received a telephone call from a Geelong Police Officer. The Police Officer told Mr Foster he had been contacted by the Lodge. The Police Officer asked Mr Foster to check on Ms Foster as they *'would have to make her a missing person if she wasn't at her home'*.[43]

38. At approximately 11.00am, Mr Foster attended Ms Foster's home. The front door was unlocked, and he found Ms Foster lying on the floor in the kitchen dining area, apparently

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36 ESTA Radio Communications dated 6 June 2016, Coronial Brief.
37 Event Chronology Event Numbers P1606039532 and P16060639544 dated 6 June 2016.
38 Statement of Neville Foster dated 7 June 2016, Coronial Brief; SWARH – Barwon Health – McKellar Centre Progress Notes, Coronial Brief.
39 Statement of Senior Constable Jessica Johnston dated 24 January 2017, Coronial Brief.
40 Statement of Wendy Davies dated 7 June 2016, Coronial Brief; SWARH – Barwon Health – McKellar Centre Progress Notes.
41 Statement of Wendy Davies dated 7 June 2016, Coronial Brief.
42 Phone records of Ms Foster's telephone dated 6 June 2016 and 7 June 2016; Email correspondence from Detective Sergeant Adam Forehan dated 20 November 2018.
43 Statement of Neville Foster dated 7 June 2016, Coronial Brief.

deceased. He immediately contacted emergency services.[44] Police and ambulance paramedics arrived shortly afterwards and confirmed Ms Foster was deceased.[45]

39. Police observed a puncture wound on Ms Foster's left arm consistent with intravenous drug use. Police also located an uncapped syringe and spoon on a dining table next to Ms Foster, as well as other drug paraphernalia and prescription medication throughout the premises. Police located a handwritten note in the bedroom in which Ms Foster raised a number of queries regarding her ability to access hospital respite or rehabilitation, her concern about being able to make her own major life decisions, her deteriorating memory and her fear that people were following her. The note did not express suicidal intent and appeared to be future focused, with Ms Foster's wishes to live close to shops and doctor and in a place with younger people.[46]

40. Ms Foster's telephone records indicate that in the period immediately prior to and at the time of leaving the Lodge, she made a number of unanswered phone calls to persons identified by Victoria Police as being users and / or dealers of drugs of dependence. Her last recorded telephone call was at 2.19pm to East Geelong Medical Centre, but no record has been retained by the Medical Centre of this contact.[47]

Family Concerns

41. Ms Foster's daughter Sheree Pettina raised concerns as to why the police had not conducted a welfare check when requested. She also queried why she had not been contacted by the Lodge, despite holding a medical power of attorney for her mother and being located approximately ten minutes from Ms Foster's home.[48]

Missing Resident Procedures

42. Irene Sady, the Acting Facility Manager at the Lodge, informed me that Alan David Lodge is a residential aged care facility with transitional care beds available. Transitional care *'relates to patients that have been acute at a hospital facility, not well enough to return home but requires some level of care before returning to their homes'*. On admission, a patient

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44 Statement of Neville Foster dated 7 June 2016, Coronial Brief.
45 Statement of Senior Constable Christopher Fehling dated 23 December 2016, Coronial Brief.
46 Statement of Leading Senior Constable Tony Sacchetta dated 9 December 2016, Coronial Brief; Statement of Detective Senior Constable Andrew Hammond dated 8 December 2016, Coronial Brief; Statement of Detective Senior Constable Naomi Bourke dated 11 December 2016, Coronial Brief.
47 Phone records of Ms Foster's telephone dated 6 June 2016 and 7 June 2016; Email correspondence from Detective Sergeant Adam Forehan dated 20 November 2018.
48 Email correspondence from Sheree Pettina dated 11 June 2016, Coronial Brief.

registration form is completed which collects details about a client including contact details and next of kin information. Each client has a specifically constructed Care Plan developed, modified and updated according to their ongoing needs and requirements. Barwon Health also has procedures, policies and instructions for missing or absconding residents. According to Ms Sady, the Lodge is *'a care facility designed to be a home for our clients, not a prison. To remove ones liberty would be against our philosophies, principles and purpose'*.[49]

Barwon Health Policy – Reporting Missing Residents

43. Barwon Health's *Procedure for Reporting Unexplained Absence or Missing Resident* specifies that, in the event of a missing resident, the nurse in charge of the shift is to be notified and is to conduct an organised and systematic search of the Lodge and the site and contact the resident's next of kin and the After-Hours Nursing Coordinator. The procedure states if the search is unsuccessful, the following people are to be contacted and informed of the steps already taken to locate the resident: the resident's next of kin, the After Hours Nursing Coordinator if after hours, security and the resident's General Practitioner, with the After Hours Nursing Coordinator to contact the Divisional Nursing Director On-Call. The procedure notes that the police are to be contacted on 000 if the resident is not found within a timeframe which is consistent with level of risk.[50] It appears that the Lodge complied with the Barwon Health procedures for reporting unexplained absence or missing residents in relation to Ms Foster.

Victoria Police – Reporting Missing Persons

44. The Victoria Police Manual (**VPM**) – Procedures and Guidelines (**Guidelines**) for Missing persons investigations sets out reporting member responsibilities for the report and management of missing persons investigation. The Guidelines are not mandatory requirements; they are provided to support the interpretation and application of the VPM Policy Rules and concomitant responsibilities. The Guidelines define a 'missing person' as *'any person reported to police whose whereabouts are unknown, and there are fears for the safety or concern for the welfare of that person, including a person from an institution'*.[51]

45. The Guidelines state that Police Members are to immediately investigate any report of a missing person, with the initial investigation to be conducted at local level. Members are responsible for completing a Missing Persons report and Risk Assessment Form for all

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[49] Statement of Irene Sady dated 8 December 2016, Coronial Brief.
[50] Barwon Health Procedure: Reporting Unexplained Absence or Missing Resident dated 16 May 2016, Coronial Brief.
[51] Victoria Police Manual – Procedures and Guidelines: Missing persons investigations, Coronial Brief.

missing persons reported to Victoria Police. It outlines the steps that may be taken by members in urgent situations where the member believes there is a serious and imminent threat to life or health of a person, including applying to access information held by a telecommunications service provider. It requires members to undertake enquiries to locate the missing person. Whilst there are specific procedures to follow for mental health patients or disability clients reported missing, Ms Foster did not fall into either of these categories as a resident of a residential aged care facility.[52]

46. There is no VPM Policy Rule or Guideline directed solely towards how police respond to a request for a welfare check. There is a Guideline that outlines the priority categories for the Police Radio Communications (for the metropolitan area only). The categories designate a time frame for Police communications to dispatch calls to a unit. They are not relevant to how members respond to jobs that are assigned to them. There is no direction regarding the priority to be given to welfare checks.

Adverse Findings Letter

47. By letter dated 18 June 2019, I wrote to the Chief Commissioner of Police (**CCP**) to advise that the Coronial Brief contained material that may support adverse findings in relation to Victoria Police response to the request to assist Ms Foster (**the Adverse Findings letter**). The letter enclosed sections of the draft coronial finding and invited the CCP to respond to the assertions therein. The Adverse Findings letter and invitation to respond was also provided to S Taylor.

48. By letter dated 19 August 2019, the CCP advised that he does not intend to file any submissions.

49. S Taylor did not respond to the Adverse Findings letter.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

50. The investigation has been unable to ascertain Ms Foster's movements after she left the Lodge or to identify when and where Ms Foster acquired the drugs that she apparently injected herself with at her home. Ms Foster does not appear to have telephoned anyone after 2.19pm on 6 June 2016 and does not appear to have responded to phone calls to her mobile from Barwon Health at 11.01pm on 6 June 2016 and from Victoria Police at 10.02am on 7 June 2016.

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[52] Victoria Police Manual – Procedures and Guidelines: Missing persons investigations, Coronial Brief.

51. Nursing staff at the Lodge appear to have taken appropriate action to escalate their concerns regarding Ms Foster being missing to senior management. Nursing staff also contacted Victoria Police to report Ms Foster as a missing person and requested a welfare check. Police declined to take a missing persons report or to conduct a *'welfare check'*. S Taylor's comments that the attempt by staff at the Lodge to report Ms Foster as a missing person were "*...an arse covering exercise*...is regrettable. His perception that Ms Foster being missing was not a "*...police problem...*", his rhetorical question asking why they did "*...these things...*", and his assertion that the request to report Ms Foster as a missing person did not meet the criteria showed a lack of knowledge of his role and of the criteria for taking a missing persons report.

52. Regrettably, the Lodge only attempted to contact Ms Foster's next of kin, Neville Foster, who was interstate and initially uncontactable, and did not attempt to contact her daughter Sheree Pettina who was located close to Ms Foster's home and had the capacity to check Ms Foster's home address.

53. I am not able to find with any degree of certainty that Ms Foster's death would have been prevented if Ms Pettina had been alerted to Ms Foster's absence from the Lodge. However, it may be warranted for Barwon Health to review their policies and procedures with a view to addressing the concerns raised by Ms Pettina and to consider whether it may be appropriate to contact other family members where the next of kin is uncontactable, interstate or otherwise not immediately available.

54. SC Johnston appears to have acted appropriately in response to the report made by Ms Clearwater and her expressed concerns regarding Ms Foster's welfare. She contacted ESTA to request units be dispatched to the Lodge and to the nominated addresses and provided extensive information on Ms Foster's description, the circumstances surrounding her absence from the Lodge and her medical conditions. At the time of SC Johnston's request to ESTA, it appears that only two of the five patrol units were unavailable due to attending other urgent jobs. However, SC Johnston's request was countermanded by S Taylor who formed the view, based on limited information, that Ms Foster's absence from the Lodge did not meet the criteria for lodgement of a missing persons report. I am unable to find with any degree of certainty that the outcome would have altered, and Ms Foster's death been prevented or avoided, even if units had attended the Lodge to take a missing persons report and attended Ms Foster's home as initially instructed.

RECOMMENDATIONS

55. Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendations:

1. In the interests of public health and safety and preventing like deaths, **I recommend** the Chief Commissioner of Police consider reviewing the processes, policies and procedures for conducting welfare checks, with particular reference to the urgency with which welfare checks are conducted and the application of existing VPM Procedures and Guidelines.

FINDINGS AND CONCLUSION

56. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the Act:

    (a) the identity of the deceased was Janet Foster, born 21 November 1960;

    (b) the death occurred between 6 June 2016 and 7 June 2016 at Unit 1, 3 Gerbera Avenue, Norlane, Victoria, from mixed drug toxicity in a woman with cardiomegaly and chronic obstructive airway disease; and

    (c) the death occurred in the circumstances described in paragraphs 18 – 40 above.

57. There is no evidence to indicate that Ms Foster intended to end her own life. I find that her death was the unintended consequence of her intentional use of illicit drugs.

58. I convey my sincerest sympathy to Ms Foster's family.

59. Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this finding be published on the internet.

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

    (a) Ms Sheree Pettina, senior next of kin;

    (b) Mrs Lorraine Judd, Barwon Health;

    (c) Sergeant Taylor, Victoria Police;

    (d) Mr Jared Clow, on behalf of the Chief Commissioner of Police;

    (e) Detective Sergeant Adam Forehan, Victoria Police, Coroner's Investigator.

Signature:

DARREN J. BRACKEN

CORONER

Date: 5 FEBRUARY 2020