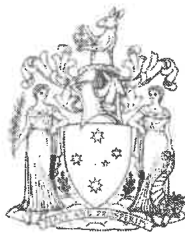

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 6534

FINDING INTO DEATH WITH INQUEST

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

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	Kim Melissa Hall
Delivered on:	19 March 2021
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	30 October 2020
Assisting the Coroner:	Senior Constable James Kett Police Coronial Support Unit

INTRODUCTION

1. Kim Melissa Hall was a 36-year-old woman who lived alone in a Ministry of Housing unit at 33B Curacoa Drive in Hastings at the time of her death.

2. Ms Hall enjoyed a happy childhood. Although her mother, June Hall, died when she was one year old, her father, Douglas Hall, married Virginia Hall who raised Ms Hall as her own child. Ms Hall was loved and supported by a blended family that included her father, step-mother, biological brother, and step-sister and step-brother.[1]

3. Ms Hall's increased alcohol consumption and dependence was triggered by the untimely death of her brother, Benjamin, at the age of 22 years in 2001. She was significantly affected by his death and the tragic event led to an escalation in her drinking and consumption of prescription and non-prescription medication, both of which would later play a catastrophic and heartbreaking part in her life and forever change the lives of her family.[2]

4. At the time of her death, Ms Hall was in a relationship with Gavin Andrews, which had commenced in 2011.[3] According to police records, there had been a number of family violence incidents between the couple, both of whom had been recorded as the respondent on at least one occasion. A Family Violence Intervention Order was made on 7 October 2015, which prevented Mr Andrews from communicating or approaching Ms Hall, amongst other things. This order was active at the time of Ms Hall's death.

5. Ms Hall died on 26 or 27 December 2015 from the combined effects of baclofen toxicity and blunt head injury.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. Ms Hall's death was reported to the Coroner as it was violent, unnatural and appeared to have resulted, directly or indirectly, from an accident or injury, and so fell within the definition of a reportable death in the *Coroners Act 2008*.

7. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[4] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the

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[1] Coronial brief compiled by Detective Sergeant Robert Catania (**CB**), 77.
[2] CB, 78.
[3] CB, 92.
[4] Section 89(4) *Coroners Act 2008* (Vic).

identity of the deceased person, the cause of death and the circumstances in which death occurred.[5]

8. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[6] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[7] or to determine disciplinary matters.

9. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

10. For coronial purposes, the phrase "*circumstances in which death occurred*,"[8] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

11. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the Court's "*prevention*" role.

12. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;[9]

    (b) to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[10] and

    (c) to make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including recommendations relating to public health or safety or the administration of justice.[11] These powers are the vehicles by which the prevention role may be advanced.

[5] Preamble and section 67 *Coroners Act 2008* (Vic).
[6] *Keown v Khan* (1999) 1 VR 69.
[7] Section 69(1) *Coroners Act 2008* (Vic).
[8] Section 67(1)(c) *Coroners Act 2008* (Vic).
[9] Section 72(1) *Coroners Act 2008* (Vic).
[10] Section 67(3) *Coroners Act 2008* (Vic).
[11] Section 72(2) *Coroners Act 2008* (Vic).

13. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[12] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw.*[13]

14. Section 52(1) of the Act states a coroner may hold an inquest into any death that the coroner is investigating. Section 52(2) states a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria and (a) the coroner suspects the death was the result of homicide.

15. Some of the circumstances of Ms Hall's death, such as the evidence at the scene of her death were equivocal, and she had a significant number of unexplained injuries identified at the autopsy. As there were suspicious aspects to her death of a possible homicide, I formed the belief an inquest was mandatory. At inquest I heard direct evidence from the investigating police officer, Detective Sergeant Robert Catania, and the forensic pathologist, Dr Linda Iles.

16. This finding reflects my conclusions drawing on a combination of evidence, both from the statements on the coronial brief, as well as the oral evidence at inquest.

17. Three issues were considered during the inquest: Firstly, the examination by police of the scene of Ms Halls' death, secondly, the prescription of baclofen and the formulation of the cause of death which included injuries that may have been caused by trauma, and thirdly, whether Ms Hall may have taken her own life and whether the evidence is sufficient to support that finding.

IDENTITY OF THE DECEASED PURSUANT TO SECTION 67(1)(a) OF THE ACT

18. On 30 December 2015, Kim Melissa Hall, born 10 December 1979, was identified via dental record comparison.

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

BACKGROUND

20. In approximately 2005, Ms Hall's alcohol dependence culminated in a family intervention. This event led to Ms Hall undergoing treatment at Mormont Recovery and Support, Wonthaggi, for approximately 12 months. According to her father, Douglas Hall, she did

[12] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[13] (1938) 60 CLR 336.

"really well" at the facility. Sadly, when Ms Hall returned home, she resumed drinking significant amounts of alcohol.[14]

21. In 2009, Ms Hall was again treated for alcohol dependence, this time at Odyssey House, Lower Plenty. Mr Hall stated that during her 15-month stay, Ms Hall did well and resumed her enthusiasm for performance art. After leaving Odyssey House, she again resumed drinking but returned to the treatment facility again for approximately six months.[15]

22. Despite significant periods spent in treatment facilities, Ms Hall continued to drink alcohol to excess. She subsequently became a patient of Dr Andrew Taylor at Frankston Health Care. Dr Taylor stated that Ms Hall's main problem was advanced alcohol liver disease,[16] complicated by hepatitis C infection, believed consequent on other drug use.[17]

23. In June and September 2015, Ms Hall was hospitalised after drinking methylated spirits and consuming drugs.[18]

24. In September 2015, Dr Taylor began prescribing baclofen to Ms Hall to reduce her alcohol cravings and diazepam to help with withdrawal symptoms.[19] These drugs were in addition to citalopram for depression.[20] He introduced baclofen at a low dosage, which was slowly titrated up to a maximum of 75 mg per day. Dr Taylor stated that the medication was proving to be effective as Ms Hall was able to achieve prolonged periods of abstinence.[21] Dr Taylor explained:

> *Baclofen is generally considered a safe drug in the treatment of alcoholism and other addictions. Patients are routinely warned not to exceed prescribed doses or medications. Like any drug or product it can be misused and clearly can prove lethal.*[22]

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[14] CB, 78.
[15] CB, 79.
[16] CB, 67. At autopsy Dr Linda Iles, forensic pathologist, did not find any evidence of cirrhosis in the liver.
[17] CB, 197.
[18] CB, 80, 197.
[19] CB, 198.
[20] CB, 349.
[21] CB, 198.
[22] CB, 198.

25. Dr Taylor last saw Ms Hall on 30 November 2015, at which time he noted her mood was elevated and he became concerned that she was using or intending to use methamphetamines.[23]

26. Ms Hall last filled a prescription for baclofen on 15 December 2015 (last prescribed on 25 November 2015).[24]

27. According to Mr Hall, following her last hospital admission, Ms Hall stopped drinking alcohol and found a job working at Harvey Norman. Mr Hall fondly recalled that his daughter was proud of the number of sober days she achieved – initially it began with five days, which then became a 100-day period. Her family was also very proud of her efforts.[25]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO SECTION 67(1)(c) OF THE ACT

28. Despite a current Family Violence Intervention Order prohibiting Mr Andrews from approaching or communicating with Ms Hall, the couple spent the period from 23 to 25 December 2015 at Mr Andrews's home in Dandenong.[26]

29. At approximately 3.30pm on 25 December 2015, Ms Hall left Mr Andrews's house and returned home in a taxi. Mr Andrews stated that at this time, Ms Hall was upset[27] and took two of his quetiapine tablets, intending to take them later that night to help her sleep.[28] Quetiapine is an anti-psychotic drug used to treat schizophrenia, bi-polar disorder, or depression.

30. The taxi driver stated that Ms Hall was quiet during the drive to Hastings. When she exited the vehicle, the driver observed Ms Hall walk slowly up the driveway to her home.[29]

31. At 6.50am the next morning, one of Ms Hall's colleagues arrived to collect her for work. He stated that it took over 10 minutes to rouse Ms Hall. When she opened the door, it was evident that she was not ready to work. She appeared confused and disorganised, had difficulty

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[23] CB, 199.
[24] CB, 250, 349.
[25] CB, 80-81.
[26] CB, 93.
[27] CB, 93.
[28] CB, 99.
[29] CB, 103-104.

turning off her television, and was not wearing her uniform. Once she got into her colleague's car, she announced she could not go to work.[30]

32. At approximately 11.20am, Ms Hall called her manager at Harvey Norman to let her know she was feeling ill but would attend work the next day; however, she was told not to come in. Ms Hall sobbed and apologised during this call.[31]

33. Ms Hall's conversation with her manager was overheard by her neighbour, Brendan Niechcial while he was in his backyard. He stated that he heard Ms Hall apologising and she sounded upset. He called out to her to see if she was okay. Ms Hall thereafter approached Mr Niechcial and explained to him she had *"stuffed up with work"*, that she was supposed to work that day but did not go in. Mr Niechcial recalled that Ms Hall appeared disorientated and affected by something. Her speech was slow and slightly slurred.[32]

34. Following their conversation, Ms Niechcial drove Ms Hall into Hastings as he was going to the laundromat in Victoria Street. Ms Hall headed toward Coles and Mr Niechcial went into the laundromat. A short time later, Ms Hall returned to the laundromat in the mistaken belief she had left her mobile phone in the car, but it was actually in her hand. Mr Niechcial stated that she still appeared disorientated at this point in time, possibly worse than before.[33]

35. At approximately 11.48am, Ms Hall went into Liquorland and purchased two bottles of white wine.[34] She thereafter went into Coles and bought some other groceries. Closed-circuit television **(CCTV)** within Coles captured Ms Hall forgetting her shopping bag at the register, which was returned to her by a staff member, and then dropping several grocery bags at the supermarket entrance.[35]

36. At 12.04pm, Ms Hall boarded the 782 bus service from King Street. At 12.10pm, she disembarked the bus at Wallaroo Place, Hastings, and walked home.[36]

37. Along the way, CCTV captured Ms Hall dropping one of her grocery bags on the footpath and then the road.[37]

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[30] CB, 133-134.
[31] CB, 145.
[32] CB, 167.
[33] CB, 167-168.
[34] CB, 188, 247.
[35] CB, 247.
[36] CB, 247.
[37] CB, 246-248.

38. Between 2.00pm and 3.00pm, one of Ms Hall's neighbours observed her on the footpath outside her unit. She described Ms Hall as looking lost and dazed.[38]

39. There are no further confirmed sightings of Ms Hall after this time.[39]

40. At 10.25pm that night, Mr Andrews telephoned Ms Hall and they engaged in a short conversation. Mr Andrews stated that at this time Ms Hall sounded delirious and tired; she did not sound right, was not making any sense, and her speech was slurred. He believed that she was affected by something and possibly intoxicated.[40] Ms Hall did not answer any further calls from Mr Andrews.

41. At approximately 9.38pm on 27 December 2015, Mr Andrews made an anonymous call to the Emergency Services and Telecommunications Authority (also known as 000) to request a welfare check on Ms Hall. He stated she was a recovering alcoholic and he believed that she may have relapsed.[41]

42. Victoria Police members arrived at Ms Hall's unit at approximately 10.00pm. After Ms Hall did not respond to their repeated knocking, the members opened the front sliding window at which time they smelled gas coming from within the unit. They discovered the side gate was unlocked and the rear door was closed but unlocked. The members turned off the gas at the meter and requested assistance from the Country Fire Association (**CFA**).[42]

43. At 10.11pm, several CFA units attended. Lieutenant Craig Densley entered the unit and discovered two gas burners on the stove switched on. He also observed some clothing pushed up against the bottom of the front door. Upon entering the bathroom, he found Ms Hall deceased on the floor. The tap at the bathroom sink was running.[43]

44. Police members subsequently observed Ms Hall lying face down and naked from the waist up. The furniture and items in the unit were in disarray. There was a considerable amount of blood on her body and around the bathroom.[44]

45. Due to the circumstances in which Ms Hall was found, the investigation was referred to the Homicide Squad.

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[38] CB, 173.
[39] CB, 251.
[40] CB, 98-99.
[41] CB, 242.
[42] CB, 202, 206.
[43] CB, 178.
[44] CB, 203, 211, 215, 243.

Victoria Police Homicide Squad investigation

46. A team comprising of Homicide Squad investigators and examiners from the Major Crime Scene Unit examined Ms Hall's unit.

47. There was no evidence of a disturbance or forced entry into the property and no evidence of a struggle or theft.[45] Her mobile phone,[46] $105 in cash,[47] and a digital camera[48] were found in the unit.

48. Investigators found blood in Ms Hall's bedroom but concluded that it was unrelated to the events surrounding her death as there was no blood trail between the bedroom and the bathroom.[49]

49. Forensic examination of trace DNA on the gas stove burner knobs detected Ms Hall's DNA.[50]

50. Investigators also found an empty wine bottle underneath the couch in the lounge-room.[51] A blister pack of medication, brand name of Apo-Citalopram, was found next to the front door.[52] There was no evidence of medication containing baclofen, morphine, or codeine within the unit.[53]

51. Investigators also conducted a residential canvass in the immediate area surrounding Ms Hall's unit.

52. Investigators have not identified any evidence to support the notion that another party was involved in the circumstances leading to Ms Hall's death.[54]

MEDICAL CAUSE OF DEATH PURSUANT TO SECTION 67(1)(b) OF THE ACT

53. On 28 December 2015, Dr Linda Iles, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination and provided a written report, dated 1 April 2016 In that report, Dr Iles concluded that a reasonable cause of death was *"1(a) The combined effects of baclofen toxicity and blunt head injury"*.

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[45] CB, 226, 251.
[46] CB, 5.
[47] CB, 6.
[48] CB, 243.
[49] CB, 6.
[50] CB, 232.
[51] CB, 5.
[52] CB, 47.
[53] CB, 251.
[54] CB, 252.

54. Dr Iles noted that parts of Ms Hall's upper body and the soles of her feet were stained with blood.

55. The examination revealed evidence of multiple applications of blunt force trauma to Ms Hall's face along with a single laceration to the scalp. These were associated with scalp bruising and intracranial injuries, which included subdural haemorrhage and traumatic left temporal lobe haemorrhage along with features of multifocal traumatic axonal injury.

56. There were also multiple bruises and abrasions over the entirety of Ms Hall's body, some of which appeared to be of varying ages. The majority of these were located about the extremities. Some bruising to the trunk and back was noted. The latter injuries were not associated with fracture or intrathoracic or intra-abdominal injury.

57. Dr Iles noted that there were features of the scalp bruises and intracranial injuries that indicated a period of survival of at least a small number of hours following blunt head injuries being sustained. The presence of a raised vitreous creatinine in keeping with dehydration is supportive of this conclusion. Likewise, post mortem CRP (an acute inflammatory marker) was also raised. This may reflect the development of bronchopneumonia prior to death. This may also reflect an inflammatory response to blunt soft tissue injury.

58. Dr Iles observed that while Ms Hall's injuries, particularly about her head and neck, were multiple and not insignificant, it was possible that this constellation of injuries had been sustained during multiple falls in the setting of drug and/or alcohol intoxication.

59. With respect to Ms Hall's injuries, in evidence Dr Iles noted the laceration to the right occipital scalp. She described there having been an aggregation of blunt force trauma to that area "*that could be occasioned by hitting ... a firm ... flat surface.*"[55] The most significant injury was the laceration to the under surface of Ms Hall's chin resulting in teeth injury to her mouth. Dr Iles was of the opinion this was caused by a blunt force trauma to the under surface of her chin, "*... it could occur as a result of a fall ...*".[56] The bruising around Ms Hall's eyes was the result of either a direct blow to the peri-orbital, or scalp bruising, which can track downwards over time.[57]

60. Dr Iles' opinion was that it was a combination of injuries that resulted in Ms Hall's death. There was traumatic external injury in the brain, some haemorrhage around the brain, and

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[55] Transcript (T), 68.
[56] T, 69.
[57] T, 70-71.

lacerated injuries. All of these injuries compounded together to produce a decreased conscious state, however not just one of the injuries was fatal. Dr Iles was able to state that Ms Hall did not have a fatal or traumatic brain injury and in isolation, the brain findings were survivable.[58] Findings at autopsy, such as active responses in her brain, indicated Ms Hall did not die immediately following blunt force trauma.[59]

61. Dr Iles was not able to give an age to Ms Hall's respective injuries, nor was she able to state what age her different coloured bruises were. She stated, "*I believe Kim's death is multifactorial, in terms of blunt head trauma and baclofen toxicity ... it's a combination of those elements, not one in particular thing and certainly not one.*"[60]

62. There were no definite findings at autopsy to indicate whether Ms Hall had a seizure, and that is generally so in all cases. Dr Iles stated that in the absence of baclofen it was possible that a seizure related to her head injuries could have caused her death. She also agreed that a firm head strike could have triggered a seizure.[61]

63. Toxicological analysis identified the presence of baclofen, citalopram,[62] quetiapine,[63] morphine,[64] codeine,[65] and nordiazepam, oxazepam, and temazepam.[66]

64. The amount of baclofen in the postmortem toxicological analysis was 4.8 mg/L. Concentrations over 1.0 mg/L have been associated with toxicity.

65. Dr Iles commented that this elevated concentration is capable of causing death in isolation. She explained that baclofen is an agent traditionally used to treat muscle spasm but is also used as a treatment for chronic alcoholism. Baclofen overdose can manifest as encephalopathy, seizures, respiratory depression, somnolence and coma as well as cardiac conduction abnormalities and hyper-reflexia. In evidence Dr Isles was unable to say, in the absence of any injuries, whether the level of baclofen alone was sufficient to cause Ms Hall's death. She explained, "*there's no one level that I can say would definitely cause death in*

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[58] T, 76.
[59] T, 77.
[60] T, 72-3.
[61] T, 77.
[62] Citalopram or escitalopram are selective serotonin inhibitors with antidepressant activity.
[63] Quetiapine is an antipsychotic drug used in the treatment of schizophrenia.
[64] Occasionally, small amounts of morphine are associated with codeine use.
[65] Codeine is a narcotic analgesic related closely to morphine but having approximately one-tenth the activity if morphine as an analgesic and possessing antitussive activity.
[66] Diazepam is a sedative/hypnotic drug of the benzodiazepines class. Metabolites of diazepam include nordiazepam, temazepam, and oxazepam.

isolation ... it's capable, but whether or not that is actually the case for Kim ... I can't know that for sure."[67]

66. In her evidence, Dr Iles explained that encephalopathy could present as delirium, such as confusion and slurred speech, or confusion and agitation. Dr Iles was of the view Ms Hall's injuries "*may be accounted for by the effects of baclofen,*"[68] but she could not definitively say that was the cause of her blunt force injury.

67. Dr Iles also commented that whilst morphine and codeine were not detected in blood, morphine and codeine were present in urine at a ratio that is seen following heroin use. She noted that it is possible that some of Ms Hall's injuries may have been sustained whilst under the influence of morphine/heroin and baclofen a number of hours prior to eventual death. However, the lack of morphine or codeine in her blood toxicology results means these drugs were not operative factors at the time of her death.[69]

68. In summary, Dr Iles stated Ms Hall had evidence of significant blunt force trauma to the head and face. Based on autopsy findings alone, it was not possible to exclude inflicted injury. However, the presence of morphine and codeine in urine and the concentration of baclofen in blood may account for at least some of these injuries in the setting of multiple falls and possible seizure activity whilst intoxicated.[70] Although Dr Isles was aware there was no alcohol in Ms Hall's toxicology results, she stated she included "*whilst intoxicated*" as she could not exclude the possibility that alcohol had been involved earlier, because of the time period and the possibility of metabolisation. It could also include alcohol and/or drug intoxication.

69. In answer to a question from Ms Hall's family whether Ms Hall could have had a tolerance for baclofen, Dr Iles stated it was unlikely because the toxicology results showed a "*... really large dose ... this concentration in the blood is very, very dangerous.*"[71] Dr Iles described it as, "*... at least ten-fold what I'd normally see and I don't believe that tolerance, or habituation, would account for that ... I do believe that this concentration is significant and would have significantly affected Kim's behaviour and in terms of being confused and ...*

[67] T, 80-81.
[68] T, 58.
[69] T, 62.
[70] CB, 74.
[71] T, 81.

potentially having seizure activity and all the other things that are described. So it ... is one potential explanation."[72]

70. At the inquest, Dr Iles gave evidence that Ms Hall had mild or specific chronic hepatitis, but she did not have an alcohol liver disease such as cirrhosis. She explained it depends on the genetic profile whether people who consume large amounts of alcohol will develop features of alcoholic deficits.[73]

71. I accept Dr Iles's opinion as to cause of death.

FAMILY CONCERNS

72. On 21 July 2017, Ms Hall's family sent an email to the Court that outlined their concerns with the police investigation into her death. Their concerns can be summarised as follows:

    (a) there was a lack of evidence of Ms Hall's drug and alcohol use when they attended Ms Hall's unit;

    (b) Ms Hall's injuries appear to have been caused by another person;

    (c) police investigators did not properly examine the scene;

    (d) some of the witnesses were unreliable; and

    (e) they do not believe Ms Hall intended to take her own life.

73. Detective Sergeant Rob Catania, Coroner's Investigator, gave evidence about the investigation at the inquest. He stated he has been unable to establish whether Ms Hall was the victim of an assault or if she died as a result of multiple falls in the setting of baclofen and other drugs. Investigators were also unable to rule out that Ms Hall took her own life.[74]

74. Detective Sergeant Catania stated that some aspects of the scene were unusual, for example in the bedroom drawers were misaligned and the mattress was not sitting correctly on the bed. However, Ms Hall's mobile phone was located in her unit, as was her wallet with identification and cash, as well as a digital camera still in its box in the wardrobe.[75]

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[72] T, 82.
[73] T, 66.
[74] CB, 251-252.
[75] T, 23.

75. In respect of forensic analysis, although there was blood on the mattress, there was no blood leading to the bathroom where Ms Hall was located. Given the amount of blood on the mattress, Detective Sergeant Catania stated he would have expected there would be a passage of blood to the bathroom. This led investigators to believe it was unrelated to Ms Hall's death.[76]

76. Further inquiries, following Dr Iles's examination, revealed the state of the unit was consistent with its usual state of disarray rather than reflecting third party involvement.[77]

77. When police entered Ms Hall's unit the gas burners were on. DNA taken from the gas knobs located only a single source profile which was attributed to Ms Hall.[78]

78. With respect to Ms Hall's head injuries, Detective Sergeant Catania stated it was very hard to "*pinpoint an area where Kim may have collided with an area of wall ... or objects in that room.*"[79] There was no evidence of a forced entry to the unit or weapons located. When asked about the likely source or cause of Ms Hall's head injuries, Detective Sergeant Catania commented that given Ms Hall's levels of baclofen, the injuries "*... could have been caused in a setting of seizures ... or collapse ...*".[80]

79. Detective Sergeant Catania noted that due to the state of the scene, medications and prescriptions were not seized, as "*it wasn't the focus of attention at the time that the scene was examined.*" Further, there was no evidence at the scene consistent with heroin use.[81]

80. Ms Hall's family asked about the two bottles of wine Ms Hall was seen carrying on the CCTV footage following her shopping trip to the supermarket. Detective Sergeant Catania indicated that he could not say with certainty what had happened to the bottles, there was only one bottle located at Ms Hall's unit. The CCTV footage showing Ms Hall with the two bottles was obtained only after the scene had been examined.[82]

81. Detective Sergeant Catania indicated that Gavin Andrews had been a person of interest in Ms Hall's death. He had interrogated Mr Andrews' phone records after Ms Hall left his premises on 25 December 2015. He stated there was no evidence that Mr Andrews's phone had been in the vicinity of Ms Hall's address in Hastings over the relevant period between

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[76] T, 24.
[77] T, 26.
[78] T, 28.
[79] T, 29.
[80] T, 29.
[81] T, 32.
[82] T, 84-85.

25 and 27 December 2015. Mr Andrews was not formally interviewed by police concerning Ms Hall's death as they were satisfied about his movements around the time of Ms Hall's death. He made the anonymous call to 000 seeking a welfare check for Ms Hall and Detective Sergeant Catania understood that was because of the current intervention order that prohibited contact between himself and Ms Hall. Mr Andrews had also texted Sarah Doddington and another friend that he was going to call police and ask them to check on Ms Hall's welfare. A neighbour at 33C Curacoa Drive, Barry Carlstrom, had made a statement about an incident of violence he witnessed between Ms Hall and Mr Andrews approximately 12 months prior to Ms Hall's death, on 27 January 2014, which police attended and his statement is consistent with the police report of a family violence incident.

82. Detective Sergeant Catania was ultimately unable to say either way whether Ms Hall may or may not have contributed to her own death. He was however able to confirm that he had "*no evidence of third-party involvement in relation to her death.*"[83]

83. The circumstances in which Ms Hall was found were shocking to say the least. Upon first view of the written description and the photographs of the scene of her death, it appears that her injuries were the result of a vicious assault. I do note that Dr Iles was unable to exclude inflicted injury. However, I am satisfied that the homicide investigation was reasonable and that it did not elicit any evidence of another person being involved in Ms Hall's death. I am therefore satisfied to the coronial standard that Ms Hall's injuries were sustained in a series of falls in the context of baclofen overdose.

84. I am not satisfied that the evidence points to Ms Hall taking her own life.

BACLOFEN TOXICITY

85. I note that in her report, Dr Iles indicated that the presence of morphine and codeine in urine and the concentration of baclofen in Ms Hall's blood may account for at least some of these injuries in the setting of multiple falls and possible seizure activity whilst intoxicated.

86. For this reason, Ms Hall's death was referred to the Coroners Prevention Unit (**CPU**) for advice regarding baclofen, generally and in relation to Ms Hall's prescription.

87. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience

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[83] T, 44.

to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised. The 'general' arm of the CPU provides non-clinical advice for cases such as deaths from drug overdoses or motor vehicle accidents.

Baclofen generally

88. The CPU explained that baclofen is a synthetic form of gamma-aminobutyric acid **(GABA)**, a major neurotransmitter in the human central nervous system. Baclofen binds to a class of GABA receptors called the GABA-B receptors, which inhibit neurotransmitter release in the central nervous system.[84] Baclofen is usually prescribed in tablet form (the available tablet strengths are 10mg and 25mg baclofen) and taken orally.

Indicated (approved) uses

89. The Therapeutic Goods Administration **(TGA)** has approved baclofen in tablet form for the following indications:

> *Suppression of voluntary muscle spasm in: Multiple sclerosis; Spinal lesions of traumatic, infectious, degenerative, neoplastic and unknown origin, causing skeletal hypertonus and spastic dyssynergic bladder dysfunction.*[85]

90. Baclofen is also administered, albeit less commonly, in solution form as an intrathecal injection[86] for the following TGA-approved indications:

> *[...] patients with severe chronic spasticity of spinal origin (associated with injury, multiple sclerosis, or other spinal cord diseases) or of cerebral origin who are unresponsive to orally administered antispastics (including oral baclofen) and/or who experience unacceptable side effects at effective oral doses.*[87]

91. The exact mechanism of action for baclofen as an antispastic agent is not fully understood, however researchers hypothesise that it probably works because of its neurotransmitter

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[84] For more specific information on the function of GABA-B receptors see SJ Enna, "The GABA Receptors", in *The Receptors: The GABA Receptors*, Edited by Enna and Möhler, 3rd edition, Totowa, New Jersey: Humana Press, 2007, pp.10-12.

[85] See for example Therapeutic Goods Administration, Department of Health, *Summary for ARTG Entry: 77577 APO-BACLOFEN baclofen 10mg tablet bottle*, 16 July 2019, p1. Note that a muscle spasm is by definition an involuntary muscle contraction. The "voluntary muscle spasm" here refers to involuntary spasms of muscles over which humans usually have voluntary control, such as the skeletal muscles.

[86] An intrathecal injection is an injection into the space under the arachnoid membrane of the spinal cord; this space contains the cerebrospinal fluid.

[87] See for example Therapeutic Goods Administration, Department of Health, *Summary for ARTG Entry: 53835 LIORESAL intrathecal baclofen 10mg/20mL injection ampoule*, 3 July 2019, p1.

inhibition effect. Specifically, spasticity is an involuntary activation of muscles,[88] and the baclofen may act via GABA-B receptor stimulation to suppress the release of the neurotransmitters that in turn elicit this involuntary activation.[89] For this reason, baclofen is often referred to as a muscle relaxant.

Off-label prescribing

92. In addition to its TGA-approved uses, baclofen – like all drugs – can be prescribed for a range of other therapeutic purposes. Prescribing for non TGA-approved indications in Australia is known colloquially as off-label prescribing and is not necessarily poor clinical practice. As previously noted in an Australian Prescriber review, the fact that the TGA has not approved a drug for a particular indication does not mean the TGA has rejected the indication:

> *There is no legal impediment to prescribing off label, however the onus is on the prescriber to defend their prescription for an indication that is not listed in the product information. If, in the opinion of the prescriber, the off-label prescription can be supported by reasonable quality evidence, for example the indication is identified in the Australian Medicines Handbook, the prescriber should proceed if this in the patient's best interests.*[90]

93. A major off-label prescribing purpose for baclofen, is to treat alcohol dependence. While the Australian Medicines Handbook and the TGA-approved baclofen tablet Product Information do not approve the use of baclofen to treat alcohol dependence,[91] neither do they state this use is contraindicated. However, there is a warning in the Product Information that baclofen taken in combination with alcohol increases the risk of respiratory depression and sedation, and therefore it should be used with caution where patients have a history of alcoholism.

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[88] Ganesh Bavikatte and Tarek Gaber, "Approach to spasticity in general practice", *British Journal of Medical Practitioners*, vol 2, no 3, September 2009, p29

[89] David E Karol, et al., "A case of delirium, motor disturbances, and autonomic dysfunction due to baclofen and tizanidine withdrawal: a review of the literature", *General Hospital Psychiatry*, vol 33, no 1, January-February 2011, p.84.e2; RD Penn, "Intrathecal Drugs for Spasticity", in *Textbook of Stereotactic and Functional Neurosurgery*, Edited by Lozano, Gildenberg and Tasker, 2nd edition, vol 2 of 2, New York: Springer, 2009, p.1973; Kelly W Shirley, et al., "Intrathecal Baclofen Overdose and Withdrawal", *Pediatric Emergency Care*, vol 22, no 4, April 2006, p.258; A Dario, et al., "Relationship between intrathecal baclofen and the central nervous system", *Acta Neurochirurgica Supplementum*, vol 97, no 1, 2007, p.462.

[90] Richard Day, "Off-label prescribing", *Australian Prescriber*, vol 36, 2 December 2013.

[91] "Baclofen", *Australian Medicines Handbook*, July 2019; Apotex Pty Ltd, "APO-Baclofen Product Information", revised 16 July 2019, p3.

94. Regarding this scientific evidence, the CPU confirmed that there is an emerging (and substantial) body of literature about baclofen as an effective treatment for alcohol dependence, though its mechanism of action in this respect is not well understood.[92]

Contraindications and cautions in prescribing baclofen

95. The Australian Medicines Handbook includes a general precaution that baclofen prescribing carries a risk of aggravating psychiatric disorders.[93] The precaution regarding mental illness in the TGA-approved Product Information for APO-Baclofen (a generic brand of baclofen tablet) is more specific and states the following:

> *Baclofen should be used with caution in patients who suffer from spasticity together with psychotic disorders, schizophrenia, depressive or manic disorders or confusional states. These patients should be kept under careful surveillance, because treatment with baclofen may exacerbate these other conditions.*[94]

96. In addition, the TGA-approved Product Information for APO-Baclofen lists the following interactions with other medications:

    (a) in patients with Parkinson's disease receiving treatment with baclofen and levodopa (alone or in combination with the DOPA decarboxylase inhibitor, carbidopa), there have been reports of mental confusion, hallucinations, headaches, nausea and agitation. Worsening of the symptoms of Parkinsonism has also been reported. Hence, caution should be exercised during concomitant administration of baclofen and levodopa/carbidopa;

    (b) increased sedation and respiratory depression may occur when baclofen is taken concomitantly with other drugs acting on the central nervous system, including other muscle relaxants (such as tizanidine), with synthetic opiates or with alcohol. The risk of respiratory depression is also increased. In addition, hypotension has been reported with concomitant use of morphine and intrathecal baclofen. Careful monitoring of respiratory and cardiovascular functions is essential, especially in patients with cardiopulmonary disease and respiratory muscle weakness;

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[92] See for example Giovanni Addolorato and Lorenzo Leggio, "Safety and Efficacy of Baclofen in the Treatment of Alcohol-Dependent Patients", *Current Pharmaceutical Design*, vol 16, no 19, June 2010, p.2113; GM Dore et al, "Clinical experience with baclofen in the management of alcohol-dependent patients with psychiatric comorbidity", *Alcohol and Alcoholism*, vol 46, no 6, 2011, pp.714-720; Renaud de Beaurepaire, "Suppression of alcohol dependence using baclofen: a 2-year observational study of 100 patients", *Frontiers in Psychiatry*, vol 3, December 2012.

[93] "Baclofen", *Australian Medicines Handbook*, July 2019.

[94] Apotex Pty Ltd, "APO-Baclofen Product Information", revised 16 July 2019, p3.

(c) the effects of baclofen may be potentiated during concurrent treatment with tricyclic antidepressants, leading to pronounced muscle hypotonia;

(d) concurrent use of oral baclofen and lithium resulted in aggravated hyperkinetic symptoms (excessive restlessness and excessive movement). Thus, caution should be exercised when baclofen is used concomitantly with lithium;

(e) since concomitant treatment with baclofen and antihypertensive agents is likely to potentiate the fall in blood pressure, the dosage of antihypertensive medication should be adjusted accordingly;

(f) drugs or medicinal products that can significantly impact renal function may reduce baclofen excretion leading to toxic effects;

(g) concurrent use of baclofen and monoamine oxidase (MAO) inhibitors[95] may result in increased CNS-depressant and hypotensive effects. Caution is recommended and dosage of one or both agents may require reduction;

(h) since baclofen may increase blood glucose concentrations, dosage adjustments of insulin and/or oral hypoglycaemic agents may be necessary during and after concurrent therapy;

(i) there have been reports of mental confusion, hallucinations, headaches, nausea and agitation in patients with Parkinson's disease receiving treatment with levodopa plus carbidopa, who also required treatment with baclofen; and

(j) studies in rats indicate that diazepam potentiates the agonistic effects of baclofen on gastric acid secretion.[96]

97. The Australian Medicines Handbook concurs with this advice, however summarises it in a more general way:

> *Baclofen causes CNS [central nervous system] and respiratory depression and hypotension; administration with other drugs that also cause hypotension or depress respiration or the CNS may add to these adverse effects.*

[95] Examples of MAO inhibitors include the antidepressant moclobemide and the antihypertensive hydracarbazine.
[96] Apotex Pty Ltd, "APO-Baclofen Product Information", revised 16 July 2019, pp 5-6.

Baclofen may lower the seizure threshold; use with drugs that may increase the risk of seizures may further increase this risk; avoid combination in epileptics or those at risk of seizures.

Baclofen can increase blood glucose concentration.[97]

Appropriateness of prescribing baclofen to Ms Hall

98. Dr Taylor prescribed baclofen to Ms Hall because *"she had significant alcohol addiction which required treatment"*, an assessment shared *by "all four doctors at [Frankston Health Care]"*.[98] Dr Taylor explained the prescribing with reference to both his own experience of using baclofen as an addiction therapy to his patients for over 10 years without problems, as well as a great deal of *"scientific evidence to support the use of baclofen"*, adding that *"the use of baclofen is promoted by specialists in drug addiction"*.[99]

99. The CPU's literature search confirmed that baclofen is clearly recognised to be an emerging treatment for alcohol dependence. Additionally, the extant baclofen prescribing information in Australia does not list alcohol dependence as a contra-indicated condition for baclofen prescribing. Therefore, the CPU did not identify an issue with Dr Taylor prescribing baclofen to treat Ms Hall's alcohol dependence.

100. However, the CPU identified two specific concerns regarding how Dr Taylor prescribed the baclofen to Ms Hall.

Prescribing baclofen to patients with mental health issues

101. According to her step-mother, Ms Hall was diagnosed as having bipolar disorder at some point in or about 2001, following her brother's suicide, but did not regularly take medication to treat this condition.[100]

102. Medical records reveal that Dr Taylor prescribed Ms Hall 20mg citalopram per day (for depression) in the period proximal to her death.[101] I note citalopram is not a tri-cyclic anti-depressant, which is specifically warned against in the TGA-approved Product Information for APO-Baclofen list of medication interactions.

[97] "Baclofen", *Australian Medicines Handbook*, July 2019.
[98] CB, 198.
[99] CB, 198.
[100] CB, 85.
[101] CB, 349.

103. Given the precautions listed for baclofen exacerbating mental illness, the CPU noted a possibility existed that Ms Hall's bipolar disorder and/or her depression may have been exacerbated by her taking baclofen. The medical records provided to the CPU do not contain enough detail to establish whether Dr Taylor (or any other clinicians at Frankston Health Care) had considered the potential risks of prescribing baclofen to an individual with mental health issues before prescribing it to her.

104. Dr Taylor was asked for his response to this aspect of his prescribing. Dr Taylor stated:

> *Ms Hall did not suffer Bi Polar Disease. In my opinion she had border line personality disorder with comorbid anxiety and depression, and she was impulsive. She suffered severe Poly Substance Abuse, and the complications of that – both physical and psychiatric. These mental health conditions were all clearly addressed and treatment, as possible was given. In particular anti depressant medication was prescribed and psychological therapies suggested. Treatment of the root cause addictions was most certainly undertaken.*
>
> *Risks of depression with baclofen, in particular, are very much less than the risks with alternatives such as naltrexone. Other alcohol treatment options include acamprosate, usually ineffective in my experience and disulfiram which is an extremely high risk alternative. I have also used a wide range of other drugs with their advantages and disadvantages but it is my belief and experience that baclofen is by far the safest and most effective.*[102]

105. It appears Dr Taylor was aware of potential risk of baclofen and balanced this against other possible medications with significant side effects, as well as the physical and psychiatric effects of Ms Hall's poly substance abuse and the need to treat her root cause addiction.

Quantity of baclofen prescribing

106. Ms Hall saw doctors at Frankston Health Care on a total of six occasions between 2 September 2015 and 25 November 2015, starting with appointments two weeks apart until 28 September 2015, and then approximately one month apart thereafter. During this period, Ms Hall was prescribed baclofen tablets on five occasions, as follows:

    (a) 100 tablets of 25mg baclofen on 2 September 2015, prescribed without repeat by Dr Taylor, and dispensed on the same date;

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[102] Letter from Dr Andrew Taylor to Coroners Court.

(b) 100 tablets of 25mg baclofen on 16 September 2015, prescribed without repeat by Dr Taylor, and dispensed on the same date;

(c) 100 tablets of 25mg baclofen on 28 September 2015, prescribed without repeat by Dr Taylor, and dispensed on the same date;

(d) 100 tablets of 25mg baclofen on 28 October 2015, prescribed without repeat by Dr Emad Tadros, and dispensed on the same date; and

(e) 100 tablets of 25mg baclofen on 25 November 2015, prescribed with two repeats by Dr Taylor. This script was dispensed on the same date, and the first of the repeats was dispensed on 15 December 2015. The second repeat does not appear to have ever been dispensed.

107. Ms Hall attended one other appointment at Frankston Health Care on 6 October 2015 with Dr Taylor, at which time she was not prescribed any medication. On this occasion, Dr Taylor changed her dose of baclofen from half a tablet, three times per day to one tablet, three times per day.

108. In total, Ms Hall was prescribed and dispensed 600 tablets of baclofen 25mg between 2 September 2015 and 27 December 2015, which was equivalent to just over five baclofen tablets per day. However, during this period, the clinical directions for Ms Hall were for her to take one-and-a-half baclofen tablets per day between 2 September 2015 and 6 October 2015, and then three baclofen tablets per day between 7 October 2015 and 27 December 2015. The number of tablets prescribed and dispensed to Ms Hall therefore markedly exceeded these clinical directions.

109. Given Ms Hall's lengthy history of polysubstance abuse, and the fact that baclofen can cause and exacerbate central nervous system depression – particularly when it is concurrently prescribed with other central nervous system depressants such as diazepam, as was the case with Ms Hall – the CPU concluded that providing such large quantities to her in excess of prescribed clinical need was extremely concerning.

110. Dr Taylor was asked for his response. Dr Taylor stated:

> *Baclofen seems to be safe, non addictive and has a very wide therapeutic window. Dosing usually commences at 10mg - 12.5mg three times daily and is increased by the patient to an initial dose of 25 mg three times daily. This increase occurs quite*

quickly, and continues incrementally until either side effects or benefit. The dose is usually further increased, over days usually rather than weeks, according to the incidence of symptoms ... The dose is very commonly escalated to 6 tablets (150 mg) daily or more. In fact I have many patients who regularly take more than 225 mg daily in order to maintain alcohol abstinence ....

I have absolutely no concerns over the quantities prescribed. Baclofen is not abused much at all as it does not cause either a 'high' or a pleasant emotional experience. It is slightly sedating when taken in excess. After treating many, many hundreds, if not thousands, of patients with baclofen only one has become addicted to baclofen. And that was readily and easily addressed and is resolved.

The medication use is one of the main discussion points at each and every consult, as is alcohol use. I believe that Ms Hall was taking baclofen properly, and with excellent results.

... I did recognise that Ms Hall was greatly improved at the consultation on 7 October... Her improvement continued through out November and she reported abstinence at that time. She did achieve better than 60 days sober. She was well when I last saw her. Her death was very very much unexpected.

... Finally it is my experience with having treated numerous patients with baclofen at a wide range of high doses, and for a wide range of addictions, that death by baclofen is extremely rare. Non fatal over doses do occur but are still a relatively rare cause of over dose in this patient group.

111. I accept Dr Taylor's explanation as reasonably put in the context of his clinical practice. In my view Dr Taylor is a very experienced general practitioner who specialises in addiction medicine. Not only is his use of baclofen to treat alcohol addiction soundly based, he clearly had a reasoning process with regards to his levels of prescribing which he regularly monitored and discussed with Ms Hall who demonstrated positive effect. There is no broader concern about baclofen prescribing generally to people who are alcohol dependent.

112. The level of baclofen found in the post mortem toxicology results indicates that Ms Hall has taken a large quantity of baclofen. It is unknown when she took it, or for whatever reason, but possibly for a combination of factors including emotions incited at Christmas time, and frustration or anguish at having jeopardised her newly found employment by her non-attendance at work on 26 December 2015.

113. The fact that there was no evidence of baclofen medication located at the scene of Ms Hall's death ascribes to Detective Sergeant Catania's evidence that the initial police investigation of the scene focussed on possible third party involvement rather than medication misadventure.

Victorian deaths from baclofen toxicity between 2009 and 2018

114. The CPU also collated information regarding deaths in Victoria for the period 1 January 2009 to 31 December 2018 where baclofen was causal or contributory.

115. The CPU identified 31 baclofen-involved overdose deaths that were reported to Coroners Court of Victoria. In summary, the CPU found:

(a) of the 31 baclofen deaths occurring in Victoria in the last 10 years, only four featured baclofen as the sole recorded contributory drug (including the death of Ms Hall); the remaining 27 deaths all involved at least one, and usually more than one, co-contributing drug aside from baclofen;

(b) all 31 deaths were of individuals with complex medical histories, often featuring polysubstance abuse and/or use of multiple drugs (both prescribed and illicit);

(c) moreover, 17 of these deaths involved an intentional overdose of drugs (including baclofen), rather than an unintentional death arising from baclofen toxicity; and

(d) of the 31 baclofen deaths, 15 were of individuals to whom baclofen had been prescribed, but the reason for it being prescribed to them was not recorded in the available information. Seven deaths involved an unknown source of baclofen, and five deaths were of individuals to whom baclofen had been prescribed to treat alcohol cravings and dependence. Baclofen was prescribed to individuals to treat anxiety and alcoholic tremors, restless legs, and cramps in one death each respectively. In the final remaining death, baclofen was obtained by the deceased through diversion, with them having taken baclofen tablets which had been prescribed to a family member.

Conclusion

116. The CPU examined the circumstances of 31 baclofen-involved overdose deaths that occurred in Victorian between 2009 and 2018 and noted that all deaths – including that of Ms Hall – involved people who had complex medical histories including mental ill health and/or drug dependence. However, it rarely was the only contributing drug in the death, and in just over half of cases the overdose was intentional. Again, then, the complexities of the individual deaths make it very difficult to identify whether there was any systemic commonality relating to baclofen – other than that it contributed in the deaths. Therefore, the CPU could not identify any opportunity for a broader recommendation regarding baclofen prescribing.

117. The available evidence suggests providing medical treatment to Ms Hall was a challenge, particularly as she was not always compliant with such treatment (as statements provided by family and friends included in the coronial brief indicated). Dr Taylor's choice to prescribe baclofen to Ms Hall to treat her alcohol dependence did not represent unusual prescribing (despite it being off-label) and was not without precedent amongst clinicians treating similar patients.

118. I am not of the view that Ms Hall taking the excessive amount baclofen reflected in the toxicology results reflects on or impugns the appropriateness of Dr Taylor's prescribing of baclofen to Ms Hall.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

119. Although there was an intervention order in place against Mr Andrews, Ms Hall spent the two days to Christmas with him at his premises in Frankston and returned home by taxi on Christmas Day. Her family was unhappy with her continued involvement with Mr Andrews, therefore she was not at her own family's Christmas celebrations.[103] Ms Hall's general practitioner, Dr Taylor, described Mr Andrews as "*a violent and controlling partner, a man who was very familiar to the police. A man who had been jailed due to violent attacks against her. Her medications were allegedly taken off her by him – for reasons of control I assumed.*"[104]

120. The history of family violence between Ms Hall and Mr Andrews is documented in police records of family violence reports. Their relationship began in 2011 and the first recorded incident is on 18 September 2013. At the time of Ms Hall's death, a two-year final order had

[103] CB, 81.
[104] Letter from Dr Andrew Taylor to the Coroners Court dated 29 May 2020.

been made on 7 October 2015 against Mr Andrews which included prohibiting him from committing family violence against her or being in contact or within five metres of Ms Hall.

121. The Royal Commission into Family Violence concluded its investigation and report in March 2016. In its consideration of the nature, dynamics and effects of family violence it noted family violence is often a long-term pattern of behaviour, which, in addition to including physical abuse can have the effect of isolating a woman from her family and friends. Despite the two-year intervention order prohibiting contact being in place, Ms Hall and Mr Andrews appeared to remain in a relationship, which may have been based on their mutual drug dependence. Her recent contact with Mr Andrews between 23 and 25 December 2015 immediately preceding Ms Hall's death appears to have conspired to thwart Ms Hall's efforts at rehabilitation which were slowly being realised towards the end of 2015 by her commitment to baclofen, staying sober for 100 days and her new job.

122. Mr Andrews was cleared by police of any third-party involvement in Ms Hall's death. He did supply her with two tablets of his Seroquel 300 mg tablets when she left his house to return home on 25 December 2015.

123. On the morning of 26 December 2015 Ms Hall rang in sick for work. This was the job she had obtained at Harvey Norman some three weeks prior and she was told not to come back. Mr Andrews described her as "*really excited about working and she was enjoying it,*"[105] and her father described her as "*doing really well.*"[106]

124. Ms Hall was clearly upset about missing work which she expressed to her neighbour, Mr Niechcial, who later the same morning gave her a lift her into Hastings. Whilst there Ms Hall visited Liquorland and was captured on CCTV as she purchased two bottles of wine.

125. Ms Hall had suffered from trauma following her brother's untimely death and had developed an alcohol addiction. After reaching a nadir in 2015 following hospitalisation for consuming methylated spirits, in September 2015 Dr Taylor prescribed baclofen for Ms Hall. She achieved 100 days sober and obtained a job.

126. Her self-disappointment at missing work on 26 December combined with the emotions of Christmas may have been the reasons Ms Hall took a large amount of baclofen. I do not find she did so with the specific intention of ending her life. The unfortunate effect of the medication was for Ms Hall to become delirious and unco-ordinated, and possibly suffer

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[105] CB, 93.
[106] CB, 81.

seizures whereby she injured herself significantly over a period of many hours whilst at home alone.

127. When Ms Hall was discovered by police, I am of the view the scene was properly investigated and examined. The disrupted scene of Ms Hall's unit, as well as the blood and injuries to Ms Hall was appropriately referred to the Homicide Squad and examined by the Crime Scene Unit. The relevance of the whereabouts of the second bottle of wine, and Ms Hall's packets of medications were not realised at the time of the initial investigation as police originally suspected third party involvement. It was only following the autopsy that other aspects of the investigation were realised to be relevant and by then the scene had been unsecured. The contemporaneous decisions made at the time were in accordance with the evidence at the scene, and I am not of the view any different actions or avenues of investigation would have led to different conclusions regarding Ms Hall's death.

128. Whilst there are chaotic aspects to the scene, such as the gas burners being left on, there is insufficient evidence for me to be satisfied that Ms Hall intended to end her life. Her disorientation and delirious condition from the baclofen toxicity may have led to her turning the gas and the water on and them remaining on. I find her death was the inadvertent and unintended consequence of an overdose of baclofen which resulted in her incurring, in her disoriented state, extensive and traumatic injuries.

FINDINGS AND CONCLUSION

129. Having investigated the death, and having held an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Kim Melissa Hall, born 10 December 1979, died on 26 or 27 December 2015 at 33B Curacoa Drive, Hastings, Victoria, from the combined effects of baclofen toxicity and blunt head injury in the circumstances described above.

I convey my sincere condolences to Ms Hall's family for their loss.

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

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

Douglas Hall, Senior Next of Kin

Dionne Hall

Dr Andrew Taylor

Peninsula Health

Detective Sergeant Rob Catania, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH

DEPUTY STATE CORONER

Date: 19 March 2021