IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 006445

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Deceased:	T
Delivered on:	7 February 2025
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	Summary inquest 23 July 2024
Findings of:	Coroner Sarah Gebert
Counsel assisting the coroner:	Grace Horzitski, Senior Coroner's Solicitor
Key words:	*Death in care; Care by Secretary Order; Adolescent drug related death; heroin and methamphetamine toxicity*

INTRODUCTION

1. On 24 November 2019, T was 15 years old when he died after ingesting heroin and methamphetamine.

2. At the time of his passing, T lived in Frankston and was subject to a Care by Secretary Order[1] made by the Children's Court.

THE CORONIAL INVESTIGATION

3. T's death was reported to the coroner as it fell within the definition of a reportable death[2] in the *Coroners Act 2008* (**the Act**) because his death appeared to have been unexpected, unnatural or violent or to have resulted from accident or injury. In addition, T was "*in care"* as defined by the Act at the time of his death.[3]

The coronial role

4. Coroners independently investigate reportable deaths to find, if possible, identity, cause of death and the surrounding circumstances of the death.[4] Cause of death in this context is accepted to mean the medical cause or mechanism of death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death.

5. Under the Act, coroners have an additional role to reduce the number of preventable deaths and promote public health and safety by their findings and making comments and or recommendations about any matter connected to the death they are investigating.

[1] A Care by Secretary Order (**CBSO**) gives parental responsibility for a child's care to the Secretary or delegate to the exclusion of all other persons. This order is made for a period of two years. A CBSO is appropriate when a child has been in an out-of-home care for a period of 24 months, or earlier where it has been determined that a child will not be able to safely return to the care of the parent and the appropriate permanency objective is adoption, or permanent care, long-term out-of-home care.

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

[3] Section 3(1) defines *"person placed in custody or care"* and includes a person for whom the Secretary to the Department of Families, Fairness and Housing has parental responsibility under the *Children, Youth and Families Act 2005.*

[4] Section 67(1).

6. When a coroner examines the circumstances in which a person died, it is to determine causal factors and identify any systemic failures with a view to preventing, if possible, deaths from occurring in similar circumstances in the future.

7. The standard of proof applicable to findings in the coronial jurisdiction is the balance of probabilities and I take into account the principles in *Briginshaw*.[5]

Mandatory inquest

8. As T died whilst *"in care",* an inquest was mandatory under section 52(2)(b) of the Act.[6]

Sources of evidence

9. As part of the coronial investigation, Coroner's Investigator Leading Senior Constable Holly Ticehurst prepared a coronial brief. The brief comprises statements from his mother, health professionals involved in his care, those present at the scene of the incident, the forensic pathologist who examined him, investigating police officers, as well as other documentation such as photographs.

10. I obtained T's medical records from Baxter Medical Centre, Monash Health, the Royal Children's Hospital, and the Royal Melbourne Hospital.

11. I also obtained records from the then Department of Health and Human Services and a statement from Taanya Gounas, Executive Director, Bayside Peninsula Area, in the South Division at the Department of Families, Fairness and Housing (**DFFH**), which outlined T's social background and DFFH's[7] involvement with him.

RELEVANT BACKGROUND

12. T was born to parents T's mother, and T's father (deceased).

[5] *Briginshaw v Briginshaw* (1938) 60 CLR 336, especially at 362-363. *"The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences …".*
[6] The Act provides an exception where the death is due to natural causes.
[7] Previously known as the Department of Health and Human Services.

Summary of T's living arrangements

13. T lived with his parents from the time of his birth until two years of age.

14. In December 2005 his father took his own life and T and his sister remained in the care of their mother. In March 2006 she placed T and his sister with her parents.

15. T remained in the care of his grandparents for approximately 10 years. His maternal uncle was also present. The placement ended in February 2017 reportedly due to T's aggressive behaviours. After leaving his grandparents care there were six attempts to place him in home based care, which were for short periods of time after which he was placed at a residential unit through Anglicare.

16. Attempts were also made for T to return to the care of his grandparents in December 2017 however this was unsuccessful reportedly due to physically aggressive behaviour from T as well as other issues.

17. T then experienced multiple placement changes. According to available records, in the two years that he was placed in out of home care, T had over 20 placements.

18. Following his mother's release from prison at the end of December 2018, T was regularly absconding from placement to spend time with her in Richmond.

First report to Child Protection

19. On 21 January 2004, just days after T' s birth, a report was made to Child Protection in relation to parental substance use. It was reported that both of T's parents had used illicit drugs and were transient.

20. T's parents subsequently worked with Child Protection to develop a safety plan, however their compliance and engagement wavered.

21. Child Protection made an assessment that there was a likelihood of physical harm and harm to T's physical development or health and, in April 2004, the Children's Court granted an Interim Protection Order which allowed a further period of monitoring, assessment, and support while T remained in the care of his parents.

22. Child Protection continued to monitor T under the Interim Protection Order and sought no further order when it expired on 6 July 2004. Child Protection assessed that there had been positive change based on information gathered and there were no current significant concerns.

T appeared to be developing well, and the family were in stable accommodation. His parents agreed to attend a drug relapse prevention counselling program and maintain regular contact with the Maternal and Child Health Nurse. Child Protection therefore closed their involvement with T and his parents on 15 July 2004.

23. On [redacted], T's mother and T's father welcomed a baby into the family.

Second report to Child Protection

24. The second report to Child Protection was made on 27 December 2005 and remained open until T's passing. This report was initiated at the time of T's Father's death after it was reported T had been left in the care of an unknown male for an unknown period.

25. During Child Protection's investigation it was established that T's parents had not engaged with available services, including the Maternal and Child Health Nurse, and there were concerns about their ongoing substance use and transience.

26. At the beginning of 2006, T's mother moved in with her father and stepmother. However, over the following months, T's mother moved out of the home and T's maternal grandparents later took over his care.

27. Following several interim orders, a Care by Secretary Order was granted on 22 January 2007. This order was extended several times, and T remained subject to an order at the time of his passing.

28. T continued living with his maternal grandparents and sister throughout his early childhood and he was case managed by a community service organisation who provided ongoing support. T had intermittent contact with his mother.

29. T began exhibiting behavioural issues at an early age and as T grew older, his grandparents found it increasingly difficult to manage these challenging behaviours. This placement unfortunately broke down in February 2017.

30. Over the following months, T was trialled in home-based care before moving to residential care. In December 2017, T returned to his grandparents' care. They clearly loved him and endeavoured to provide him with ongoing care.

31. The family were provided intensive case management. However, in February 2018 the placement broke down again due to T self-harming and being physically aggressive to family

members. T was subsequently placed in residential care and thereafter experienced multiple placement changes.

32. At about this time, T was assessed in response to sexualised behaviour/sexual threats, self-harm and suicidal ideation, and other behaviours of concern (including violence to others). The subsequent assessment highlighted T's vulnerability to a deterioration in his mental health (anxiety and self-harm) due to his experience of rejection, perceived abandonment, and instability of care. It was identified that T needed a measured response that ensured stability of care and the sustained involvement of therapeutic services.

33. In November 2018, T moved to a residential care placement with Allambi Care, and this was maintained over the following year.

34. According to Ms Gounas, Child Protection's focus was on developing plans to support T's stability, whilst managing significant concerns for his safety and wellbeing, which included addressing his absconding behaviour and associated risk issues.[8] This was in the context of T's significant trauma history, coupled with the breakdown of his long-term kinship placement and subsequent placement instability. His mental state was fragile, and he seemed to be deteriorating, which was evidenced by his escalating drug use, absconding from care, and self-harming behaviours.

35. Ms Gounas noted that Child Protection were often required to take urgent action to ensure T's safety in response to his circumstances and risks they identified for him. Twenty-three emergency care warrants[9] were granted between March 2018 and November 2019. T was placed in Secure Care Services[10] on two occasions in April and October 2019.

36. On 18 November 2019, a decision was made to move T to an alternative residential care unit. Due to T not being at his placement when this decision was made, the placement change

[8] Between 10 August 2017 and 4 November 2019, T was recorded as a missing person 23 times.

[9] A warrant obtained under section 598 the *Children, Youth and Families Act 2005* specifically applies to a child or young person who is absent from placement or where there is a failure to comply with a lawful direction of the placement of a child or young person. The search warrant authorises members of Victoria Police to enter and search any place where the child named in the warrant is suspected to be and place them in emergency care. The young person can be returned to a place specified in the warrant or pace nominated by child protection, undergo further assessment by child protection or if young person considered to be at substantial and immediate risk of harm can be admitted to secure care services.

[10] Secure Care Services is the current term used to refer to a secure welfare service: which is 'a community service that has lock-up facilities' that is established under the *Children, Youth and Families Act 2005.* A young person may be placed (via an interim accommodation order) in a secure welfare service by the Children's Court, generally at a point prior to an ongoing protection order being made. Child Protection may also place a young person in secure care where the Secretary has parental responsibility and is satisfied there is substantial and immediate risk of harm and a placement in a secure setting provides the only suitable option for ensuring their protection.

decision was not communicated with him directly, but there was communication between Child Protection and T's mother.

T's contact with his mother

37. T had limited contact with his mother throughout his earlier life other than for a period during 2010-2011 when they had regular contact with each other.

38. When T's mother was released from prison in December 2018, T increasingly sought to have contact with her. Records indicate T and T's mother had a turbulent relationship at times. These unplanned and unsupervised contacts caused some concern to Child Protection practitioners.

39. Ms Gounas noted that Child Protection continued to grapple with the role of T's mother in T's life given the considerable amount of time he was choosing to spend with her, and the challenges faced by Child Protection in managing this. Understandably, T actively sought connection with her. Records indicate that over time there appears to have been a greater level of acceptance by Child Protection of the time T spent with her.

40. A Practice Leader was eventually able to engage with T's mother toward the end of T's life, at which time she expressed concern about T's drug use and acknowledged her own current heroin use.

T's mental health

41. Ms Gounas noted that T's suicidal behaviour was evident from 2015. This escalated at about the time his placement with his maternal grandparents ended, and he required hospitalisation and mental health assessments on multiple occasions.

42. From 2016, T was linked into multiple mental health services including private psychologists, Take Two clinicians, Monash Health Early in Life Mental Health Service (**ELMHS**), Intensive Mobile Youth Outreach Service (**IMYOS**), South Eastern Centre Against Sexual Assault (**SECASA**), Headspace, and through his admissions into Stepping Stones[11] in 2017 and 2018.

[11] Stepping Stones is an adolescent inpatient unit for secondary school aged young people up to 18 years of age, provided by ELMHS.

43. Child Protection made a referral on 22 October 2018 to Berry Street Take Two[12] for an assessment, which occurred over the following weeks. The Take Two assessment identified that T met the criteria for generalised anxiety disorder. The report echoed the earlier assessment in relation to the importance of stability of caregiving and therapeutic support, including the continued involvement of services, such as SECASA AWARE,[13] ELMHS, IMYOS, and Berry Street Children in Residential Care[14] as part of the care team, and other actions to support him.

44. ELMHS had some involvement during mid-2019 with T but closed on 25 July 2019 on the basis that there was no evidence of acute mental health issues, and T's risks remained low-medium and chronic. They recommended Youth Support and Advocacy Service (**YSAS**), to assist in reducing T's substance use, and secondary consultation through the Monash Health Intake, Assessment, Consultation & Treatment Team.

45. During the Secure Care Services admission in October 2019, the Youth Health and Rehabilitation Service (**YHARS**) identified that T was a high risk of suicide, reporting several prior deliberate unsuccessful attempts by heroin overdose. He was again referred to ELMHS.

46. A clinician from YSAS noted that T had disclosed several previous suicide attempts, with the most recent attempt six weeks previously. He denied suicidal ideation at the time (25 October 2019). He had completed an ELMHS assessment but was not engaging with the service and had not found mental health services beneficial in the past.

47. According to Ms Gounas, despite the involvement of various services, T did not appear to receive consistent and continuing mental health care. She explained that effective engagement and service delivery was unable to be achieved in a sustained and meaningful way due to barriers such as differing views about T's risk and eligibility criteria impacting on services accepting referrals for him. As a result, mental health services were engaged with T only periodically.

[12] The Intensive Treatment Service (Take Two) aims to improve the functioning, safety and well-being of children and young people subject to child protection intervention through the provision of specialist intensive therapeutic counselling and multiple treatment methods aimed at addressing trauma and attachment disorders involving children, their families, and carers and communities where necessary.
[13] SECASA AWARE program is a voluntary service that provide assessment and treatment of harmful sexual behaviour in children and young people, whilst providing support to their parents and carers.
[14] Education Support Services for Children in Residential Care (**CIRC**) program supports young people in residential care to connect or re-establish their education and pathways. The CIRC program team are experienced Specialist Educators using a trauma-informed approach, along with up-to-date integration and teaching strategies.

48. While T would have benefitted from receiving a consistent and longer-term specialist mental health response, this unfortunately was not achieved.

T's drug use

49. Ms Gounas stated records indicated that by early 2019 T had started using illicit substances, which coincided with his reconnection with his mother after she was released from prison.

50. In March 2019, police members found T at his mother's home, having recently used ice. In April 2019, T was admitted to hospital due to an overdose at his mother's home, and in September 2019 T was again taken to hospital due to concerns for his possible overdose.

51. When T was assessed by a YSAS general practitioner in April 2019, T disclosed that he was using multiple substances and engaging in intravenous use of methamphetamines and heroin. While he stated that he was interested in reducing his substances, he did not want to engage with any drug or alcohol support services.

52. In October 2019, T was reported to be experiencing symptoms of opiate withdrawal. T reported ongoing intravenous drug use and said he was increasingly using heroin over methamphetamines and had used heroin with his mother. He had been referred to but not engaged with drug and alcohol services. He did not want to participate in detox or rehab. T disclosed that he used drugs to numb his emotional pain. He also reported accidental overdose on one occasion and deliberate overdose on four or five occasions. T was subsequently referred to the YSAS drug and alcohol worker, but he was not able to be seen before his death.

53. On 28 October 2019, T informed his YSAS doctor that he planned to see a drug and alcohol worker in Frankston later that day with a possible plan to commence on suboxone (opiate replacement therapy).

54. In her statement, T's mother stated her son had been a drug user for about two to three months. She was aware that he was using a couple of points of ice a day and heroin every now and then.

55. According to T's mother's partner, Robert, T had used drugs during the whole time he had known him – about two years. Robert believed T used heroin daily.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

56. According to T's mother, T had been in residential care for about two years and was in the process of moving in with her in Richmond at the time of his passing.

57. On the evening of 23 November 2019, T had dinner with his mother and her friend, Breanna.

58. T later gave his mother a handwritten note apologising for breaking the windscreen of her car. She last saw T alive when she fell asleep on the couch at about 10.30pm.

59. According to Breanna, T went into the bathroom for a shower at about 11.00pm that evening. About 30 minutes later, he popped his head out to ask for some shorts but then yelled out that he had found some. Breanna stated she went to bed about 1.00am, at which time T was still in the bathroom.

60. According to T's mother's partner, Robert, he heard T having a shower at about 3.00am the next morning, 24 November 2019, when he (Robert) was watching television in the lounge-room. He subsequently heard a thud come from the bathroom but then heard T get up and exit the bathroom. T subsequently came into the lounge-room and said to Robert he was getting some clothes from the bedroom. Robert then heard T go back into the bathroom.

61. About 30 minutes later, Robert headed to bed and found T lying on the floor between the bathroom and the hallway. Robert stated he was not alarmed by this because T often slept on the floor.

62. Robert stated that he told T's mother to get him up, to which she replied, *"He'll be right"*. He then went to bed. T's mother recalls that after she fell asleep on the couch, she did not speak to anyone that night and was asleep all night.

63. T's mother later woke up at about 8.20am, 24 November 2019, at which time she found T lying on the floor in the doorway of the bathroom. Realising he was deceased, she called out to Robert and Breanna who contacted emergency services.

64. Ambulance Victoria paramedics arrived at 8.26am and verified T's death at 8.30am.

65. Victoria Police members later seized a used syringe and a small white bag containing a white rock substance from the bathroom.

66. According to Leading Senior Constable Ticehurst, there was no evidence to suggest that T took his own life, or that his death resulted from the actions of any other person.

IDENTITY OF THE DECEASED

67. On 24 November 2019, T , born [redacted], was visually identified by his mother, T's mother.

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

CAUSE OF DEATH

69. Forensic Pathologist, Dr Victoria Francis, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination on 26 November 2019 and provided a written report of her findings dated 18 December 2019.

70. The post-mortem examination revealed some pale scars and healing injuries over his left forearm and a possible 2 mm puncture wound over the left antecubital fossa on a background of scarring.

71. Toxicological analysis of post-mortem samples identified the presence of heroin[15] and methylamphetamine.[16]

72. Dr Francis provided an opinion that the medical cause of death was *"1(a) Combined heroin and methamphetamine toxicity"*.

73. I accept Dr Francis' opinion.

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[15] Heroin is a semi-synthetic opioid produced from morphine obtained from the opium poppy. It has no legitimate medical use in Australia. The detection of 6-monoacetylmorphine in blood is regarded as evidence of heroin use within the 1-2 hours preceding death. Adverse effects of heroin include apathy, cold and clammy skin, coma, confusion, constipation, drowsiness, hypotension, hypothermia, miosis, nausea, pulmonary oedema, respiratory depression, and vomiting. Respiratory depression can be greatly exacerbated with concurrent use of other central nervous system depressants, particularly benzodiazepines and alcohol. There are a number of ways that death can follow an injection of heroin: 1. Death can be immediate. In these cases the needle may still be in situ. The mechanism is unknown but may be related to the injection rather than the pharmacological properties of heroin. 2. Death is the result of heroin intoxication and consequent respiratory depression. 3. Death is a complication of unconsciousness caused by a non-fatal intoxication. Any unconscious person, particularly those with medical conditions that limit physiological reserve (e.g., heart disease, lung disease, obstructive sleep apnea, obesity, and advanced age), is at risk from death if the airways become obstructed either as a consequence of posture or vomitus.

[16] Methylamphetamine is a derivative of amphetamine and has no legitimate therapeutic use in Australia. Methylamphetamine is supplied in powders or pills form (speed), as crystal methylamphetamine (crystal meth or ice), and a sticky paste (base). It may be ingested orally, snorted, injected, or smoked. The desired effects sought by methylamphetamine users include an increased alertness, reduced fatigue, weight loss, and intense euphoria. The onset of effects is rapid after intravenous injection or smoking, and slower after oral ingestion. The effects typically last four to eight hours but residual effects may persist for up to 12 hours. Adverse effects of methylamphetamine use include dizziness, headache, restlessness, and tremor. Overdose may cause anxiety, cardiac arrhythmias, circulatory collapse, coma, confusion, convulsions, hallucinations, hypertension, and hyperthermia. Users of methylamphetamine may develop psychosis, particularly a paranoid psychosis that is oftentimes indistinguishable from schizophrenia. This can often lead to irrational or violent behaviour.

FURTHER INVESTIGATION

Children and Young people in care

74. It is well recognised that children and young people in statutory care have poorer physical, developmental, and emotional health outcomes than other children and young people. They are less likely to achieve good educational qualifications and more likely to have greater health, well-being, and housing needs as adults, to be involved in substance misuse,[17] to have a disability or diagnosed mental, emotional or behavioural issues,[18] and to have contact with the criminal justice system.

75. The *In our words* systemic inquiry conducted by the Commission for Children and Young People into the lived experiences of children and young people in out-of-home care was established in April 2018.[19] As part of the inquiry, the Commission spoke with a total of 204 young people from rural, regional and metropolitan Victoria who were currently living in or had recently left out-of-home care, inviting them to tell their stories of what it is like to live and grow up in the out-of-home care system, what works well and what needs to change. It was noted that,

> *Instead of a place where they can heal from harm, children and young people have spoken out on state care to say it too often inflicts more harm, they are moved around too much, their placements – especially in residential care – are unsafe, and there are not enough supports to help them recover from trauma*.

76. The Inquiry *"found a pressured, poorly resourced system that repeatedly failed to take the views of children and young people into account when deciding where they should live, what*

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[17] Anglicare Victoria's 2016 *Children in Care Report Card* (How children in care are faring in comparison to their peers in the community) showed that the proportion of children and young people in care who reported smoking cigarettes or taking illicit substances remains substantially higher than similarly aged peers in the community. For example, close to 27% of children and young people in Out of Home Care had smoked cigarettes and 33.3% had taken illicit drugs in the previous 12 months. This compares to 5% of young people in the broader community who reported smoking, and 17.6% who reported taking illicit substances. (Anglicare Victoria, *Children in Care Report Card,* 2016)

[18] Senate Community Affairs References committee - Out of Home Care Report at para 4.71 *Children in care are more likely to experience mental health issues, and associated emotional and behavioural problems. A 2007 review by AIFS found that children and young people in care experience relatively negative outcomes when compared to the general population in regard to mental health. It also highlighted a strong coincidence of early trauma and abuse and subsequent placement instability for children and young people with high support needs. Anglicare's 2014 report found one of the most striking differences between children and young people in care and their peers is their experience of emotional and behavioural difficulties (53.4 per cent compared to 13.3 per cent).*

[19] Pursuant to section 39 of the *Commission for Children and Young People Act 2012*. Tabled in the Victorian Parliament on 27 November 2019.

they needed from their workers and carers, what was happening to them in care, and the contact they had with friends, family and community".[20]

77. T experienced over 20 placements over two years. I note that during many of T's presentations to the Emergency Department, documentation suggested that he was well mannered and easily engaged with clinicians, but complained about his residential placement, such as being frustrated by always needing to move, not feeling safe in his residence due to the threatening and abusive behaviour of other residents, and constant conflict with other residents.[21]

78. During an assessment when T was a month short of 15 years old, T's three wishes were noted to be: an X-box One; to have a long-term placement and not get moved; and to have decent kids in placement (eg. *Like me*).

79. Relevant to the issue of placement security, is evidence suggesting that the stability of a child's placement has a significant impact on the child's wellbeing and outcomes.[22]

T's DFFH experience

80. As part of my investigation, and in particular to determine whether there were any prevention opportunities arising from the circumstances of T's death, I asked DFFH whether it had complied with applicable and best practice processes and procedures, whether there was or should have been a cumulative harm review, and whether there have been any changes to DFFH practice as a result of T's death. Ms Gounas provided responses to these issues in her statement.

Whether DFFH complied with applicable and best practice processes and procedures

81. Ms Gounas stated that in the six to eight months prior to T's passing, records indicated that practitioners' practice and professional judgement was guided by relevant policies and procedures.

82. In the months preceding his death, T appeared to have been particularly difficult to engage with. Ms Gounas noted that T's case management centred on responding to day-to-day crises and incidents as impacted by T's drug use, deteriorating mental health, contact and exposure to parental substance use and other behaviours, inclusive of difficulties in engaging with his

[20] *In our own words* made 17 recommendations calling for whole-of-system change.
[21] He reported when he was 13 years old that an older resident had made derogatory comments about his deceased father and told him to 'Go join him', 'Why don't you kill yourself like him'.
[22] Australian Institute of Family Studies, *What contributes to placement moves in out-of-home care?* CFCA Paper No. 61, 2021.

mother and T missing from care, noting that a crisis management plan was in place. She also highlighted that it was difficult to effectively implement plans for T because he was absent from placement and not engaging with his Child Protection case manager and residential carers.

83. Child Protection recognised there was an escalation in T's drug use, and a further decline in his mental health, following his mother's release from prison in December 2018. Secure Care Services admissions occurred in April and October 2019, with multiple emergency care warrants granted.

84. Child Protection also recognised that T required specialist mental health care and continued to advocate for this. Referrals were made for numerous supports to assist T, but there were differing views about the service best placed to support T, particularly around the mental health response by mental health services.

85. At the time of his death, Child Protection were in the process of considering T's placement stability in the context of his high-risk behaviours, mental health, frequently missing from care, placement changes, and the role of his mother. A new placement had been located for T and attempts were being made to encourage T and his mother to work collaboratively regarding his return to residential care placement.

86. Ms Gounas conceded that there had not been clear communication with T or his mother about T's new placement details, and this evidently created confusion for T during the days prior to his passing. She noted that greater attention should have been paid to the impact of instability on T, and the need to scaffold and communicate well during particularly unsettled periods.

Whether there was or should have been a cumulative harm review

87. The best interests principles under section 10 of the *Children, Youth and Families Act 2005* require that cumulative harm is considered and that it is considered in an ongoing manner in decisions even without formal assessments.

88. Ms Gounas confirmed that Child Protection's reviews of T's case took into consideration cumulative harm.

89. The Child Protection risk assessment for T identified and recognised that he was at significant risk of harm considering his presenting issues and behaviours, and feedback received from professionals, his care team, and key stakeholders. Child Protection practitioners identified a

number of risk factors, particularly in relation to T's deteriorating mental health and substance use, and the challenge monitoring this when he was missing from placement, and spending time with his mother. T was significantly impacted by the harm he experienced, the circumstances surrounding his family relationships, disrupted attachment, and placement instability.

90. In addition, the Divisional Principal Practitioner report in 2018 thoroughly considered cumulative harm, analysed this information, and made recommendations accordingly. The subsequent Take Two assessment built on this. Ms Gounas stated that the risk to T, including the impact of cumulative harm, was known.

Changes to DFFH practice as a result of T's death

91. Ms Gounas identified a number of changes implemented following T's death. These included:

(a) practice leadership has been strengthened through additional recruitment and training;

(b) Practice Leaders and Principal Practitioners are linked with the most vulnerable children to ensure that the needs of the young person are identified early, and plans implemented;

(c) developing practice to support risk assessment and planning for infants from a trauma informed and relationship perspective which recognises the impact of adverse childhood experiences and cumulative harm;

(d) strengthening the relationship between Child Protection and child and adolescent mental health services. Secondary consultation now occurs monthly with Alfred Health Child and Youth Mental Health Services and ELMHS. There are now also Berry Street Take Two trauma consults;

(e) a new risk assessment model was implemented in November 2021. The SAFER children framework is designed to strengthen Child Protection practice by supporting and guiding practitioners in information gathering, analysis, risk judgement and decision making, formulating and enacting a case plan, and reviewing the development and wellbeing of individual children within their family, culture and community;

(f) new therapeutic residential care homes have been established with planned funding for therapeutic supports which prioritise trauma recovery, trauma-informed care, and evidence-based therapeutic support for young people; and

(g) a partnership meeting has been established across Child Protection, residential care providers, Victoria Police, and Youth Justice. The focus of this partnership is to reduce children and young people living in residential care being absent from placement.

92. I thank Ms Gounas for providing a particularly detailed statement to assist this coronial investigation.

SAFER children framework

93. The Children and Young Persons Commission noted the following in relation to the SAFER children framework:

> *… in November 2021, DFFH introduced a new child protection risk assessment and management framework called the SAFER Children Framework. SAFER aims to improve risk assessment practice by providing more detailed guidance to practitioners and integrating the Multi-Agency Risk Assessment and Management framework to strengthen family violence risk assessment.*
>
> *In 2024, DFFH rolled out practical and reflective training across Victoria for all child protection practitioners on SAFER, to increase confidence in the workforce in applying the framework. Staff in the Commission's inquiries team were also provided with training on using the framework, which has been very helpful in informing our service reviews. The Commission welcomes the efforts to improve child protection risk assessments. The Commission notes that seven of the completed child death inquiries this year related to children who died prior to DFFH introducing SAFER.*[23]

94. From a child protection perspective, T's case was very complex and as he grew older he was making his own decisions about where he wanted to live and it is apparent (and understandable) that he wanted to be with his mother.

FURTHER SUBMISSIONS

95. I received two late submissions,[24] not from interested parties, drawing my attention to potentially relevant matters in the context of T's death that I had not previously considered:[25] specifically the operation of the Medically Supervised Injecting Room (**MSIR**) at North

[23] Annual Report of CCYP 2023-24.

[24] They were correspondence to the Court but I have referred to them as submissions.
[25] Neither had been brought to my attention at the time of the summary inquest.

Richmond Community Health on Lennox Street in North Richmond. The two writers offered very different perspectives on the nexus between the MSIR's presence, heroin use and availability in the North Richmond area, and T's death; however when considered together they both pointed to a potential prevention opportunity that I believe warrants consideration.

96. In the following discussion I use the term MSIR, but I note that in some documents the term Medically Supervised Injecting Centre (**MSIC**) is used instead of or in addition to MSIR.

Community member

97. The first submission was from a community member who indicated the correspondence was strictly confidential, however I have assumed that the information contained therein was provided to inform my investigation, and therefore the author contemplated that I may rely upon it in this finding.

98. They advised that T was observed buying drugs at various locations along Lennox Street, including in the carpark of Richmond West Primary School (which is situated next to the MSIR). It was their concern that open drug supply and drug use were becoming normalised in the local area, largely following the establishment of the MSIR; and this in turn facilitated T's access to drugs, as well as putting at risk other young people residing in the local area.

99. They were further concerned that in this context T did not receive the assistance he needed, including drug rehabilitation services.

Letter from Sione Crawford

100. The second submission was from Harm Reduction Victoria (**HRV**) Chief Executive Officer, Sione Crawford. I note that HRV is a peer-led community organisation for people who use drugs and is widely respected for its advocacy on safer drug use, including its contributions to, and critiques of, drug policy in the state.

101. Mr Crawford asserted that T's death in close proximity to the MSIR was preventable, however raised a concern that under the legislation establishing the MSIR, children and young people are not permitted to access the service. He wrote:

> *We state emphatically that a core tenet of any harm reduction service is indiscriminate accessibility to all.*

102. Mr Crawford further wrote:

> *We ask that the Coroner consider recommending amendments to the Drugs, Poisons & Controlled Substances Act 1981 to reverse this discrimination against young Victorians, empower the MSIR to reach a wider range of age groups, and truly fulfill its mandate as an innovative, life-saving, evidence-based harm reduction service.*

MSIR's relevance as a potential point of intervention

103. At the outset I acknowledge the distress that community members would experience at seeing a young person, such as T, in the North Richmond area repeatedly acquiring drugs; and why they would be concerned that interventions should be in place in these circumstances. In fact, it is likely to be distressing for any community member to see any form of drug purchase, regardless of age, openly in our streets.

104. The reasons why T commenced and continued to use drugs are complex and appear to have their roots in his early childhood and continued difficult life experiences; the existence of the MSIR would have had no bearing on this matter.

105. In addition, as already outlined, T was referred to services including specialist alcohol and drug services on several occasions, and he made his own decisions about engaging (or not) with these services. I do not have a basis in these circumstances to criticise any health service regarding alcohol and drug treatment they offered or provided to T in the period leading up to his death.

106. Regarding his ability to access drugs and its relationship to the MSIR, it is my understanding that other inquiries and reviews have documented that North Richmond's street drug market existed for decades before the MSIR was established, which is why the first Victorian MSIR was established in North Richmond. It is unclear whether its continuation was a factor which contributed to T's ability to access drugs when he did. Relevantly it was noted:

> *Given the focus on the trial in public discussions, it is understandable that the impacts of drug use in North Richmond tend to be strongly associated with the MSIR. Yet these effects are not only the result of the MSIR's operations, but also of the ongoing public burden of a drug market that existed long before the trial began.*[26]

107. It is also impossible to say whether T would have accessed the MSIR's services had they been available to him at the time of his passing. But I accept that in any event, the MSIR being accessible to T may have created the opportunity for him to attend and (with reference to the community member's concerns) possibly get the help that he needed. As a young person who (according to the available evidence) chose not to engage with many of the services to which he was referred, an alternate pathway to harm reduction education and treatment via the MSIR may have been effective, although clearly this will never be known.

108. To help determine issues around the recommendation Mr Crawford proposed, and to deepen my understanding of the issues raised, I sought to review relevant documents regarding the legislative process that culminated in the establishment of the MSIR. My particular focus was on any commentary or reasoning within these documents which would explain why children were specifically excluded from accessing the MSIR.

Prohibition on children accessing the MSIR

109. The legislative process to establish the MSIR commenced with the introduction by the Hon Fiona Patten of the *Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017* (Vic) to the Legislative Council on 7 February 2017. This Bill sought to provide for licensing and operation of an MSIR for an initial 18-month trial, through amendments to the *Drugs, Poisons and Controlled Substances Act 1981* (Vic). The Bill included the following licence condition for the operator of the MSIR:

[26] Medically Supervised Injecting Room Review Panel, *Review of the Medically Supervised Injecting Room - Final Report: Key Findings and Recommendations*, Melbourne: Victorian Government, February 2023, p.7.

98J Statutory conditions of licences

The following provisions are to be necessary conditions of any licence of an injecting centre—

(a) no child is to be admitted to that part of the centre that is used for the purpose of the administration of any drug of dependence

110. Section 28 of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) requires that when a member of Parliament introduces a Bill into a House of Parliament, a statement of compatibility must be prepared outlining whether in the member's opinion the Bill is compatible with human rights. The statement of compatibility for this Bill, did not address the exclusion of children but advised that that the Bill *"does not limit any human rights"*.[27] In the accompanying Second reading speech, the rationale for excluding children was not outlined.[28]

111. On 21 February 2017 the Scrutiny of Acts and Regulations Committee (**SARC**) queried whether excluding children was compatible *with "the Charter right of every child to such protection as is in his or her best interests"*,[29] and resolved to write to the member on this question. I could not locate a response to SARC's query. Following debate on 22 February 2017 the Bill was referred to the Legislative Council's Legal and Social Issues Committee for consideration who reported back to the Legislative Council on 7 September 2017. The Committee's report noted a submission from the Penington Institute that age restrictions on access to the MSIR should be replaced with a youth-specific support strategy within MSIRs;[30] however did not make any explicit finding regarding age-based exclusions to accessing the MSIR.

112. Following the Committee's report, Minister for Mental Health the Hon Martin Foley introduced a new *Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Bill 2017* to the Legislative Assembly on 31 October 2017. This Bill specified the following licence condition:

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[27] Victoria, *Parliamentary Debates*, Legislative Council, 8 February 2017, p.94 (Fiona Patten, Member for Northern Metropolitan).
[28] Victoria, *Parliamentary Debates*, Legislative Council, 8 February 2017, pp.94-5 (Fiona Patten, Member for Northern Metropolitan).
[29] Scrutiny of Acts and Regulations Committee, Parliament of Victoria, Alert Digest no 2 of 2017, p.2.
[30] Parliament of Victoria Legislative Council, Legal and Social Issues Committee, *Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017*, Melbourne: Parliament of Victoria, September 2017, p.5.

55H Conditions of medically supervised injecting centre licence

(1) The medically supervised injecting centre licence is subject to the following conditions—

(a) no child is to be admitted to any part of the licensed medically supervised injecting centre that is used for the purpose of the administration of any injecting centre drug

113. In the accompanying human rights statement of compatibility, concerning the protection of families and children it was stated:

> *The bill includes provisions that prevent children from admission to any part of the centre that is used for the purpose of the administration of any prohibited drug […]. This condition engages the right of a child to such protection as is in his or her best interests and is needed by him or her by reason of being a child. It does not, however, limit this right. The reason the bill does not allow children to access the supervised injecting services of the centre is that there are more appropriate and targeted treatment options to effectively meet the needs of young persons with addiction issues. There is a network of alcohol and other drug youth treatment providers across the state, operating on an integrated continuous care model with a focus on proactive engagement and family-focused care. In 2016–17, over 7500 young people accessed these treatment services. Given the particular vulnerabilities of children due to their age, it is not considered that it is in their best interests to access the services of a supervised injecting centre.*[31]

114. With respect to the *right to equality before the law*, the Hon Martin Foley stated:

> *The bill includes provisions that prevent children from accessing any part of the centre that is used for the purpose of administration of a prohibited drug […]. These restrictions are reasonable limits upon the right to equality. They are important safeguards for the protection of children, both from using illicit drugs themselves and from being exposed to drug use and its adverse effects.*
>
> *The restrictions upon children accessing the services of the medically supervised injection centre are consistent with the prohibitions upon children consuming alcohol on licensed premises. They reflect the broader policy inherent in our legal system that children do not have full autonomy to make decisions of this nature, and remain*

[31] Victoria, *Parliamentary Debates*, Legislative Assembly, 1 November 2017, p.3567 (Martin Foley, Minister for Mental Health).

subject to the supervision of their parents. Insofar as children are treated differently from adults, thereby engaging the right to equality in s 8, those limits are reasonable and justified. As set out above, given the particular vulnerabilities of children it is not considered that it is in their best interests to access the services of a supervised injecting centre and there are more appropriate and targeted treatment options to effectively meet the needs of young persons with addiction issues.[32]

115. During the Legislative Assembly debate regarding the Bill, several members spoke about the impact of drug addiction on families and children; the pain of parents losing children to overdose, and children losing parents; children from the local primary school in North Richmond being exposed to drug use; and other related themes evoking children and families.[33] The same themes also permeated the Legislative Council debate after the Legislative Assembly passed the Bill on 16 November 2017.[34]

116. The Bill received Royal Assent on 19 December 2017. When the *Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act 2017* (Vic) came into operation on 28 February 2018, licensing the operation of the MSIR at North Richmond Community Health on a trial basis, section 55H(1) of this Act including the following condition on the licence:

> *(a) no child is to be admitted to any part of the licensed medically supervised injecting centre that is used for the purpose of the administration of any injecting centre drug*

117. On 22 June 2018 then Department of Health and Human Services Secretary Kym Peake gave notice that a licence had been issued for North Richmond Community Health to operate the MSIR trial, with the initial operating period being 30 June 2018 to 29 June 2020. The licence for the trial was subsequently extended until 29 June 2023, and two reviews of the trial were undertaken.

118. Throughout these reviews, the exclusion of children from the MSIR was occasionally alluded to but was not directly addressed. The first review (the 'Hamilton Review'[35]), published in

[32] Victoria, *Parliamentary Debates*, Legislative Assembly, 1 November 2017, pp.3567-3568 (Martin Foley, Minister for Mental Health).
[33] Victoria, *Parliamentary Debates*, Legislative Assembly, 15 November 2017, pp.3826-3830, 3841-3850, 3871-3890.
[34] Victoria, *Parliamentary Debates*, Legislative Council, 14 December 2017, pp.6859-6862, 6872-6893.
[35] With panel chair Prof Margaret Hamilton AO.

June 2020, noted that the conditions of the MSIR licence excluded young people from accessing all MSIC services, and that:

> *Referrals are offered to any presenting young person under the age of 18 years to youth services including the Youth Support and Advocacy Service.*[36]

119. The review's authors did not offer any view on the appropriateness of excluding children from MSIR services, observing only that "*many people who use the MSIR first injected at a relatively young age*".[37]

120. The second review (the 'Ryan Review'[38]), published in February 2023, also did not explicitly address exclusion of children from the MSIR, however recommendation 2 encouraged a reconsideration of barriers to eligibility generally:

> *Based on these findings, the Panel recommends that the Minister for Mental Health:*
>
> *2. Minimises the number of people injecting in public by expanding MSIR access to include peer/partner injecting and that the Clinical Advisory Council (see recommendation 5a) consider the removal of other eligibility barriers including people on court orders.*[39]

121. Following the Ryan Review final report, the *Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Bill 2023* (Vic) was introduced to the Legislative Assembly by the Hon Gabrielle Williams, Minister for Mental Health. The primary purposes of this Bill included to provide for licensing of an MSIR on an ongoing basis. The Bill requested no amendments to Section 55H(1)(a) of the *Drugs, Poisons and Controlled Substances Act 1981* (Vic), meaning that children would continue to be excluded from accessing the MSIR.

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[36] Medically Supervised Injecting Room Review Panel, *Review of the Medically Supervised Injecting Room*, Melbourne: Victorian Government, June 2020, p.37.
[37] Medically Supervised Injecting Room Review Panel, *Review of the Medically Supervised Injecting Room*, Melbourne: Victorian Government, June 2020, p.36.
[38] With panel chair John Ryan.
[39] Medically Supervised Injecting Room Review Panel, *Review of the Medically Supervised Injecting Room - Final Report: Key Findings and Recommendations*, Melbourne: Victorian Government, February 2023, p.24. Recommendation 5a referenced in recommendation 2 was as follows:

> *Based on these findings, the Panel recommends that the Minister for Mental Health:*
> *5. Creates the role of Chief Addiction Medicine Advisor in the Department of Health, appointed on a three-year rotating basis, to provide strategic leadership on issues around drug use and dependency.*
> *a. Additionally, establish a broad-based, independent Clinical Advisory Council to advise and support the work of the Chief Addiction Medicine Advisor.*

122. The statement of compatibility accompanying the 2023 Bill did not make any reference to human rights issues with the exclusion of children,[40] and the debate surrounding the Bill in the Legislative Assembly did not touch upon this topic.[41] In the Legislative Council, though, the issue received sustained attention.

123. The Hon Aiv Puglielli submitted proposed amendments to the Bill on behalf of the Victorian Greens, one of which was to ensure that a person is not refused admission on the basis of age. The proposed new clauses included:

> ***31A Conditions of medically supervised injecting centre licence***
>
> *(1) For section 55H(1)(a) of the Principal Act substitute—*
>
> *"(a) except as provided for by paragraph (ad), no person is to be—*
>
> *(i) refused admission to any part of the licensed medically supervised injecting centre that is used for the purpose of the administration of any injecting centre drug; or*
>
> *(ii) refused admission to the centre generally; or*
>
> *(iii) refused access to any service or assistance at the centre—*
>
> *on the basis that the person has a protected attribute under subsection (1A);".*
>
> *(2) After section 55H(1) of the Principal Act insert—*
>
> *"(1A) A person has a protected attribute for the purposes of subsection (1)(a) if—*
>
> *(a) the person is a child; or*
>
> *(b) the person is pregnant; or*
>
> *(c) the person is subject to a court order, a tribunal order, a parole condition or a bail condition other than an order or condition that has the effect of prohibiting the person from attending the centre or from accessing services or assistance at the centre;".'.*

[40] Victoria, *Parliamentary Debates*, Legislative Assembly, 8 March 2023, pp.788-792.
[41] Victoria, *Parliamentary Debates*, Legislative Assembly, 22 March 2023, pp.1115-1140, 1151-1164, 1190-1200.

124. He stated in support of the proposal:

> *The Ryan review's recommendations clearly identify the need to expand the eligibility criteria for clients of the MSIR. Creating barriers to accessing safe injecting services will not reduce the number of injecting drugs being used; all it will do is ensure people use these drugs on the streets without supervision or a safety net. It is unclear why the government refused to accept the expert panel's recommendation to expand the eligibility criteria for use of the MSIR. As it stands, currently people under the age of 18 years, pregnant people and those under a court order, as well as people requiring peer- and partner-assisted injecting, cannot access the safe injecting room. These groups are some of the most vulnerable, and denying them access to supervised injecting or referring them away to another site when they are standing at the front desk of the North Richmond site is putting them at risk of more harm.*[42]

125. In directly addressing the proposed amendments he further stated:

> *Secondly, our amendments expand the eligibility for people to access the MSIR. As I have mentioned already, there are currently certain groups of very vulnerable people who do not have access to safe injecting at the MSIR. Our amendments would permit access to this service to pregnant people, those under 18 and those on a court order, provided that the court order does not prohibit them from attending the centre or accessing its services. They also provide for those who require peer- or partner-assisted injecting to have access to the MSIR. Our amendments are based on a health-led response to drug use. They acknowledge the reality that all sorts of people inject drugs and that if this is occurring, then we want them to have access to safe injecting and wraparound services to provide them with medical supervision and support pathways that reduce harm.*[43]

126. The Hon Sarah Mansfield similarly stated:

> *[…] people who inject drugs are just that – they are people first and foremost. People who inject drugs are of all ages, genders and stages of life, including sometimes children and pregnant people. Drug use is just one aspect of their life. They have a broader life story. They have families, they have friends, they are members of our*

[42] Victoria, *Parliamentary Debates*, Legislative Council, 4 May 2023, p.1240 (Aiv Puglielli, Member for North-Eastern Metropolitan).
[43] Victoria, *Parliamentary Debates*, Legislative Council, 4 May 2023, p.1241 (Aiv Puglielli, Member for North-Eastern Metropolitan).

community. One in 20 Australians over 16 has a substance use disorder. […] We have heard several contributions today that implore us to think of the children. I agree; we should think of the kids and the message we are sending them. We should be sending them the message that as a society we care for and include everyone and that when people experience health issues, we provide health services to support them.[44]

127. The Hon David Ettershank stated in response to the proposed amendments:

In relation to the amendments that are before the house, I make these comments. Consistent with the findings of the Ryan and Hamilton reviews, the centre should allow under 18-year-olds, pregnant women and people on court orders or parole, as well as partner injecting. It would be naive to think that refusing entry to these cohorts will stop them injecting. Rather, they will inject in more dangerous circumstances where they are more likely to do harm to themselves or their unborn children and where there are not the wraparound supports to help transition them away from heroin use. Additionally, it is also discriminatory to deny some members of our community access to this life-saving centre.[45]

128. In contrast, the Hon Melina Bath did not support this amendment:

I could go into it in detail, but we do not want children under 18 injecting themselves, we do not need peer-to-peer injections and we do not need a free licence to create other centres without the rigour and oversight of a parliamentary process.[46]

129. During further debate, the Hon Aiv Puglielli stated:

We cannot draw arbitrary lines based on who we think should have access to this service based on optics or political narrative. Everyone deserves to be resuscitated. Everyone has a right to medical care. We do not take these changes lightly. It is not pleasant to think about pregnant people or children injecting heroin, but it is not just a thought, it is a reality in Victoria. Every day there are pregnant people and minors using heroin. Just a few years ago a teenager died of a drug overdose just a few

[44] Victoria, *Parliamentary Debates*, Legislative Council, 4 May 2023, p.1279 (Sarah Mansfield, Member for Western Victoria).
[45] Victoria, *Parliamentary Debates*, Legislative Council, 4 May 2023, p.1280 (David Ettershank, Member for Western Metropolitan).
[46] Victoria, *Parliamentary Debates*, Legislative Council, 4 May 2023, p.1287 (Melina Bath, Member for Eastern Victoria).

hundred metres from the Richmond site. It is such a terrible tragedy that might have been prevented if they had been able to access the MSIR.[47]

130. The Hon Georgie Crozier indicated no support for the amendment.[48] The Hon David Limbrick, Libertarian member, stated that:

> *Whilst I share Mr Puglielli's concerns about children and drug use – it is particularly tragic – I cannot bring myself to see this injecting centre as somewhere that is suitable for children. I acknowledge that there are children that have problems with drugs, but I do not think that this is a solution. I think that the government needs to come up with a different solution to help these children. I do not think that this is a place for children, and therefore I will not be supporting this amendment.*[49]

131. The Hon Harriet Shing, Labor member said that:

> *[…] use by minors of intravenous drugs is not permissible. This is also about engagement. What is it that young people need to address the causes of addiction? Often there is that vulnerability and that disconnect between the wraparound services, care, family, kinship networks and support that often exacerbates the vulnerability that is there.*[50]

132. The proposed amendment was defeated, the Bill passed, and the *Drugs, Poisons and Controlled Substances Act 1981* (Vic) at present retains in section 55(H)(1) this condition:

> *(a) no child is to be admitted to any part of the licensed medically supervised injecting centre that is used for the purpose of the administration of any injecting centre drug*

[47] Victoria, *Parliamentary Debates*, Legislative Council, 4 May 2023, p.1326 (Aiv Puglielli, Member for North-Eastern Metropolitan).
[48] Victoria, *Parliamentary Debates*, Legislative Council, 4 May 2023, p.1326 (Georgie Crozier, Member for Southern Metropolitan).
[49] Victoria, *Parliamentary Debates*, Legislative Council, 4 May 2023, p.1326 (David Limbrick, Member for South-Eastern Metropolitan).
[50] Victoria, *Parliamentary Debates*, Legislative Council, 4 May 2023, p.1327 (Harriet Shing, Member for Eastern Victoria).

Conclusion

133. Having examined the available documents outlining the rationale behind the section 55(H)(1)(a) exclusion of children from the MSIR, I have a greater understanding of the debate around the proposal for expansion. I note that regardless of which side was being advocated, there was a shared concern about drug use amongst children and young people, and there being sufficient and targeted services in place to address this most distressing issue in our community.

134. Broadly the reasons for exclusion included the weight of best interest principles; there being more appropriate and targeted treatment options to effectively meet the needs of young persons with addiction issues; that children do not have full autonomy to make certain decisions and they remain subject to the supervision of their parents; and the protection of children from using and being exposed to illicit drug use. Alternate reasons included the arbitrary discrimination on the basis of age; principles of harm minimisation; that children and young people will continue to take drugs and in those circumstances monitoring is necessary and appropriate as a prevention strategy.

135. It also became apparent that the mere idea of legally permitting the supervision of a child to inject heroin, even where prevention opportunities could arise, was likely considered by many to offend sensibilities.

136. In this case, T's death tragically underscores that, permissible or not, minors are using intravenous drugs. On the occasion of his passing, he was however at home with his mother.

137. The expansion of the MSIR for children and young people is a complex public policy decision that was debated in the Victorian Parliament less than two years ago. Fundamental issues concerning equality of access and engagement of the Charter were canvassed at that time.

138. I note that the original pilot appears to have been designed and established for adult consumers. There are other exclusions, but these also relate to adults. Neither of the reviews conducted to evaluate the MSIR pilot specifically considered the expansion of the MSIR for children and young people.

139. Aside from the reviews and discussions highlighted, I do not have any further information to support the proposed expansion, including at a minimum, research regarding best practice drug harm interventions for children and youth, and within that research, an analysis of the effectiveness of the proposed intervention in the location where it would operate. In these

circumstances, I consider there to be an insufficient basis for me to make the recommendation proposed.

140. On the basis of the information available, I favour the development of a youth-specific support strategy within MSIR and/or specific outreach services for children and young people, such as T, who are observed purchasing drugs in known drug areas (including, practical prevention strategies such as the provision of naloxone spray to the individual, their friends and family members).

141. I have been informed however that there is an existing youth specific outreach service in the area (**YSAS**) which performs this task. Whether more or different services are needed, is a matter for the Department of Health and I have determined to provide a copy of this finding to this Department for their consideration.

FINDINGS AND CONCLUSION

142. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the deceased was T, born [redacted];

(b) the death occurred on 24 November 2019 at [redacted] Street, Richmond, Victoria, from combined heroin and methamphetamine toxicity; and

(c) the death occurred in the circumstances described above.

143. Having considered all of the circumstances, I am satisfied that T's death was the unintended consequence of the drugs he consumed.

144. T's death, like almost all illicit drug related deaths, was preventable and his passing speaks of potential and a life tragically cut short.

145. T was interested in poetry, cooking and baking, and had aspirations to become a patisserie chef.

146. I note that despite the numerous disadvantages and adversities he faced, T was described as an "*engaging and likable young man"*, who was eager to learn and return to school. Professionals who engaged with him knew him to be very bright with a particular strength in academia ("*an extremely bright young man"*). This is despite attending a vast number of schools and bullying being a feature of his school experience.

147. I convey my sincere condolences to T's family for their loss and acknowledge the sudden and distressing circumstances in which his death occurred.

PUBLICATION OF FINDING

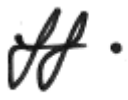
148. Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

DISTRIBUTION OF FINDING

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

T's mother, senior next of kin
Dr Tania Kazuko Nishimura (care of Avant Law)
Royal Children's Hospital
Melbourne Health (NorthWestern Mental Health)
Commission for Children and Young People
Department of Families, Fairness and Housing
Department of Health
Leading Senior Constable Holly Ticehurst, Victoria Police, Coroner's Investigator

Signature:



Date: 7 February 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.