IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 004687

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of GM

Findings of:	Coroner Kate Despot
Delivered on:	27 April 2026
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria, 3006
Hearing dates:	23 April 2026
Counsel Assisting the Coroner:	Mr Ralph Zeeman of the Coroners Court of Victoria
Keywords:	Inpatient Treatment Order, Death 'in care', Mental Health, Suicide, Paracetamol Toxicity

INTRODUCTION

1. On 22 August 2023, GM was 19 years old when she passed away at The Austin Hospital. At the time of her death, GM was subject to an Inpatient Treatment Order (**ITO**) *pursuant to the Mental Health Act 2014*.[1]

2. GM lived at [redacted] with her parents, Ms KRA and Mr CJA. She is survived by her parents, her sister and her stepbrother.

THE CORONIAL INVESTIGATION

Jurisdiction

3. GM's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. In addition, GM's death was reportable because she was a 'person placed in custody or care' within the meaning of the Act, as at the time of her death, she was subject to an ITO set to remain in force until 1 January 2024.

4. Section 52(2)(b) of the Act requires me to hold an Inquest into the death of a person placed in care, unless that death is due to natural causes.

5. Having considered the available evidence, I have determined that this matter would be appropriately finalised by way of Summary Inquest and *Form 37 Finding into Death with Inquest*.

6. Interested Parties were informed of my determination by way of a formal notice for a Summary Inquest to held on 23 April 2026.

Purpose of a coronial investigation

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances.[2] Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The

[1] Coronial Brief of Evidence [**CB**], ITO of the Mental Health Tribunal dated 4 July 2023. The ITO was in force for a period of 26 weeks, due to expire on 1 January 2024.
[2] Section 67(1) of the Act.

purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

8. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refer to the context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.[3]

9. The Coroners Court of Victoria in an inquisitorial jurisdiction.[4] Coroners are not empowered to determine civil or criminal liability arising from the investigations of a reportable death and are specifically prohibited from including in a finding or comment any statement that any person is guilty of an offence.[5]

Standard of proof

10. All coronial findings must be made based on proof of relevant facts *on the balance of probabilities*. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*.[6]

11. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of GM's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

12. Further inquiries, relevant to my investigation, were undertaken by the Court at my direction.

13. This finding draws on the totality of the coronial investigation into the death of GM including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

BACKGROUND

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

[4] Section 89(4) of the Act.

[5] Section 69(1) of the Act. However, a Coroner GM include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence GM have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.

[6] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

14. GM resided at her [redacted] family home for her entire life. She attended secondary school at Melbourne Girls' College and then went on to study nursing at university. GM's father, CJA, described her as an "adored community member…she was funny, cheeky and intelligent. She had a strong sense of what was right and wrong and would stand up for herself".

15. CJA reflected that GM struggled with the restrictions arising from the COVID-19 pandemic and her family observed a noticeable change in GM following a holiday to South Australia around March 2020.

16. In early March 2021, CJA reported that his daughter consulted her General Medical Practitioner, Dr Jill Spargo, about a general medical condition. Dr Spargo expressed concern about GM's weight and recommended that she consult a dietician to support her health and wellbeing. From there, the dietician suggested Family Based Therapy to assist with GM's eating habits.

17. CJA recalled that they would attend at GM's school and have lunch together in a nearby park. Despite some positive progression in her health and relationship with food, GM reportedly consumed an excessive amount of paracetamol around this time.

18. Dr Meurer, practising as a private psychologist at the Centre for Eating, Weight and Body Image provided a statement to assist the coronial investigation. Dr Meurer stated that she had approximately 70 sessions with GM over a period of approximately two years. She stated: "GM was a very complex case. Although I was able to build rapport with her and I believe she found our sessions helpful, her mental health struggles were severe and, unfortunately, the support she was provided by her wider care team did not prevent her suicide." Dr Meurer further noted that at times she lacked information from GM's wider care team, though she acknowledged that it was not essential for her to have this information, it would have been helpful. Without wishing to diminish Dr Meurer's clinical experience in this respect, I make no further comment given my conclusions which are elaborated on below.

19. GM was initially referred to Dr Meurer by general medical practitioner, Dr Spargo, in September 2021 for treatment of an eating disorder. At this time, GM had already been diagnosed with anoxeria nervosa. Dr Meurer reported that her treatment started with Enhanced Cognitive Behavioural Therapy (CBT-E) (a modified form of Cognitive Behavioural Therapy that has been developed to treat patients with eating disorders).

20. GM was admitted to St Vincent's Hospital (**St Vincents**) Acute Inpatient Service (**AIS**), Mental Health on 28 July 2023.

21. According to Consultant Psychiatrist at the AIS, Dr Kochar, GM was transferred from the Austin Eating Disorders Unit (the Austin), where she had been receiving care for anorexia nervosa, restricting subtype, since 23 May 2023. According to Dr Kochar, GM's past psychiatric diagnoses included: Anorexia Nervosa, Borderline Personality Disorder, suicidal ideation, depression, eating disorder unspecified, Generalised Anxiety Disorder, and Attention Deficit Hyperactivity Disorder.

22. Dr Kochar further reported that GM's admission to the Austin had been complicated by medical complications, multiple self-harm attempts, suicidal ideation and depressive symptoms.

23. Upon admission to the AIS, GM reported that she had ongoing suicidal thoughts and intended to act upon those thoughts if discharged. GM said that the main trigger for her suicidal thoughts was increasing her oral intake. GM was reviewed again the following morning at which time she reported that she "would suicide if discharged home" but felt safe in hospital.[7]

24. Over the subsequent days, GM reported to clinicians that she did not find the hospital environment to be therapeutic. It was considered that a trial at home under the supervision of GM's parents would provide her treating team with an indication of safety and the therapeutic benefits outside an inpatient setting. GM went home on overnight leave on 5 August 2023 and returned to hospital on 6 August 2023. Both GM and her parents confirmed that this leave "went well"; it was reported that GM experienced a reduction in suicidal ideation while on leave but struggled to meet her food intake. According to Dr Kochar, upon her return to the ward GM developed "self-harm urges" after dinner. GM reported that "she would always feel suicidal but did not want to spend most of her time in hospital".

25. On 7 August 2023, a family meeting was held with a view to further overnight leave on 8 August and possible discharge thereafter, if the leave went well. GM engaged in safety planning well and indicated that she felt safe to return home, denying any thoughts of suicide or intention to self-harm. Dr Kochar stated further that the St Vincent's Community Mobile Support Team had agreed to a referral and was available to meet with GM on the following

[7] CB, statement of Dr Kochar.

day, 8 August at 11.30am. It was considered that this service would be most suitably equipped to coordinate and manage GM's mental health concerns and level of risk.

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

Circumstances in which the death occurred

26. On 8 August 2023, GM returned home from St Vincents to spend the night with her family. CJA recalled that GM appeared "very withdrawn" but was making enquiries about her employment and planning to meet with friends. Later that day, GM walked to their local post office to collect her passport.

27. On 9 August 2023, CJA noted that GM was up at about 8.00 am and had some breakfast. GM said that she "felt sick" and CJA advised her to go lie down. A short while later, when CJA checked on his daughter and observed that she "looked worse". CJA contacted emergency services and while he was on the phone, GM disclosed that she had "taken Panadol". The evidence indicates that GM had taken the Panadol the previous night prior to her going to bed.

28. CJA reported that all medications were secured at the family home. Based on James' subsequent perusal of GM's bank statement, it appeared that GM had attended at a local service station, when she went to the post office that day, and where she was likely to have purchased the Panadol.

29. GM was subsequently transported by ambulance to St Vincent's Emergency Department (**ED**). Pathology results indicated that the concentration of paracetamol in GM's blood was very high and her liver function abnormal. GM was then admitted to the Intensive Care Unit (**ICU**) on the morning of 9 August 2023 with the following concerns noted:

    - progressing hepatic injury most likely paracetamol toxicity with elevated INR (measure of blood clotting);
    - Fluctuating conscious state (no abnormality had been detected on the computed tomography (**CT**) scan of the brain);
    - Metabolic acidosis

30. GM was intubated to facilitate further therapy. Following discussions between medical experts, a decision was made to transfer GM to the Austin Hospital ICU under the care of the Austin liver unit given the high likelihood of her continuing deterioration and the potential that GM would require a liver transplant.

31. On 11 August 2023, GM was transferred to the Austin Hospital where she was found to have clinical features consistent with fulminant liver failure. Sadly, GM's condition continued to deteriorate.

32. On 22 August 2023, GM passed away.

33. In consultation with family, GM became an organ donor.

INVESTIGATION PRECEDING THE INQUEST

Identity of the deceased

34. On 22 August 2023, GM, born [redacted], was visually identified by her mother, KRA, who signed a formal Statement of Identification.[8]

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

Medical cause of death

36. Forensic Pathologist Dr Victoria Francis of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination upon the body of GM on 25 August 2023 and provided a written report of her findings dated 28 August 2023.

37. In the execution of her duties Dr Francis considered the following primary sources of evidence:

    i. Victoria Police Report of Death, Form 83;
    ii. Post-mortem CT scan;
    iii. E-Medical Deposition Form of The Austin Hospital;
    iv. Medical records from Richmond Hill Medical Centre;
    v. Correspondence from The Austin Hospital ICU doctor/pathology test results.

38. The post-mortem examination revealed signs of acute jaundice. The post-mortem CT scan showed severe cerebral oedema with pseudo subarachnoid haemorrhage. There was evidence of organ donation.

    <u>Toxicology</u>

[8] CB, Statement of Identification.

39. Toxicological analysis of ante-mortem samples identified the presence of diazepam, nordiazepam, fentanyl, fluoxetine, norfluoxetine, midazolam, and laudanosine. These drugs were detected in therapeutic concentrations, unless otherwise indicated, and administered in a hospital setting.

Forensic pathology opinion

40. Dr Francis provided an opinion that the medical cause of death was 1 (a) complications of fulminant hepatic failure due to paracetamol toxicity.

41. I accept Dr Francis' opinion.

REVIEW OF CARE

42. Having reviewed all the evidence and, given the tragic loss of a life at such a young age, I requested that GM's medical treatment be reviewed by the Coroner's Prevention Unit (**CPU**).[9] I note that in determining to refer this matter to the CPU for advice I did so to assist me in understanding the complexities of GM's medical needs.

43. A clinician from the Health and Medical Investigations Team (**HMIT**) reviewed the materials. While acknowledging the profound tragedy of GM's death, the HMIT clinician advised me that her overdose occurred in the setting of overnight leave from admission to the inpatient psychiatric unit at St Vincent's Hospital. Although GM endured chronic suicidality, she had not had any significant suicide attempts nor disclosed active suicidal ideation prior to having been granted leave.

44. The HMIT clinician advised that management during GM's admission at St Vincent's appeared to be reasonable with goal planning, engaging in safety planning, liaison with family and private psychiatrist, inpatient psychologist and outpatient services.

45. In conclusion, the HMIT clinician did not have any specific concerns with the care provided to GM, a very unwell young woman with complex mental health concerns; GM had refractory

[9] The CPU was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

depression and an eating disorder, with chronic suicidality at baseline. Ultimately, the CPU was unable to identify any opportunities for prevention in this matter.

46. The HMIT clinician commented that the purpose of psychiatric admission cannot be to contain someone indefinitely. It must be balanced with the risks of prolonged admission and potential institutionalisation. For those with complex mental health issues and chronic suicidality, it is preferable to have intensive mental health supports in the community, which was in the process of being put into place at St Vincent's at the time of GM's passing.

FINDINGS AND CONCLUSION

47. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased is GM, born [redacted];

    b) her death occurred on 22 August 2023 at Austin Hospital 145 Studley Road Heidelberg Victoria 3084, from complications of fulminant hepatic failure due to paracetamol toxicity; and

    c) her death occurred in the circumstances described above.

48. Having considered all the circumstances, I am satisfied that GM sadly took her own life in the context of a history of complex and chronic health conditions. I am unable to identify any opportunities which may have prevented GM's tragic passing. I am satisfied that GM received appropriate medical care in the period proximate to her passing, together with the unwavering support of her loving parents who clearly did everything they could to support GM's health and wellbeing in the setting of her complex health needs.

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

ORDERS AND DIRECTIONS

To enable compliance with section 73(1) of the Act, I order that this Finding is 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:

CJA and KRA, Senior Next of Kin

St Vincent's Health, Australia

Austin Health

The Melbourne Clinic

Barry Nilsson Lawyers, on behalf of Capella Meurer

Leading Senior Constable Laura Bailey, Coroner's Investigator

Signature:

Coroner Kate Despot

Date: 27 April 2026

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