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IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 2564

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

INQUEST INTO THE DEATH OF JZA

Findings of:	Coroner Leveasque Peterson
Delivered On:	6 November 2023
Delivered At:	65 Kavanagh Street Southbank, Victoria, 3006
Hearing Dates:	8 to 12 November 2021
Counsel Assisting the Coroner:	Mr Duncan Chisholm of counsel, instructed by Ms Sam Brown, Principal In-House Solicitor and Ms Kajhal McIntyre, Coroner's Solicitor
Representation:	Ms Estelle Frawley of counsel representing the Department of Families, Fairness and Housing, instructed by Ms Namrata Kant Mr Raph Ajzenstat of counsel representing Berry Street Victoria, instructed by Ms Fiona Karmouche, Lander & Rogers

	Ms Fiona Ellis of counsel representing three residential support workers, RSW2, RSW3, and RSW4 instructed by Ms Mandy Tisler, Barry Nilsson Lawyers
Keywords:	In Care, GHB Toxicity, Drug Overdose, Monitoring Substance Affected Youth in Residential Care

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SUMMARY

1. JZA[1] was 17 years old at the time of her passing from gamma-hydroxybutyrate (**GHB**) toxicity.

2. JZA was born on 2 April 2000 at the Royal Women's Hospital to JZA's mother[2] and JZA's father.[3] She was the eldest of two sisters. After only a few years, the relationship between JZA's mother and JZA's father began to break down and family dynamics from this time were challenging.

3. JZA's mother noted that by Year 8, JZA experienced some traumatic events and "*started to go off the rails*". JZA felt uncomfortable and vulnerable and began to self-harm, use drugs and form unhealthy relationships.

4. On 24 April 2014, the Department of Health and Human Services (**DHHS**), now the Department of Fairness, Families and Housing (**DFFH**),[4] received a report that JZA and her younger sister had been exposed to family violence.[5] From that instance until her death, JZA was the subject of a series of interventions by DHHS.

5. On 2 May 2017, the Children's Court at Broadmeadows granted a DHHS application to place JZA on an Interim Accommodation Order (**IAO**). The plan was to place JZA in out of home care through Berry Street Victoria (**BSV**) in an effort to address concerns regarding JZA's substance use and the risks this posed to her family. At that time there were no suitable care options available. Given that JZA was approaching 18 years old, the case plan was for JZA to be supported to transition to independent living.

6. JZA was subsequently placed at a BSV Residential Care Unit (**the unit**). The unit had two other residents.

7. Tragically, on 1 June 2017, JZA passed away at the unit from GHB toxicity.

[1] A pseudonym has been applied pursuant to my order dated 20 October 2021.
[2] A pseudonym has been applied pursuant to my order dated 20 October 2021.
[3] A pseudonym has been applied pursuant to my order dated 20 October 2021.
[4] On 1 February 2021, a machinery of government change took effect, restructuring the former Department of Health and Human Services into two departments, Department of Health (**DH**) and the Department of Families, Fairness and Housing (**DFFH**). Child protection was previously located within DHHS but is now part of DFFH.
[5] Statement of Carmel Prendergast.

CORONIAL INVESTIGATION

Jurisdiction

8. JZA's death constituted a *'reportable death'* pursuant to section 4 of the *Coroners Act 2008* (Vic) (**Coroners Act**), because her death occurred in Victoria and, immediately before her death, JZA was a person placed in care, as defined in the Coroners Act.

Purpose of the Coronial Jurisdiction

9. The jurisdiction of the Coroners Court of Victoria (**Coroners Court**) is inquisitorial.[6] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.

10. The cause of death refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

11. The circumstances in which the death occurred refers to the context or background and surrounding circumstances of the death. It is confined to those circumstances that are sufficiently proximate and causally relevant to the death.

12. 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 recommendations by coroners. This is generally referred to as the prevention role.

13. Coroners are empowered to:

    i. report to the Attorney-General on a death;

    ii. comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and

    iii. make recommendations to any Minister or public statutory authority or entity on any matter connected with the death, including public health or safety or the administration of justice.

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

14. These powers are the vehicles by which the prevention role may be advanced.

15. It is important to understand that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including a finding or comment or any statement that a person is, or may be, guilty of an offence.[7] It is not the role of the coroner to lay or apportion blame, but to establish the facts.[8]

16. Whilst it is sometimes necessary to examine whether a person's conduct falls short of acceptable or normal standards, or was in breach of a recognised duty, this is only to ascertain whether it was a causal factor in a death, or merely a background circumstance.

17. When assessing a professional person's actions, a coroner must consider the prevailing standards of the relevant profession or specialty. An act or omission will not usually be regarded as contributing to death unless it involves a departure from reasonable standards of behavior or a recognised duty.

18. It is also important to recognise the benefit of hindsight and to discount its influence on the determination of whether a person acted appropriately. I am conscious of the need to judge the actions of all involved with JZA at the time of her passing prospectively, having regard to the information known to them at the time.

Standard of Proof

19. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[9] The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[10]

20. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[11] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence

[7] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69(2) and 49(1) of the *Coroners Act*.
[8] *Keown v Khan* (1999) 1 VR 69.
[9] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[10] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J (noting that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in the Federal Court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mson CJ, Brennan, Deane and Gaudron JJ.
[11] (1938) 60 CLR 336.

provides a comfortable level of satisfaction that they caused or contributed to the death. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[12]

Mandatory Inquest

21. Section 52(2)(b) of the Coroners Act provides that a coroner must hold an inquest into a death if the death occurred in Victoria and the deceased was, immediately before death, a person placed in care. Because JZA was in the care of the State at the time of her death an inquest was mandatory.

22. JZA's death was reported to the Court on 1 June 2017. I took carriage of the coronial investigation in March 2020. Detective Leading Senior Constable Trent Barker had been appointed as the coroner's investigator and he compiled the coronial brief which was subsequently supplemented with additional information.

23. The inquest hearing commenced on 8 November 2021 and ran to 12 November 2021. The inquest proceeded with COVID 19 restrictions in place.

24. On 20 October 2021, I made an order pursuant to section 55(2)(e) of the Coroners Act that required a pseudonym to be applied where it was necessary, in the proceedings, to refer to the identity of certain individuals in published documents.

Scope of Inquest

25. The scope of the inquest was as follows:

    i. the response of BSV residential support workers and clinicians between 31 May 2017 and 1 June 2017, including:

        a. supervision of JZA;

        b. when JZA did not return to the residential unit by curfew (9.00pm);

        c. when JZA returned to the residential facility at around 5.30am in a distressed state;

        d. when it was identified that JZA appeared to be substance affected; and

[12] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336.

e. monitoring of JZA's condition between 6.00am and 1.35pm.

ii. training, information and instruction provided to residential care facilities and support workers about identifying, responding to, and monitoring substance affected youths who are under IAOs in out of home care in residential care facilities;

iii. supervision of youths who are under IAOs in out of home care in residential care facilities by DFFH (as it is now known) and residential care facilities, including youths who have been identified as at risk of substance use;

iv. what remedial changes have been implemented by BSV, DFFH or its predecessor DHHS, in response to JZA's death; and

v. identification of any further measures that might be taken to prevent similar deaths in the future.

Sources of evidence

26. A coronial brief of evidence was compiled by Acting Detective Sergeant Trent Barker. The brief comprised statements from witnesses including JZA's mother, a friend who was with JZA the night before she died, staff from BSV who were tasked with looking after JZA, other residents of the BSV Residential Care Unit, representatives of DFFH, a forensic pathologist and members of Victoria Police.

27. At inquest, the following witnesses were called:

i. four residential care workers from BSV involved in JZA's care;

ii. A Take Two clinician / registered psychologist;

iii. Jenny McNaughton, Deputy CEO and Executive Director, BSV; and

iv. Tracy Beaton, Chief Practitioner and Executive Director of the Office of Professional Practice, DFFH.

28. This Finding draws on the totality of the materials produced to the court throughout the coronial investigation into JZA's death. That is, the court records, the brief of evidence and further material sought and obtained by the Court, the evidence adduced during the Inquest and submissions provided by Counsel Assisting and Counsel Representing the Interested Parties.

29. In writing this Finding, I do not purport to summarise all the evidence. I have referred only to such information and in such detail as is warranted by the forensic significance and for narrative clarity. The absence of reference to any aspect of the evidence does not mean that it has not been considered.

CIRCUMSTANCES OF DEATH

30. This section summarises evidence included in the coronial brief concerning the circumstances of JZA's death.

Events of 31 May 2017

31. On 31 May 2017, JZA spent the day at the BSV Residential Care Unit, playing music in her room.

32. At about 3.30pm, JZA told Residential Support Worker 1 (**RSW1**)[13] that she was going to see her mother that afternoon but could not get there as there was no one to drop her off. RSW1 told JZA that she would take her to her mother's home. JZA told RSW1 that she would tell her when she was ready to go.[14]

33. Just after 4.00pm, RSW1 returned to the unit after picking up another resident. Upon arrival, JZA told her that she was ready to go and looked happy. After getting into the car, JZA asked RSW1 to drop her off to Macleod Train Station as she wanted to see a few friends before she went to her mother's house. JZA did not say which friends she wanted to see. RSW1 dropped JZA off at Macleod Train Station at approximately 4.15pm. JZA told RSW1 that she would let her know when she wanted to be picked up.[15]

34. That evening, JZA arranged to see an old friend, SBW.[16] At about 8.00pm, JZA met SBW at Eltham Train Station. SBW observed that JZA did not appear to be using drugs, had not been picking her skin, and seemed *"awake and happy"*. She spoke about going to court the following day to get out of the residential unit and return to her mother's home and was excited about this. JZA asked SBW to get her a 'goon sack' (wine) as she wanted to relax due to being stressed about court.[17]

[13] A pseudonym has been applied pursuant to my order dated 20 October 2021.
[14] Statement of Residential Support Worker 1, dated 1 June 2017, CB 58.
[15] Statement of Residential Support Worker 1, dated 1 June 2017, CB 58-59.
[16] A pseudonym has been applied pursuant to my order dated 20 October 2021
[17] Statement of SBW dated 2 February 2019, CB 48.

35. The pair returned to SBW's house with wine and orange juice. JZA spoke to each of her parents on the phone and told them she was with SBW.[18]

36. Later in the evening JZA asked SBW whether she could stay the night, but SBW told her that she had to go back to the residential unit as they would be looking for her and she had court the next day. SBW stated that it *"seemed as though she did not want to return to the Resi House. There were a couple of calls she ignored and she seemed scared of something"*.[19]

37. At about 7.30pm, RSW1 called JZA, but there was no answer. She sent JZA a text message asking JZA to let her know if there was anything she needed. JZA replied *"No I'm not, I'm dead. Haha,"* in what RSW1 believed was a jovial manner.[20]

38. At about 7.58pm, another residential support worker Residential Support Worker 3 (**RSW3**)[21] sent a text message to JZA. JZA responded at about 8.30pm saying she was fine. When completing the handover summary and checklist that night for the overnight shift, RSW3 made a note that JZA was out.[22]

39. At about 10.30pm, SBW stated that he drove JZA to the train station and dropped her off. He asked JZA if she wanted him to stay with her until the train arrived, but she said it was okay and told him to go home. JZA told him that she was waiting for a train to go back to her residential unit.[23] Subsequently, SBW sent JZA a few text messages but her responses to him were blunt, which was out of character. SBW thought JZA was angry at him for not letting her stay the night.[24]

Monitoring of JZA overnight

40. Residential Support Worker 2 (**RSW2**)[25] commenced work at about 10.30pm. He had not previously worked with JZA and received a handover from RSW1.[26] RSW1 stated that she told RSW2 to keep texting JZA and another resident of the unit who was also out to see if they were okay.[27]

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[18] Statement of SBW dated 2 February 2019, CB 48.
[19] Statement of SBW dated 2 February 2019, CB 49.
[20] Statement of Residential Support Worker 1, dated 1 June 2017, CB 59-60.
[21] A pseudonym has been applied pursuant to my order dated 20 October 2021.
[22] Statement of Residential Support Worker 3, dated 11 March 2020, CB 93.
[23] Statement of SBW dated 2 February 2019, CB 49.
[24] Statement of SBW dated 2 February 2019, CB 49.
[25] A pseudonym has been applied pursuant to my order dated 20 October 2021.
[26] Statement of Residential Support Worker 2, dated 3 February 2019, CB 61.
[27] Statement of Residential Support Worker 1, dated 1 June 2017, CB 60.

41. RSW2 stated that he did a welfare check by sending JZA a text message, but did not speak to her until 12.07am on 1 June 2017 when JZA rang the unit requesting details of her credit card. RSW2 heard other young people in the background during the call. JZA did not indicate the reason she wanted her credit card details. Due to JZA's history of alcohol and drug use, her vulnerability and the time of night, RSW2 declined her request for the credit card details and encouraged her to come back to the unit. RSW2 asked JZA what time she planned to return to the unit. JZA told him that she was staying at a friend's home in St Helena and that she had informed her mother and mother's friend of her whereabouts.[28]

JZA's return to the residential unit

42. RSW2 heard nothing further from JZA until about 5.30am. He was in the office, when he heard someone crying as they walked down the driveway towards the front door. RSW2 opened the door and established it was JZA. RSW2 saw JZA was extremely distressed, crying and unable to put many words together. JZA's speech was "*blurred*", she was unsteady on her feet and appeared to RSW2 to display *"all the signs"* of being intoxicated. According to RSW2, JZA admitted to having consumed alcohol and he could smell alcohol on her.[29]

43. RSW2 gave JZA something to eat and drink and filled up her water bottle to make sure she kept up her fluids. JZA began to fall asleep whilst eating her food, so RSW2 woke her up and JZA put herself to bed at about 6.00am.

44. RSW2 also stated that he saw what appeared to be fresh scratch marks on JZA's back but did not question her about it at the time due to JZA's presentation. RSW2 returned to the office and wrote an Incident Report.[30]

Monitoring of JZA on the morning of her death

45. RSW2 reported that he conducted regular checks on JZA and observed that JZA was sleeping on her side and was snoring.[31] RSW2 stated that he went into JZA's room before he completed his shift at 8.30am and observed that she was still sleeping.[32]

[28] Statement of Residential Support Worker 2, dated 3 February 2019, CB 61.
[29] Statement of Residential Support Worker 2, dated 3 February 2019, CB 61-2.
[30] Statement of Residential Support Worker 2, dated 3 February 2019, CB 62.
[31] Statement of Residential Support Worker 2, dated 3 February 2019, CB 62.
[32] Statement of Residential Support Worker 2, dated 3 February 2019, CB 62.

46. At about 8.00am, RSW2 conducted a handover with the morning shift residential support workers, RSW3 and Residential Support Worker 4 (**RSW4**)[33]. RSW3 recalled being told by RSW2 that JZA was intoxicated, but that RSW2 had settled her and that she had eaten.[34]

47. At about 8.30am, RSW3 noted that JZA was in her room asleep.[35]

48. RSW4 reported that he checked on JZA between 8.30am and 9.30am. He observed that JZA was fully clothed, lying on top of her sheets on her side with her face down and towards the wall. He observed that JZA's feet were twitching and she was snoring. He attempted to wake JZA verbally, by saying *"Good morning rise and shine, time to get up"*, but there was no response.[36]

49. At about 9.30am, RSW4 left the unit to attend a care team meeting at Anglicare. RSW3 remained at the unit.[37]

50. At about 9.50am, RSW3 went into JZA's room to give her a wake-up call as she was scheduled to have her first assessment with Take Two Clinician 1 (**TTC1**)[38] that morning. RSW3 observed that JZA was asleep and her chest was moving.[39]

51. At 10.00am, RSW3 made another wake-up call to JZA and noted that she was still asleep.[40]

52. At 10.20am, RSW3 completed a further wake-up call.[41]

53. At about 10.50am, TTC1 arrived onsite to see JZA. RSW3 and TTC1 went to JZA's room to try and wake her but she did not get up.[42] TTC1 observed that JZA was snoring loudly, and moved her shoulder when RSW3 tapped her on the shoulder, but remained

[33] A pseudonym has been applied. It is noted that the Schedule of Pseudonyms attached to my order dated 20 October 2021 mistakenly applied the same pseudonym of Residential Support Worker 3 or RSW3 in relation to two individuals. In this Finding, the second worker denoted in the Schedule of Pseudonyms as RSW3 has instead been allocated the pseudonym of Residential Support Worker 4 or RSW4. Statement of Residential Support Worker 2, dated 3 February 2019, CB 62.
[34] Statement of Residential Support Worker 3 dated 11 March 2020, CB 93.
[35] Statement of Residential Support Worker 3 dated 11 March 2020, CB 93.
[36] Statement of Residential Support Worker 4, dated 1 June 2017, CB 67.
[37] Statement of Residential Support Worker 4, dated 1 June 2017, CB 67.
[38] A pseudonym has been applied pursuant to my order dated 20 October 2021.
[39] Statement of Residential Support Worker 3 dated 11 March 2020, CB 93.
[40] Statement of Residential Support Worker 3 dated 11 March 2020, CB 93.
[41] Statement of Residential Support Worker 3 dated 11 March 2020, CB 93.
[42] Statement of Residential Support Worker 3 dated 11 March 2020, CB 93; Statement of Take Two Clinician 1, dated 11 December 2019, CB 89.

asleep.[43] TTC1 left the unit at 11.00am, and RSW3 made a note for staff to contact TTC1 later once JZA was awake and active.[44]

54. At about 11.10am, RSW4 returned to the unit and received an update from RSW3 who told him about TTC1's visit and that he had tried to wake JZA up for the meeting, but she didn't get up.[45]

55. RSW4 thought that he *"possibly"* checked twice on JZA between 11.10am and 12.50pm by popping his head in and yelling, but JZA still did not wake up. He thought JZA appeared to be breathing heavy, but noted in his statement that his memory on this was not certain.[46]

56. At about 12.50pm, RSW4 again checked on JZA and observed that she was not breathing heavy, had stopped twitching and seemed to be sleeping heavily. JZA was still unresponsive and RSW4 thought she was hungover. RSW4 returned to the office, checking his emails, Facebook and passing the time with RSW3.[47] RSW3 left the unit at about 1.30pm at the end of his shift.[48]

57. At about 1.35pm, a family friend called to ask why JZA had not attended court. After receiving the call, RSW4 went to JZA's room to wake her. He shook JZA, but she was unresponsive. RSW4 moved some things that were between JZA's face and the wall including a make up bag, and observed that JZA's face was pale and her lips were blue.[49]

58. RSW4 immediately called 000, commenced cardiopulmonary resuscitation (**CPR**) as instructed by the call operator, and moved JZA on to the floor. Metropolitan Fire Brigade officers and Ambulance Victoria paramedics arrived a short while later and continued CPR.[50] Despite these efforts, JZA was unable to be revived and was pronounced deceased at 2.08pm.[51]

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[43] Statement of Take Two Clinician 1, dated 11 December 2019, CB 89.
[44] Statement of Residential Support Worker 3 dated 11 March 2020, CB 93-94.
[45] Statement of Residential Support Worker 4, dated 1 June 2017, CB 67-68.
[46] Statement of Residential Support Worker 4, dated 1 June 2017, CB 68.
[47] Statement of Residential Support Worker 4, dated 1 June 2017, CB 68.
[48] Statement of Residential Support Worker 4, dated 1 June 2017, CB 68; Statement of Residential Support Worker 3 dated 11 March 2020, CB 94.
[49] Statement of Residential Support Worker 4, dated 1 June 2017, CB 68.
[50] Statement of Residential Support Worker 4, dated 1 June 2017, CB 68-69.
[51] Statement of Stuart Shepherd, Ambulance Paramedic, dated 14 March 2019, CB 79-80; Statement of David Neely, Ambulance Paramedic, dated 8 March 2019, CB 81; Statement of David Mati, Ambulance Paramedic, dated 2 March 2019, CB 83-84.

Police investigation

59. Victoria Police attended the scene and commenced a coronial investigation.

60. Investigators examined the room and located a bong between the bed and wall, two empty cans of bourbon under the bed and two full wine bladders. There was no medication or indication of illicit drug use in the room apart from the bong.[52] There was also no evidence that JZA had intended to end her life.

61. Investigators were unable to locate JZA's phone at the unit. However, analysis of JZA's phone records indicated that JZA was in Eltham at 7.24pm on 31 May 2017. Her phone was used in Diamond Creek at 11.47pm, and then in the nearby Wattle Glen area at 12.03am on 1 June 2017. At 12.24am, the phone appeared to be in Bundoora West and then in the Fawkner area between 1.44am and 5.23am.[53]

62. Investigators explored various avenues of enquiry in an effort to ascertain JZA's movements prior to returning to the unit. These enquiries were unfruitful, and investigators were unable to confirm how JZA travelled back to the unit or how she accessed GHB as identified in post-mortem toxicology.[54]

OTHER INVESTIGATIONS

63. BSV conducted a review into the circumstances of JZA's death which was finalised on 5 December 2017. The Review found, relevantly, that the Berry Street staff were aware of but unclear about the BSV procedure for substance use. Specifically, staff did not adhere to the monitoring requirement for substance affected clients.

IDENTITY OF DECEASED

64. On 6 June 2017, JZA was visually identified by her aunt and uncle. JZA's identity was not in dispute and required no further investigation.

[52] Statement of Detective Leading Senior Constable Trent Barker dated 3 February 2019, CB 73.
[53] Statement of Detective Leading Senior Constable Trent Barker dated 3 February 2019, CB 73-4.
[54] Statement of Detective Leading Senior Constable Trent Barker dated 3 February 2019, CB 73-6.

MEDICAL CAUSE OF DEATH

65. On 5 June 2017, Dr Malcolm Dodd, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an autopsy on the body of JZA. Dr Dodd provided a written report of his findings dated 24 November 2017.

66. The post-mortem examination was essentially normal: there was no evidence of offensive or defensive type injury and there was no evidence of significant naturally occurring disease. In particular, there were no scratches identified on JZA's back.

67. Toxicological analysis of post-mortem specimens revealed the presence of gamma hydroxybutyrate (**GHB**)[55] in both blood and urine, at a level consistent with excessive and potentially fatal use. In addition, delta-9-terahydrocannbinol (also known as THC, the active form of cannabis) was detected in blood, and 11-nor-delta-9-carboxy-tetrahydrocannabinol (THC-COOH, carboxy metabolite of THC) and methylamphetamine[56] was detected in urine. No ethanol (alcohol) was identified in post mortem specimens.[57]

68. Dr Dodd commented that post mortem concentrations in fatalities attributed to GHB use showed an average concentration of approximately 329 mg/L. In this case, the level of GHB found in blood was approximately 250 mg/L, however the urine concentration was exceedingly high (~3285 mg/L), indicating a much higher level in blood at a previous time. Dr Dodd explained that GHB consumption may lead to death as a consequence of central nervous system depression.

69. Dr Dodd provided an opinion that the medical cause of death was '*1(a) Gamma hydroxybutyrate (GHB) toxicity.*'

70. I accept and adopt Dr Dodd's opinion as to the medical cause of death.

[55] Gamm-hydroxybutyrate is an illegal drug known as GHB, GBH, Fantasy, and liquid ecstasy, amongst other names. It is a white colourless white solid freely soluble in water, with a half life between 20 to 60 minutes. Blood concentrations following common "street" doses may peak at around 100 mg/L, but may be much higher. Oral or intravenous doses of 10 mg/kg may cause amnesia and hypotonia (weak muscle tone) leading to anaesthesia at 50 mg/kg. Doses of 25 mg/kg causes dizziness or drowsiness and a mean plasma concentration of 80 mg/L after half an hour.

[56] Methylamphetamine is a potent central nervous stimulant mainly used as a recreational drug.

[57] I accept submissions on behalf of BSV that no evidence was adduced to demonstrate that JZA was not also affected by alcohol at the time that she returned to the unit.

CORONIAL INQUEST

71. At inquest, extensive evidence was heard in relation to the circumstances of JZA's death. This evidence is summarised below with reference to the inquest scope, drawing significantly from the final submissions of Counsel Assisting.[58]

RESPONSE OF BSV RESIDENTIAL SUPPORT WORKERS

72. BSV operates numerous residential care homes in Victoria. The residential care unit in which JZA was housed at the time of her death had capacity to house three young persons, although there was only one other female resident at the relevant time. The unit was staffed by residential support workers including RSW1, RSW2, RSW3 and RSW4. Typically, at least two workers were on shift in the unit at any given time, working either a day or night shift.

73. Submissions on behalf of BSV contend that it is apparent from a reading of the Monthly Placement and Action Report for May 2017 that JZA had a "*warm, empathetic and trusting relationship with the staff at the residential unit.*"

74. I accept these submissions and acknowledge the work of the residential care workers in establishing a positive rapport with JZA. Nonetheless, I consider that the evidence raises some issues with regard the adequacy of supervision and monitoring provided to JZA between 31 May 2017 and 1 June 2017.

Curfew

75. Regarding the issue of curfew, it is apparent on the evidence that JZA did not return to the unit by 9pm, although BSV staff remained in contact with JZA intermittently throughout the night. However, I accept submissions on behalf of BSV that the evidence on this issue was limited in nature, and therefore it would not be inappropriate to make any further finding or comment on this matter.[59]

[58] With regard to the final two elements of the scope – remedial changes implemented, and identification of further measures to prevent similar deaths – I have incorporated relevant discussion throughout with regard to each issue arising.
[59] Submissions in Reply on behalf of BSV, dated 22 December 2021, page 1-2.

Shift handovers

76. The evidence raised a number of issues associated with the BSV handover process which was adopted in relation to JZA during the relevant period.

77. Witnesses provided evidence in relation to the general handover process, whereby at the conclusion of each shift, the BSV residential workers on shift would perform a handover with the incoming staff members. The witnesses explained that the handover was verbal and included, to varying extents, a review or discussion of the following documents:[60]

    a. Handover summary and checklist (the **summary**);

    c. Shift notes, whereby residential care workers would type notes into a Microsoft Word document during a shift, which would later be sent by email to the regional office where the contents would be compiled into a larger document called the "Monthly Placement and Action Report" (the **monthly report notes**);[61] and

    d. Incident reports.

78. In scheduling shifts, BSV provided for a period of half an hour of cross-over between staff which was allocated for handover. The period of time allocated was static. It did not vary according to the number of clients in the unit.[62]

79. The witnesses expressed concern that the duration of time allocated for handover was insufficient. RSW4 and RSW2 stated that 30 minutes, or 15 minutes per client, was insufficient time to consider each client and to read each clients' computer file.[63] This was particularly the case in the context of a client with JZA's complexity.

80. It is clear that residential units are busy places. The evidence established that in addition to the general supervision of the residents, workers are also required to perform domestic and administrative duties during a shift.[64] The witnesses indicated that clients felt uncomfortable during handovers as they were conscious of the fact they were the subject of the handovers.[65] It was against this backdrop that BSV expected and required its workers to provide comprehensive handovers of young people with complex histories,

[60] Transcript of Inquest, page 94-95 (RSW2).
[61] These notes were variously described during the Inquest as the *word document, shift notes, weekly* or *monthly report*.
[62] Transcript of Inquest, page 71 (RSW1) page 94 (RSW2), and pages 205-206 and 220 (RSW4).
[63] Transcript of Inquest, page 220 (RSW4), and pages 109, 142, and 220 (RSW2).
[64] Transcript of Inquest, page 295 (RSW3).
[65] Transcript of Inquest, page 388 (McNaughton).

which often (as in JZA's case) included multiple incidents reports of high risk taking behaviour.

81. RSW2 explained that the general practice was to review the monthly report notes available on the computer for the previous 24 – 48 hours.[66] RSW4 also clarified that the monthly report notes would usually contain a summary of any incident reports.[67]

82. For the purpose of the inquest, there were two relevant handovers in respect to JZA. On 31 May 2017, RSW1 provided RSW2 with a handover;[68] and on 1 June 2017, RSW2 provided RSW4 and RSW3 with a handover.[69]

83. In respect to the 31 May 2017 handover, RSW1's recollections are vague – she believes she provided a rundown of "*the important stuff*" but does not remember taking RSW2 to the handover documents.[70] It was RSW2's first time working with JZA[71] and while he recalls receiving a brief verbal handover and being shown the summary,[72] he was unable to recall the monthly report notes,[73] the Placement Referral Form,[74] nor was he aware nor made aware of previous incident reports in respect to JZA's substance misuse, breaches of curfew, and sexual exploitation.[75] However, he was referred to her Crisis Management Plan, which he states he read later in the evening.[76]

84. In respect to the 1 May 2017 handover, RSW2 reported he provided RSW4 with a verbal handover, which included the substance of the incident report from that evening concerning JZA returning home intoxicated, being distressed about her sister and the welfare checks he had performed.[77] RSW4 confirmed that he was told she returned distressed and affected by alcohol; but does not recall if he was informed of JZA's level

[66] Transcript of Inquest, pages 94-96 (RSW2).
[67] Transcript of Inquest, page 187 (RSW4).
[68] Statement of Residential Support Worker 2, dated 3 February 2019, CB 61; Statement of Residential Support Worker 1, dated 1 June 2017, CB 56.
[69] Statement of Residential Support Worker 2, dated 3 February 2019, CB 62; Statement of Residential Support Worker 4, dated 1 June 2017, CB 64.
[70] Transcript of Inquest, page 86 (RSW1).
[71] Transcript of Inquest, page 93 (RSW2).
[72] Transcript of Inquest, page 94 (RSW2); Handover Checklist and Summary (31.05.17), Exhibit 4.
[73] Transcript of Inquest, page 96 (RSW2).
[74] Transcript of Inquest, page 162 (RSW2).
[75] Transcript of Inquest, pages 97 – 103 (RSW2). See Comprehensive Report(s), Exhibit 5 – 10.
[76] Transcript of Inquest, pages 140 – 141 (RSW2).
[77] Transcript of Inquest, pages 130 - 131 (RSW2); Incident Report (01.06.17), Exhibit 13 and Comprehensive Report (01.06.17), Exhibit 14.

of intoxication before she went to bed.[78] RSW3 simply recalls being told she was intoxicated, but had settled down, had food and water and gone to bed.[79]

85. I consider that the evidence as summarised above raises a number of issues associated with BSV's handover process, specifically:

    i. the adequacy of time allocated for handovers; and

    ii. the extent to which workers had access to, and reviewed, the relevant documentation; and

    iii. the adequacy of initial handovers for a new resident.

86. At inquest, Ms McNaughton acknowledged that the evidence raised concerns with the handover process and identified several opportunities for improvement to "*put more structure*" around the process, as well as to ensure that casual workers are facilitated to provide the same quality supervision as permanent workers.[80]

87. In particular, Ms McNaughton acknowledged a need to allocate additional time for handover (in particular in respect to causal employees)[81] and to clarify which documents a worker is required to review during handover.[82] She also accepted that, in relation to the BSV handover summary and checklist, it would be sensible to include another column for agency workers relating to policies.[83] Finally, Ms McNaughton acknowledged there was an need to ensure that processes were in place to ensure that care workers are aware of information contained in incident reports.[84]

88. I commend Ms McNaughton on recognising that shift handovers represent a critical area for improvement and have made recommendations to support the implementation of such initiatives.

[78] Transcript of Inquest, page 194 (RSW4).
[79] Transcript of Inquest, page 268 – 269 (RSW3).
[80] Transcript of Inquest, page 344 (McNaughton).
[81] Transcript of Inquest, page 363-364 (McNaughton).
[82] Transcript of Inquest, page 343 (McNaughton).
[83] Transcript of Inquest, page 383 (McNaughton).
[84] Transcript of Inquest, pages 345-346 (McNaughton).

Assessment and monitoring of substance-affected youths

89. Extensive evidence was provided by the witnesses about the assessment and monitoring of substance-affected youths, and in particular, the assessment and monitoring of JZA upon her return to the unit on 1 June 2017.

90. At the relevant time, BSV had a policy for assessing and monitoring substance affected youths: *Responding to Client Substance Use in Residential Care Procedure 2015* (the 2015 Policy).[85] Relevantly, the policy required, inter alia, sleeping, substance affected youths to be checked every five minutes to observe for signs of deterioration. The policy also contained a consciousness scale to assist staff in their monitoring.

91. The evidence raises significant issues regarding awareness of, and compliance with, the 2015 Policy by the residential care workers.

92. Prior to considering these broader issues, it is first necessary to summarise the evidence presented at inquest. In this respect, I have substantially adopted the submissions of Counsel Assisting.

<u>Assessment and monitoring of JZA on 1 June 2017</u>

93. At approximately 5:30am, JZA returned to the unit. RSW2 was on duty and recalls that when JZA returned to the unit she was crying and extremely distressed. At first, she was unable to put words together, but as she slowed her breathing, she explained she was upset as her sibling was being removed from their mother.[86] Physically she was unsteady on her feet and slurring her speech. RSW2 asked JZA if she had been drinking which she confirmed.[87] He does not recall asking her is she had taken any other substance,[88] but agreed that he might have made other observations had he known that she had previously used marijuana or methamphetamine.[89] Initially, RSW2 believed she was getting better and so reheated some food for JZA.[90] However, shortly after serving it she started to fall asleep in the food, which he took to mean "*she was tired and she was slowing down and*

[85] Exhibit 15.
[86] Transcript of Inquest, pages 113-114 (RSW2).
[87] Transcript of Inquest, page 116 (RSW2).
[88] Transcript of Inquest, pages 117-118 (RSW2).
[89] Transcript of Inquest, page 118 (RSW2).
[90] Transcript of Inquest, pages 119-120 (RSW2).

her body was asking for rest."[91] He encouraged her to go to bed,[92] which she did at approximately 6:00am.[93]

94. In respect to monitoring JZA after she went to bed, RSW2 explained that he returned to JZA's room at intervals of 20 to 30 minutes to monitor her condition: "*my monitoring was just ensuring that she was still breathing, and…I would monitor that and observe that by looking at her blanket to see if that – if the blanket was going up and down around the ribcage and ensuring that she was sleeping on her side*."[94]

95. In respect to BSV's policies around monitoring substance affected youths, RSW2 did not recall having read the 2015 Policy and did not appreciate its requirements including the prescribed frequency for monitoring substance affected youths.[95]

96. From around 8:00am, RSW3 was onsite and assisted in monitoring JZA. In evidence, RSW3 had a poor recollection of these events. While he was able to confirm he checked on JZA at 8:30am, 9:50am, 10:00am, 10:20am, 10:40am and 10:57am, he could only provide limited evidence as to the substance of those checks. In respect to the first three checks, he recalls he checked if she was breathing, which involved seeing if her chest moved.[96] He also checked if she was lying on her side to ensure she did not vomit in accordance with his BSV first aid training.[97] He had no recollection of the fourth and fifth checks,[98] and at its highest believes he may have tapped JZA's shoulder during the sixth check.[99] This was ultimately confirmed by TTC1 who was present during the sixth check.[100]

97. In respect to BSV's policies around monitoring substance affected youths, RSW3 gave evidence that he did not recall the 2015 Policy[101] and believed he was required to perform a check every 30 minutes to an hour when a substance-affected youth was asleep.[102]

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[91] Transcript of Inquest, page 120 (RSW2).
[92] Transcript of Inquest, page 120 (RSW2).
[93] Transcript of Inquest, page 123 (RSW2).
[94] Transcript of Inquest, page 124-125 (RSW2).
[95] Transcript of Inquest, page 133 (RSW2).
[96] Transcript of Inquest, pages 269–272 (RSW3).
[97] Transcript of Inquest, pages 270-271 (RSW3).
[98] Transcript of Inquest, 272 (RSW3).
[99] Transcript of Inquest, page 284 (RSW3).
[100] Transcript of Inquest, page 251 (TTC1).
[101] Transcript of Inquest, page 274-275 (RSW3). I note that this evidence departs from his response during BSV's investigation. During the investigation he explained that he was aware of the procedure and understood the 5 minutes rule applied to dangerous or self-harming young persons and that he understood medical deterioration to mean "*vomiting, change in skin or breathing but we didn't see that*" (*Berry Street Investigation Report*, CB 294, 296).
[102] Transcript of Inquest, page 271 (RSW3).

98. Similarly, from 8:00am, RSW4 was monitoring JZA. At 8:00am, RSW2 provided RSW4 with a handover at the commencement of his shift. Between 8:00am and 1:45pm, RSW4 checked JZA on five occasions as outlined below.

99. At 8:30am, RSW4 observed her breathing and lying on her side with her head facing the wall.[103] Shortly thereafter, at 9:30am RSW4 informed RSW3 that he had checked in on JZA who was snoring and ok. He then he left for the Care Team Meeting.[104] Upon his return at 10:30am, RSW3 informed him that he had checked on JZA whilst he was out.[105]

100. Between 11:10am and 12:30pm RSW4 performed a further two checks. Again, he observed her breathing, checked that her chest was rising/falling and listened for auditory breathing sounds.[106] Albeit, he could not recall if she was breathing heavily or snoring.[107]

101. At 12:50pm, RSW4 returned for a fourth time. This time he observed she was not breathing heavily and had stopped twitching. RSW4 did not view this as a deterioration in her condition, but rather understood it mean she was in deep sleep.[108]

102. At around 1:30pm, JZA's family friend called the unit as she had failed to attend court. RSW4 went to check on JZA. For the first time, he tried to physically rouse her and found that her body provided no resistance, her face was pale and lips blue. RSW4 call Triple Zero (000).[109]

103. In respect to BSV's policies around monitoring substance affected youths, RSW4 gave evidence he was aware BSV had general polices but didn't recall the 2015 Policy.[110] At the time, he understood welfare checks on sleeping substance affected youths were to be performed every hour, based on common practice at BSV units.[111]

104. Following the incident, BSV implemented numerous updates to its *Responding to Client Substance Use in Residential Care Procedure* in 2017, 2019, 2020 and 2021.[112] The

[103] Transcript of Inquest, page 196 (RSW4).
[104] Transcript of Inquest, page 198 (RSW4).
[105] Transcript of Inquest, page 198-199 (RSW4).
[106] Transcript of Inquest, page 200 (RSW4).
[107] Transcript of Inquest, page 200 (RSW4).
[108] Transcript of Inquest, page 202-203 (RSW4).
[109] Transcript of Inquest, page 206-207 (RSW4).
[110] Transcript of Inquest, page 207 (RSW4).
[111] Transcript of Inquest, page 199-200 (RSW4).
[112] *Responding to Client Substance Use in Residential Care Procedure 2017*, Exhibit 20; *Responding to Client Substance Use in Residential Care Procedure 2019*, CB 1931; *Responding to Client Substance Use in Residential Care Procedure 2020*, CB 1919; *Responding to Client Substance Use in Residential Care Procedure 2021*, CB 1931.

evidence of the residential care workers suggested they were not fully aware of the substance of these updates:

i. As of December 2017 when RSW2 remained working at BSV, he stated he remained unaware of any change to the policies or procedures[113] and had not had any conversation with a manager or senior colleague about the frequency of welfare checks.[114] He stated that if a resident presented as JZA did he would not have known to welfare check them more frequently.[115]

ii. As of March 2018, RSW4 remained unaware the changes to the policies and procedures, specifically the introduction of the 2017 Policy.[116] Consequently, he was unaware of the new requirement to monitor every 15 minutes[117] or that when a substance affected youth did not respond to rousing an ambulance was to be called.[118]

iii. As of November 2020, RSW3 stated that he was aware of a change to 2015 Policy, but when questioned he did not appear to appreciate the substance of the changes: for example, the frequency of welfare checks[119] or the types of responses he was to be looking for.[120]

Issues with regard to supervision of substance-affected youth

105. The evidence of the residential care workers on this issue was concerning. While acknowledging that the passage of time may dim memory, I consider that there is sufficient evidence to conclude that the relevant BSV workers who monitored JZA in the period before her death were largely unaware of the substance of the 2015 policy.

[113] Transcript of Inquest, page 112 (RSW2).
[114] Transcript of Inquest, page 137 (RSW2).
[115] Transcript of Inquest, page 137 (RSW2).
[116] Transcript of Inquest, pages 208-209 (RSW4).
[117] Transcript of Inquest, page 209 (RSW4).
[118] Transcript of Inquest, page 209 (RSW4).
[119] Transcript of Inquest, page 276 (RSW3).
[120] Transcript of Inquest, page 277 -278 (RSW3).

106. Specifically, in May 2017, relevant BSV workers were unaware of the frequency with which they were required to check on a substance affected youth;[121] the signs of deterioration[122] or the application of the consciousness scale.[123]

107. I consider that, at least partially as a result of their lack of awareness, none of the residential care workers undertook their monitoring of JZA in full compliance with the relevant BSV training and policy.

108. Whilst recognising this deficiency, I do not regard their evidence as a foundation for any criticism of the residential care workers themselves, who presented to the court as committed and caring. Rather, I consider that the cumulative failures are more properly reflective of a flawed delivery system for the training of residential care workers.

109. This issue was conceded by Counsel for RSW2, RSW3 and RSW4, who acknowledged that at the relevant time, her clients had "*no real or sophisticated understanding*" of the frequency with which they were to conduct welfare checks or what they were to look for in determining the conscious state of a young person affected by substances who was asleep.[124] I accept Counsel's submissions that this lack of understanding reflected inadequate education and training by BSV.[125]

110. Similarly, Counsel for BSV acknowledged that the evidence of the residential care workers at inquest gave rise to concerns, including on the basis that the witnesses who cared for JZA appeared to have "*a limited ability to recall*" the content of the 2015 policy and "*limited awareness*" of subsequent policy updates.[126] Ms McNaughton stated that she considered that "*there's a lot of work … that can be done*" to ensure "*that [the policy is] understood*".[127] In this respect, Ms McNaughton outlined that BSV has implemented

[121] RSW3 believe he was to check every 30 minutes hour (Transcript of Inquest, page 271); RSW4 believed the practice was to check hourly (Transcript of Inquest, page 199); and RSW2 believed the appropriate intervals were upwards of 20 minutes (Transcript of Inquest, page 124).
[122] For example, RSW4 did not review a change in the depth of her breathing as a sign of deterioration (Transcript of Inquest, page 202-203) and similarly viewed snoring as a good sign (Transcript of Inquest, page 197), while RSW3 simply looked for a sign she was breathing, such as her chest moving (Transcript of Inquest, page 270).
[123] For example, RSW4 states he had not received any specific training on consciousness in a substance affected client (Transcript of Inquest, page 211); RSW2 did not recall understanding or knowing the term (Transcript of Inquest, page 176) nor receiving training or information about the 2015 Policy (Transcript of Inquest, page 176), while RSW1 thought she was aware of the need to assess consciousness (Transcript of Inquest 54) but did not articulate how.
[124] Submissions on behalf of RSW2, RSW3 and RSW4, dated 7 December 2021, page 6.
[125] Submissions on behalf of RSW2, RSW3 and RSW4, dated 7 December 2021, page 7.
[126] Submissions on behalf of BSV, dated 10 December 2021, pages 2-3.
[127] Transcript of Inquest, pages 320-321 (McNaughton).

numerous improvements with regard to instruction and training, described further in the section below.

111. I commend the residential care workers, Ms McNaughton, and BSV, for their respective candour in this regard.

112. I accept the submissions of Counsel for BSV that the evidence adduced from the witnesses cannot be taken to be a reflection of all BSV residential care workers or the broader organisation. Moreover, I acknowledge that evidence at inquest suggested that the content of BSV policies was generally appropriate, and that BSV has embraced the opportunity created through this inquest to strengthen its practices and procedures to improve both the experience of its clients and residential care workers.

113. Certainly, as submitted by Ms McNaughton on behalf of BSV, it is true that the strength of relationships formed between staff and young people constitutes one of the most important factors in providing quality care within a residential care unit.[128] In this respect, and as noted earlier, I consider that the residential care workers were skilled at establishing an effective rapport with JZA. Nonetheless, I consider that it is critical that residential care workers are supported to translate their skills in developing positive relationships with young people into safe and effective care, through the provision of effective training. This issue is considered further below.

Agency workers

114. In addition to broader issues with regard to the supervision of substance-affected youths, there was evidence to suggest that particular difficulties arose with ensuring that agency workers are aware of and understand relevant policies.

115. Ms McNaughton explained that agency workers are engaged on an ad hoc basis (i.e., when a worker calls in sick) and often receive an induction "*on the fly*" with no extra time allocated for handover.[129] She acknowledged this was "*not a great process.*"[130] Ms McNaughton also stated that she was unaware of whether agency workers had access to resources contained on the intranet, where they were working at the unit on their own.[131]

[128] Transcript of Inquest, page 389 (McNaughton).
[129] Transcript of Inquest, page 381 (McNaughton).
[130] Transcript of Inquest, page 380 (McNaughton).
[131] Transcript of Inquest, page 382 (McNaughton).

116. While such ad hoc arrangements are clearly not ideal, I acknowledge that the use of agency workers may represent a necessary reality in response to unexpected staff absences. I am comforted by the evidence of Ms McNaughton that BSV uses agency workers as a last resort and only engages agencies which are registered, with whom BSV knows and has a contract.[132]

117. However, I consider that there may be further opportunities for BSV to better support agency workers to grasp key policy requirements, as well as the risk profile of each resident, and thereby provide effective supervision to youths in their care including substance-affected youths such as JZA. I have made recommendations to this effect.

118. Based on Ms McNaughton's evidence, there may be several opportunities to overcome potential knowledge gaps which may be faced by agency workers.

119. Ms McNaughton acknowledged that in relation to the BSV handover summary and checklist, it would be sensible to include another column for agency workers relating to policies.[133] Ms McNaughton also stated that where a young person presented with complex risks, they might be managed by an experienced BSV worker while an agency worker might be engaged as "*back-up*" to care for the other residents.[134]

120. Ms McNaughton explained that labour hire firms have their own policies which agency workers must comply with, and that prior to engaging workers from a particular agency, she would meet with the manager of the labour hire firm to talk about how to induct agency staff.[135] This may present an opportunity to ensure that key policies maintained by the labour hire firm align with key BSV policy requirements, for example in relation to the monitoring substance-affected youths.

INFORMATION, INSTRUCTION AND TRAINING

Information, Instruction and Training by BSV

121. Ms McNaughton gave evidence that, prior to candidates becoming BSV employees, BSV provides documents, a two-day induction, and access to shadow shifts.[136] After completing shadow shifts, BSV candidates complete an interview with a team leader which is the final stage of recruitment. The candidate is required to complete a booklet

[132] Transcript of Inquest, page 380 (McNaughton).
[133] Transcript of Inquest, page 383 (McNaughton).
[134] Transcript of Inquest, page 381 (McNaughton).
[135] Transcript of Inquest, page 380 (McNaughton).
[136] Transcript of Inquest, page 307 (McNaughton).

of their reflections and be able to discuss their learnings and experiences. The team leader will collect feedback from the people that they worked alongside with and will then determine whether to make a final offer of employment.[137]

122. BSV has a number of documented procedures for dealing with children and young persons in its care: relevantly, those included the Residential Care Manual and the 2015 Policy. Ms McNaughton's evidence was that, at the relevant time, the 2015 Policy and Residential Care Manual was generally provided to candidates who were seeking to become residential care workers and the expectation was that the workers read those documents and discussed them with their team leader that was supervising their shift.[138]

123. Ms McNaughton gave evidence that once staff were employed by BSV they were offered in-person training concerning substance use in a training program called 'Alcohol and other drugs training.' At the time of JZA's death this training was not compulsory.[139]

124. BSV submitted that since JZA's death, it has implemented numerous improvements with regard to its model of staff training – namely BSV has:

    i. continually improved and refined its substance use procedure, and invested in the development of a broader range of training and instructional materials, including self-paced online video training;[140]

    ii. mandated drug and alcohol training for all residential care staff;[141]

    iii. Launched the "Out of Home Care Learning Hub";[142]

    iv. Developed a new intranet which is more user-friendly and enables people to access publications more easily;[143]

    v. Created a new arm of the organisational called "*organisational effectiveness*" responsible for policy programming and accessibility;[144]

    vi. Developed a quality governance committee which meets every two months;[145]

[137] Transcript of Inquest, page 312-313 (McNaughton).
[138] Transcript of Inquest, page 311 (McNaughton).
[139] Transcript of Inquest, page 313 (McNaughton).
[140] Submissions on behalf of BSV, dated 10 December 2021, page 5.
[141] Submissions on behalf of BSV, dated 10 December 2021, page 5.
[142] Submissions on behalf of BSV, dated 10 December 2021, page 5.
[143] Transcript of Inquest, page 316 (McNaughton).
[144] Transcript of Inquest, page 318 (McNaughton).
[145] Transcript of Inquest, page 319 (McNaughton).

vii. Developed a policy publication which is sent to all staff every two months;[146] and

viii. Publicised its Learning and Development Program by displaying the document in various places in a residential care unit, via the intranet, as well as via each staff member's own learning and development register.[147]

125. I commend BSV on these efforts to improve its practices. However, I note that despite these measures, a recurring theme in the evidence was an inadequate knowledge of BSV policies and procedures, and specifically, in assessing and monitoring substance-affected youths.

126. In this respect, Ms McNaughton conceded that further work was necessary to ensure that staff understand and comprehend the training they are required to undertake, both at the time they receive the training and during their employment thereafter. Ms McNaughton identified several possible improvements, including:

i. Yearly refresher training;

ii. Mechanisms to test staff understanding of relevant policies;

iii. A requirement to discuss policies at residential care team meetings; and

iv. Improved supervision of casual workers, to ensure they receive the same quality supervision as permanent staff.

127. As noted above, I commend Ms McNaughton on her clear commitment to embracing opportunities for improvement with regard to staff training and have made recommendations intended to support this process.

Information, Instruction and Training by DFFH

128. At the time of JZA's death, DFFH mandated that residential care providers such as BSV had policies in relation to substance abuse.[148] DFFH also provided residential care providers with general educational resources, including access to the Child Protection Manual. This includes certain information about drugs and alcohol, and other areas of

[146] Transcript of Inquest, page 319 (McNaughton).
[147] Submissions on behalf of BSV, dated 10 December 2021, page 5.
[148] Submissions on behalf of DFFH, dated December 2021, page 8.

concern relating to vulnerable children in out of home care.[149] DFFH also funds the Centre of Excellence, the peak body for the sector, which advocates, conducts research, and provides training including to BSV staff.[150]

129. Despite the provision of general resources, I accept submissions on behalf of BSV that at the time of JZA's death, the information provided by DFFH did not include any specific guidance about how to respond to a young person who is substance-affected and asleep.[151]

130. Since JZA's death, DFFH has implemented several measures intended to improve information, instruction, and training for residential care workers. In particular, DFFH:

    i. provided Alcohol and Other Drug Funding to support the Youth Out-of-Home Care Alcohol and Other Drug State-wide capacity;

    ii. provided Alcohol and Other Drug training for "Working with young people who use drugs and alcohol";

    iii. instituted a minimum qualification requirement for residential care workers in January 2018 with the Certificate IV in Child, Youth and Family Intervention, which has a component of working with young people who are substance-affected.[152]

131. Ms Beaton gave evidence that she had also contacted the Centre for Excellence in Child and Family Welfare and asked them to revisit the training that they provide including how it is that a residential care worker would understand levels of consciousness and the difference between sleep and whether a person is unconscious.[153] Ms Beaton stated that she had also sought agreement through the DFFH policy area to work with them around the residential care requirements so that it can be more specific about what it is needed in terms of practice and practice requirements.[154] I was pleased to hear about such initiatives and support ongoing work in this regard.

[149] Transcript of Inquest, pages 306 and 348-349 (McNaughton).
[150] Transcript of Inquest, page 440 (Beaton).
[151] Submissions in Reply on behalf of BSV, dated 22 December 2021, page 4.
[152] Transcript of Inquest, page 315 (McNaughton).
[153] Transcript of Inquest, page 439 (Beaton).
[154] Transcript of Inquest, pages 438-439 (Beaton).

SUPERVISION BY DFFH

132. As was appropriately acknowledged by Ms Beaton, the Secretary has a responsibility to work alongside agencies, families and carers for the best interests of children, in line with the *Children, Youth and Families Act 2005.*[155]

133. The inquest heard evidence that DFFH provided oversight and supervision in respect of youths on IAO's to out of home care service providers by several means, including:

    a. The allocation of a DFFH child protection worker to each young person on a child protection order;[156]

    b. The provision of information by DFFH to residential care providers upon a young person's placement, with regard their child protection history and needs;[157]

    c. Care Team Meetings;[158]

    c. Incident Reports;[159] and

    d. Auditing of care providers including BSV.[160]

The allocation of a DFFH child protection worker

134. While the inquest did not hear extensive evidence on this issue, it is evident that JZA was allocated a child protection practitioner by DFFH.[161]

The provision of information by DFFH to the residential care provider

135. At the time of JZA's placement with BSV, DFFH provided BSV with two documents:

    i. a Placement Referral Form; and

    ii. a Crisis Management Plan.

136. According to submissions on behalf of DFFH, the purpose of these documents was "*to provide assistance to BSV in caring for JZA and responding to her needs*."[162] In

[155] Transcript of inquest, page 405 (Beaton).
[156] Transcript of Inquest, pages 443 and 451 (Beaton).
[157] Transcript of Inquest, dated 11 November 2021, page 351 (McNaughton).
[158] Transcript of Inquest, page 350 (McNaughton).
[159] Client Incident Report Form, CB 278.
[160] Transcript of Inquest, page 404 (Beaton).
[161] Transcript of Inquest, dated 11 November 2021, page 351 (McNaughton).
[162] Submissions on behalf of DFFH, dated December 2021, page 5.

particular, the Placement Referral Form was intended to assist BSV and its residential workers in understanding the care needs of the young person: such as any substance misuse issues and/or contact issues with relatives or persons of concern.[163]

137. JZA's Placement Referral Form did identify a substance misuse issue and a person of concern.[164] However, BSV witnesses gave evidence that the information captured in the form could be improved.

138. Ms McNaughton observed that with the benefit of hindsight, JZA's form was not as detailed as she would have liked. Ideally, she would have expected more information and detail about JZA's history; substance misuse; health and well-being; as well as a robust safety plan.[165] Similarly, RSW4 considered that it would have been more helpful if JZA's form had identified the frequency with which she used substances; how she presented when substance affected; and a history of substance misuse (times/dates/locations).[166]

139. These views were put to Ms Beaton who agreed that the form could be improved.[167] Ms Beaton acknowledged that the form did not provide clear information with regard to the frequency, details and amount of substance use and that this could be an area for improvement.[168]

140. In March 2021, DFFH updated the Placement Referral Form to provide a dedicated space to share relevant information relating to risk and risk mitigation. As outlined in submissions on behalf of DFFH, there is now a mandatory field called 'placement safety' and the author of the placement referral document is required to answer a number of mandatory questions including reference to whether there have been any occurrences in the last three months of the child or young person exhibiting at risk behaviour for example drug use and if there is a current risk, ensuring that there is a plan to respond and reference to whether the child or young person is currently engaged in drug and alcohol abuse. Finally, there is now a 'prompt' in the form to add relevant notes or documents.[169]

[163] Transcript of Inquest, pages 410-411 (Beaton)
[164] Placement Referral Form, CB 101-109.
[165] Transcript of Inquest, page 350 (McNaughton).
[166] Transcript of Inquest, page 191-192 (RSW4).
[167] Transcript of Inquest, page 477-482 (Beaton).
[168] Transcript of Inquest, page 412 (Beaton).
[169] Submissions in Reply on behalf of DFFH, dated December 2021, 5.

141. In November 2021, DFFH also introduced a new risk assessment framework called the SAFER Children's Framework which may improve collection of information regarding risk.[170] Ms Beaton noted that information derived from this risk assessment could be included in the Placement Referral Form.[171]

142. The Inquest also heard some evidence that it would also have been useful for BSV workers to have access to additional information contained in the Take Two assessment, also known as the Harm Consequences Assessment form.[172]

143. While I am supportive of the undertaking by DFFH to work with BSV to discuss opportunities for improved information sharing in this regard, I accept submissions on behalf of DFFH that there may be legal difficulties with this kind of sharing information and therefore, do not consider that it would be appropriate for me to make any further findings or comments on this issue.

Care Team Meetings

144. The inquest heard that DFFH and BSV hold monthly Care Team Meetings in respect to young persons in out of home care. The key function of these meetings is to facilitate information sharing, by ensuring that everyone is aware and understands the issues facing the young person. The meetings are attended by relevant persons involved in providing care, which may include the young person's DFFH child protection worker, an allocated BSV worker or member of the residential unit, Take Two clinicians, education workers, SOCIT etc.[173]

145. During evidence, Ms Beaton explained that the meetings were established to ensure young people have care plans required under the *Children Youth and Families Act (Vic).*[174] Ms McNaughton also acknowledged that care team meetings were a mechanism through which DFFH provided BSV with support.[175]

[170] Transcript of Inquest, page 412 (Beaton).
[171] Transcript of Inquest, page 413 (Beaton).
[172] Transcript of Inquest, dated 9 November 2021, page 150 (RSW2). In submissions on behalf of JZA's mother, it was contended that if additional time had been allocated for BSV workers to review JZA's file, the Harm Consequences Assessment in combination with other material would have provided information with regard to JZA's risk factors. However, it is clear on the evidence before me that at the time of JZA's death, the Take Two assessment was not available to BSV residential care workers.
[173] Transcript of Inquest, page 227-228 (RSW4), page 415 (Beaton).
[174] Transcript of Inquest, page 414 (Beaton).
[175] Transcript of Inquest, page 350 (McNaughton).

146. While there was evidence regarding the general purpose of Care Team Meetings, I accept the submission on behalf of BSV that specific evidence about care team meetings held in relation to JZA was "*unclear and incomplete*".[176] As such, I do not propose to make any specific findings on this issue.

147. What was clear, on the evidence, was that there was a lack of clarity about key organising responsibilities, including in relation to:

    a. Arranging the meetings: Ms McNaughton stated care team meetings were arranged by DFFH;[177] while, Ms Beaton explained that although practice case managers might take that responsibility, often it was negotiated within the care team.[178]

    b. Taking meetings minutes: Ms Beaton explained that responsibility for taking minutes would also be negotiated.[179] In evidence both RSW3 and RSW4 understood that as attendees they would document the meeting.[180]

    c. Disseminating meeting minutes: RSW4 explained he would the enter the minutes into the digital file where they could be viewed[181] or emailed.[182] However, Ms McNaughton explained that where something arose it was the unit's team leader who should feed the information to the unit supervisor and then the unit.[183]

    d. Understanding the content of meeting minutes: RSW3 simply explained that "*you might just look it [the minutes] up if you have time…it's usually saved in the young person's file*."[184]

148. In the context of the above evidence, I consider there may be opportunities to improve and clarify processes with regard to Care Team Meetings. This was conceded by DFFH who accepted there was room for improvement to clarify in each case whose responsibility it is to document care team meeting minutes and ensure that residential workers are aware of action items. In reply submissions, DFFH undertook to voluntarily review the Care Team Meeting minute taking process to ensure consistent minutes are

[176] Submissions in Reply on behalf of BSV, dated 22 December 2021, page 3.
[177] Transcript of Inquest, page 350 (McNaughton).
[178] Transcript of Inquest, page 464 (Beaton).
[179] Transcript of Inquest, page 464 (Beaton).
[180] Transcript of Inquest, page 267 (RSW3) and Transcript of Inquest, page 204 (RSW4).
[181] Transcript of Inquest, page 204 (RSW4).
[182] Transcript of Inquest, page 267 (RSW3).
[183] Transcript of Inquest, page 385-386 (McNaughton).
[184] Transcript of Inquest, page 268 (RSW3).

kept, distributed and read by relevant persons. I have made a recommendation to support this initiative.

Incident reports

149. As outlined in submissions on behalf of DFFH, incident reports are another mechanism through which the Department provides supervision.

150. Incident reports are provided to DFFH by BSV and other providers, where there has been a notifiable incident.[185] If there is a major impact incident, the report is required to be sent to the Department within 72 hours. The Department reviews all incident reports and may send them back, wanting more information, correction, or may deem that it is not a major impact incident or otherwise out of scope. If it is a major incident, then a review or investigation is required to be undertaken. The purpose of an incident investigation is to determine whether there has been abuse or neglect of a client by a staff member or another client, in relation to an allegation in a client incident report. An incident review requires a senior person to review what happened, whether an incident was managed appropriately, and to identify the causes of the incident and any subsequent learnings to apply to reduce the risk of future harm. The information is then shared to the care team and ideally should be shared with unit staff.[186]

151. Ms Beaton gave evidence that, since JZA's death, there is now greater oversight by the Commission for Children and Young People, who receives all incident reports for children in residential out-of-home care.[187]

Auditing of care providers

152. During the inquest, Ms Beaton explained that the current audit process is threefold:

    i. first, providers, including BSV, are required to do a self-audit against the human services standards;

    ii. second, the Human Service Regulator audits/assesses the provider against the Human Services Standards, as a requirement of the regulation and service agreement;

[185] Transcript of Inquest, page 339 (McNaughton).
[186] Transcript of Inquest, page 385 (McNaughton).
[187] Transcript of Inquest, page 409 (Beaton).

iii. thirdly, residential care performance audits are conducted by DFFH.

153. At the time of JZA's death, Departmental audits were expected to cover a range of areas of policy and practice, including staff supervision and staff training.

154. In response to evidence that BSV workers were not aware of the substance of the 2015 Policy and that they did not feel they had sufficient training, Ms Beaton indicated that she had requested that the audit team "*think much more carefully … about how they want to examine that particular component throughout*".[188] I support this initiative, noting that policies are only as effective as their implementation.

155. DFFH also acknowledged that while other BSV units were subject to DFFH audits, JZA's particular residential unit was not audited as it was a short-term residence.

156. When questioned about whether there were any barriers to ensuring that audits were conducted on every property, Ms Beaton provided evidence that the key barrier was staff resourcing. I consider this response concerning.

157. Auditing represents one of the few tools available to DFFH which enables regular scrutiny of service providers to ensure the highest standards of care. In circumstances where DFFH has determined to contract out the provision of care to some of the most vulnerable members of our community, it is critical that auditing must be adequately resourced.

158. I acknowledge DFFH's submissions that there has been some improvement to the oversight of service provision since JZA's death, through the introduction of the Human Services Regulator which consolidated regulatory schemes across DFFH. However, it remains unclear whether the current audit process is sufficiently thorough so as to ensure that each residential unit is audited on a regular basis, or to test whether staff have the requisite knowledge to be able to implement key policy requirements. In this respect, I have recommended that DFFH should consider further enhancements to the audit process.

Findings and Conclusions

[188] Transcript of Inquest, page 438 (Beaton).

159. Having investigated the death of JZA, and having held an inquest in relation to JZA's death from 8 to 10 November 2021 at Melbourne, I make the following findings, pursuant to section 67(1) of the Coroners Act:

i. that the identity of the deceased was JZA, born on 2 April 2000;

ii. that JZA died at the Unit[189] on 1 June 2017 from gamma hydroxybutyrate (GHB) toxicity;

iii. in the circumstances described above.

160. Taking into account all available evidence, I further find that:

i. The BSV handover process did not facilitate residential care workers to access relevant information that may have assisted them to provide effective supervision to JZA, including information about her risk factors or key policy requirements;

ii. The BSV training framework was inadequate in that relevant BSV residential care workers were unaware of, and did not comply with, the substance of the 2015 policy when supervising JZA in the period leading to her death. Specifically, in May 2017, they were unaware of the frequency with which they were required to check on a substance affected youth, the signs of deterioration, and the application of the consciousness scale.

161. I accept submissions on behalf of BSV that there is insufficient evidence to conclude that any conduct of BSV, or any individual staff members, caused or contributed to JZA's death.

162. I do not consider there was sufficient evidence available from either the investigation or the inquest to determine whether JZA's death could have been prevented had BSV staff complied with monitoring requirements or called emergency services at any stage following her return to the unit on 1 June 2017.

163. Nonetheless, I consider that the circumstances of JZA's death raise key opportunities for improvement, and I am encouraged that BSV, as well as DFFH, have embraced numerous of these opportunities already. The recommendations I have made below are intended to reflect a joint commitment to the paramount importance of the safety of youth in

[189] The address of the residential unit has been protected pursuant to my order dated 20 October 2021.

residential care. I am hopeful that through the implementation of these recommendations, future deaths in similar circumstances may be prevented.

ACKNOWLEDGEMENTS

164. I would like to thank JZA's family for their dignified participation in what can only have been a very painful process.

165. I would also like to acknowledge the parties' candour and assistance throughout both the investigation and the Inquest.

166. Finally, I would like to thank and acknowledge the work of Counsel Assisting, all other Counsel and instructing solicitors for their work.

RECOMMENDATIONS

167. Pursuant to section 72(2) of the Coroners Act, and in addition to the remedial measures outlined by the respective parties:

    i. I recommend that BSV reviews the staff handover process to ensure workers are allocated sufficient paid time to read all relevant materials prior to commencing a shift;

    ii. I recommend that BSV considers how to develop a system to better support residential care workers, including new or agency workers, to quickly comprehend a client's key risk factors during handover, for example through extracting key information from incident reports, monthly reports, and care team meeting minutes into a regularly updated crisis management plan;

    iii. I recommend that BSV and DFFH jointly review the Care Team Meeting process to ensure there is a clear designation of roles and responsibilities, including the taking and dissemination of minutes;

    iv. I recommend that BSV reviews the delivery of its training modules, particularly with respect to monitoring substance affected youths, and implements measures to ensure that:

        a. Workers are allocated dedicated, paid time to complete all required training modules;

b. Workers are assessed on their comprehension of training content; and

c. Workers receive appropriately spaced refresher training to ensure the substance of training remains at the forefront of a worker's mind.

v. I recommend that BSV considers implementing measures to overcome potential knowledge gaps which may be faced by agency workers, including with regard to key policy requirements.

vi. I recommend DFFH considers how to enhance its audit function to ensure regular audits of all out of home care residential units.

ORDERS AND DIRECTIONS

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

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

The family of JZA
Department of Fairness, Families and Housing
Berry Street Victoria
Acting Detective Sergeant Trent Barker, Coroner's Investigator.

Signature:

Leveasque Peterson
Coroner

Date: 1 December 2023