IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003078

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Leveasque Peterson
Deceased:	Kevin Thomas Maloney
Date of birth:	17 February 1982
Date of death:	13 or 14 June 2021
Cause of death:	1a : Mixed drug toxicity (heroin, venlafaxine, alprazolam, pregabalin) 2 : WHO Class III obesity
Place of death:	The Willows Assisted Living 16 McKenzie Street Melton Victoria 3337
Keywords:	Supported Residential Service, SRS, Human Services Regulator, Social Services Regulator, disability care, support workers, alcohol and other drug support, mental health support, medication administration, recommendation

INTRODUCTION

1. On 14 June 2021, Kevin Thomas Maloney was 39 years old when he was found deceased in his room at Melton Willows Supported Residential Service (**The Willows**) in Melton.

2. Kevin is survived by his mother, Julie Hayes (**Julie**) and siblings Christopher and Jane. Julie fondly remembers Kevin as a *'lovely man'* with a *'heart of gold'*.

THE CORONIAL INVESTIGATION

3. Kevin'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.

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Kevin's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Kevin Thomas Maloney 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. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] 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

BACKGROUND

8. Kevin had an unstable childhood: he witnessed the volatile relationship between his parents and demonstrated *'behavioural issues'*. At around 14 years of age, Kevin first used drugs and began smoking heroin. It was around this time that he experienced mental ill health and first engaged with medical treatment. Throughout his life, Kevin underwent approximately 10 inpatient admissions to various facilities for psychiatric treatment.

9. Around 2017, Kevin began residing at The Willows. According to Julie, he enjoyed living there and the pair spoke several times a day. He was supported by a personal trainer, who helped him prepare healthy meals and go for walks to assist in his weight loss.

Medical History

10. At the time of his death, Kevin had diagnoses of an acquired brain injury (**ABI**), attention deficit hyperactivity disorder (**ADHD**), post-traumatic stress disorder (**PTSD**), treatment-resistant schizophrenia, panic disorder, conduct disorder, depression and gastro-oesophageal reflux disease (**GORD)**. He also had a history of polysubstance use including nicotine, methylamphetamines, cannabis, gamma hydroxybutyric acid (known as *'GHB'* or *'juice'*) and heroin. He had WHO Class III obesity[2] and had developed a metabolic syndrome.

11. Kevin was prescribed several medications to manage his conditions: clozapine,[3] aripiprazole,[4] venlafaxine,[5] pregabalin[6] and alprazolam,[7] atenolol,[8] duromine,[9] imovane,[10] esomeprazole,[11] salbutamol[12] and sildenafil.[13]

12. He was supported by his general practitioner (**GP**) and Drug and Alcohol Counsellor.

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[2] The World Health Organisation (**WHO**) provides stratifies Body Mass Index (**BMI**) into categories of obesity. These categories range from underweight to Class I Obesity (with a BMI of 30.0–34.9 kg/m^2), Class II Obesity (with a BMI of 35.0–39.9 kg/m^2) and Class III obesity (with a BMI greater than 40 kg/m^2). At the time of his death, Kevin had a BMI of 45 kg/m^2.

[3] An anti-psychotic.

[4] Use to treat schizophrenia.

[5] Used to treat depression.

[6] An anti-epileptic and analgesic (pain killer).

[7] A benzodiazepine.

[8] A beta-blocker used to treat angina (chest pain) and high blood pressure.

[9] A weight-loss aid.

[10] A sleep-aid.

[11] A proton pump inhibitor used to treat the symptoms of heartburn, acid-reflux and other symptoms associated with GORD.

[12] A bronchodilator used to treat chest symptoms and is commonly known by its brand name, *'Ventolin'*.

[13] A medication used to treat erectile dysfunction and is commonly known by its brand name, *'Viagra'*.

13. In early-2021, Kevin *'had been reasonably stable in his mental state, with compliance with his regular medications and abstinence from substances'*. However, in mid-March 2021, there was a physical altercation between residents at The Willows which triggered Kevin's PTSD. He relapsed in his substance use, mainly of methylamphetamines and GHB, and became non-compliant with his medication. In April 2021, Kevin underwent a two-week hospitalisation at the Sunshine Acute Adult Psychiatric Unit for the recommencement of his medication, particularly clozapine. He was willing to engage with drug and alcohol rehabilitation with his Drug and Alcohol Counsellor and following discharge was supported by the Acute Community Intensive Support until May 2021 when he was discharged to his regular treating clinicians.

14. On 25 May 2021, Kevin had a telephone consultation with his treating clinician and reported a *'reduced intensity of his auditory hallucinations'* and that he was *'getting closer to his baseline mental state'*. He expressed that *'he would be better off dead'* but reported *'no intention of suicide or deliberate self-harm'*. The clinician assessed that Kevin was at low risk of harm to himself or others.

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

Circumstances in which the death occurred

15. On 13 June 2021, Kevin spoke to Julie on the telephone. She recalled *'it was strange'* and it *'was almost as if he was trying to get off the phone to [her] because he had somewhere to be or someone to see'*. He told Julie that *'he was going to smoke some marijuana'*. Kevin's support worker, Mark Garrod (**Mr Garrod**) recalled that at around 6:00pm, he left The Willows *'to go and get a pack of smokes'*.

16. Kevin returned to The Willows and between 7:00 and 7:30pm, was in the kitchen with his personal trainer preparing meals. He told his personal trainer that *'he was hungry'* and so had a meal in the living room. Mr Garrod noticed that *'as he was eating he just fell asleep while sitting there. Kevin's face was pretty much in his meal'*.

17. Mr Garrod woke Kevin up and noticed he was *'really sweaty'*. Mr Garrod believed *'he might have used something'* but was not sure what. Mr Garrod gave Kevin his nighttime medication, helped him undress and escorted him to bed.

18. Julie however, stated that on the morning of 14 June 2021, Kevin awoke around 6am and got up for breakfast. When he entered the bedroom, Mr Garrod observed that Kevin had *'wet his*

pants' and told him to return to his room to change. It is unclear how Julie learned of this information. Mr Garrod said the last time he saw Kevin alive was when he helped him to bed on 13 June 2021.

19. Mr Garrod ended his shift and left The Willows shortly after Kevin went to bed. It is unclear whether Mr Garrod gave a handover to the night shift worker.

20. At around 9:00am on 14 June 2021, a cleaner of The Willows told Mr Garrod that Kevin was unresponsive in his room. Mr Garrod entered the room and found Kevin unresponsive on the bedroom floor in a crouched position. Emergency services were contacted.

21. Mr Garrod performed cardiopulmonary resuscitation (**CPR**) for approximately 10 minutes until emergency services arrived and took over. Ambulance Victoria paramedics assessed Kevin and determined that further resuscitation efforts were futile. At 9:34am, paramedics declared Kevin deceased.

Identity of the deceased

22. On 14 June 2021, Kevin Thomas Maloney, born 17 February 1982, was visually identified by his support worker, Mark Garrod.

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

Medical cause of death

24. Forensic Pathologist Dr Melanie Archer of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 25 June 2021 and provided a written report of her findings dated 21 October 2021.

25. The post-mortem examination demonstrated the heart was enlarged for Kevin's age – the heart weighed 594 grams (between the 75th and 90th percentile for a man of Kevin's height and weight). There was no evidence of a specific cardiomyopathy (disease of the heart muscle). Causes of cardiac enlargement can include obesity, hypertension, and ischaemic heart disease. There was a moderate blockage of one coronary artery.

26. WHO Class III obesity is a significant risk factor for a number of serious sequelae, including sudden death. The most significant complications are cardiac and pulmonary, though metabolic derangements (e.g. metabolic syndrome), sleep apnoea and hypertension are also

common associations. Cardiopulmonary effects include cardiomyopathy of obesity, pulmonary hypertension, and cor pulmonale (often secondary to disordered sleep breathing).

27. Routine toxicological analysis of post-mortem blood samples detected morphine,[14] clozapine,[15] aripiprazole,[16] venlafaxine (and its metabolite),[17] alprazolam,[18] paracetamol[19] and pregabalin.[20] Post-mortem urine samples also detected 6-monoacetlmorphine (**6-MAM**),[21] methylamphetamine (and its metabolite),[22] atenolol[23] and a metabolite of cannabis.[24]

28. The presence of 6-MAM and heroin constituents (morphine and codeine) indicates recent use of heroin prior to death. Heroin causes death due to central nervous system (**CNS**) and respiratory depression. There is no clearly defined toxic dose of heroin, and any concentration has the potential to be fatal, although individual tolerance to opioids (of which heroin is one) must be considered.

29. The stimulant methylamphetamine was detected in urine only. Methylamphetamine can persist in the urine for several days after use, and according to Dr Archer, it was not clear whether this substance had contributed to the death. The methylamphetamine metabolite, amphetamine, was also found in urine.

30. Venlafaxine (and its metabolite) were detected in blood, and its concentration is in keeping with therapeutic use, but Dr Archer stated it still could have contributed to CNS depression. The benzodiazepine sedative, alprazolam, was found in blood, in addition to the anti-seizure and analgesic medication, pregabalin. These substances can also contribute to CNS depression.

31. Dr Archer concluded that the presence of the anti-psychotic substances clozapine and aripiprazole were not contributory to the death. Paracetamol was also detected consistent with therapeutic use.

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[14] ~ 0.1 mg/L. Morphine is a metabolite of heroin.
[15] ~ 1.0 mg/L. Clozapine is an anti-psychotic.
[16] ~ 0.2 mg/L. Aripiprazole is an anti-psychotic.
[17] ~ 0.6 mg/L. Venlafaxine is used to treat depression.
[18] ~ 0.05 mg/L. Alprazolam is a benzodiazepine.
[19] Trace detected. Paracetamol is a non-opioid analgesic (pain killer).
[20] ~ 1.2 mg/L. Pregabalin is used to treat neuropathic pain.
[21] ~ 0.08 mg/L. 6-MAM is the primary metabolite of heroin.
[22] ~ 0.6 mg/L. Amphetamines is a collective word to describe central nervous system stimulants structurally related to dexamphetamine. One of this group, methamphetamine, is often known as *'speed'* or *'ice'*.
[23] Detected. Atenolol is used to treat angina (chest pain) and high blood pressure.
[24] ~ 14 ng/mL. 11-nor-delta-9-carboxy-tetrahydrocannabinol is a metabolite of cannabis.

32. Dr Archer provided an opinion that the medical cause of death was 1(a) *Mixed drug toxicity (heroin, venlafaxine, alprazolam, pregabalin)* with a contributing factor of 2 *WHO Class III obesity.*

33. I accept Dr Archer's opinion as to cause of death.

OVERSIGHT OF SUPPORTED RESIDENTIAL SERVICES BY THE HUMAN SERVICES REGULATOR

34. The Willows is a Supported Residential Service (**SRS**), a 30-bed low support residential facility for people who need help with activities of daily living. The staffing ratio was one staff member (personal care assistant) per 30 residents, plus a cook and/or cleaner. The Manager (Care Coordinator) and Proprietor were on site for a combined 11 hours per day, with a sleep-over person also present at night.

35. SRSs are independent, privately-owned business which provide personal support and accommodation to residents in a shared living environment. This support may include assistance with tasks such as showering, personal hygiene, toileting, dressing, meals and medication depending on the resident's needs. It also involved physical and emotional support and can include nursing or allied health services.

36. At the time, SRSs were required to be registered and were subject to several obligations pursuant to the *Supported Residential Services (Private Proprietors) Act 2010* (Vic) and the *Supported Residential Services (Private Proprietors) Regulations 2012* (Vic) (together the **SRS Legislation**). I note that at the time of writing, the SRS Legislation has been replaced, the consequences of this will be discussed in this Finding. The Willows was a registered SRS under the SRS Legislation at the time of Kevin's death.

37. The SRS Legislation provided a registration regime for Victorian SRSs, prescribed minimum standards of accommodation and personal support to be provided to SRS residents for their care and wellbeing, and established enforcement mechanisms to give effect to the standards and obligations of SRS proprietors.

38. The primary principle underpinning the SRS Legislation was that SRS residents *'have the same rights and responsibilities as other members of the community and should be empowered to exercise those rights and responsibilities'*.[25]

[25] *Supported Residential Services (Private Proprietors) Act 2010* (Vic) section 7(1).

39. Each SRS proprietor was required to among other things:

a) Take all reasonable steps to ensure that residents receive the healthcare and personal support they need, either through the support provided by the SRS or by ensuring the resident has access to necessary services,[26]

b) Adhere to the minimum requirement for the number, qualifications and training and screening of staff working at each SRS,[27]

c) Maintain adequate standards for the storage, distribution and administration of residents' medication;[28] and,

d) Put in a complaints system for receiving and responding to complaints received, to ensure they are addressed in a fair, reasonable, confidential and timely manner.[29]

The Role of the Human Services Regulator

40. The Human Services Regulator (**HSR**) was a unit of the System Reform and Workforce division of the Department of Families, Fairness and Housing (the HSR has since been replaced by the Social Servies Regulator and this is discussed later in this Finding), and was responsible for regulating human service providers, including SRSs.

41. The HSR carried out its regulatory role through conducting inspections (planned or responsive and announced or unannounced) at SRS facilities and planned quarterly inspections of the risk rankings of SRS facilities.[30] The HSR obtained information from a variety of sources including on-site inspections, prescribed reportable incidents, notifications from Community Visitors and complaints from members of the public.

42. If SRSs were not complying with their obligations, the HSR could accept a voluntary undertaking from the proprietor or issue a compliance notice.[31] The HSR could use sanctions if a proprietor remained in breach of a compliance notice.

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[26] *Supported Residential Services (Private Proprietors) Act 2010* (Vic) sections 59-62; *Supported Residential Services (Private Proprietors) Regulations 2012* (Vic) schedule 9.

[27] *Supported Residential Services (Private Proprietors) Act 2010* (Vic) sections 64-68.

[28] *Supported Residential Services (Private Proprietors) Act 2010* (Vic) section 63.

[29] *Supported Residential Services (Private Proprietors) Act 2010* (Vic) section 75.

[30] The 'risk' of an SES was based on criteria including the proprietor's awareness, willingness and capacity to meet their obligations under the SRS Legislation, the nature of the premises and the support needs of its residents.

[31] *Supported Residential Services (Private Proprietors) Act 2010* (Vic) section 156. According to the statement provided by Paul Paciocco, then-State-wide manager, Regulatory Compliance and Enforcement of the HSR dated 3 February 2023, he stated, *'In my view, voluntary undertakings have limited enforcement value because there is no penalty for*

INTERACTIONS BETWEEN THE WILLOWS AND THE HUMAN SERVICES REGULATOR PRIOR TO KEVIN'S DEATH

43. On 26 October 2020, two Authorised Officers of the HSR (**the HSR Officers**) conducted a planned but unannounced inspection of The Willows. On 22 December 2020, as a result of the inspection, The Willows received seven non-compliance notices. Those relevant in this circumstance were:

    a) Interim Support Plans (**ISP**) not being expanded to Ongoing Support Plans (**OSP**) after 28 days of an individual becoming a resident. The HSR Officers reviewed a random sample of support plans, and this sample included Kevin's plan. They found that his ISP was prepared on 1 September 2020, but no OSP had been prepared within 28 days of admission as required by the SRS Legislation,[32]

    b) OSPs were not updated at least every six months and lacked key information (including details of residents' health service providers, frequency and timing of health and personal supports, level of assistance required, strategies to assist with behaviour management),

    c) Failure to take reasonable steps to maintain adequate distribution and administration of residents' medication,

    d) Records of prescribed incidents, staffing rosters and training of staff were not up to date; and,

    e) There was no system to receive and deal with complaints from residents or complaints made on behalf of residents.

44. Upon receipt of the compliance notice, there were multiple interactions between the HSR and The Willows between 14 January 2021 and 14 December 2022 (including further site inspections) to try and resolve the outstanding matters.

45. The latest confirmed interaction between the HSR and The Willows occurred on 26 May 2021 when a HSR Officer attended the SRS and re-examined resident OSPs (this did not include

the SRS proprietor under the SRS Act if the undertaking is not fulfilled. However, compliance notes provide a useful function because they carry a penalty if they are breached and, in my experience, usually result in the non-compliance identified being rectified. If there is a high risk to health and safety of SRS residents, then a compliance notice would be issued rather than a voluntary undertaking'.

[32] *Supported Residential Services (Private Proprietors) Act 2010* (Vic) section 57.

Kevin's).[33] The HSR Officer *'concluded that although there were aspects of the OSPs [they] reviewed which could be improved, [the OSPs] showed substantial improvements from the previous ones [they] had reviewed'*. The HSR Officer was satisfied Kevin's OSP met the minimum requirements of the SRS Legislation.[34]

46. Between May 2023 and 1 July 2024 (when the HSR was replaced by the Social Services Regulator) it is unclear whether there were any further interactions between the HSR and The Willows. At the time of Kevin's death, some of the compliance issues which were initially identified in December 2020 remained outstanding and had not been resolved.

CORONERS PREVENTION UNIT

47. In the course of my investigation, it became apparent that some of Kevin's care needs arose due to the intersection of his mental ill health and substance use. I sought to understand the care expected to be provided in SRSs in response to these needs, and in doing so, enlisted the assistance of the Coroners Prevention Unit (**CPU**).[35]

48. The CPU reviewed the court file, coronial brief, and supplementary statements provided by Mr Garrod, The Willows proprietor, Mr Trevor Weekes (**Mr Weekes**), and representatives of the HSR.

MANDATORY MENTAL HEALTH TRAINING FOR SRS STAFF

49. Given that Kevin had an extended history of mental ill health, and that he experienced an episode of increased PTSD symptoms (which resulted in relapse of his substance use disorder and poor compliance with his prescribed medication), I sought a statement from the HSR regarding mandatory mental health training for SRS staff.

50. In a statement provided by Anthony Kolmus (**Mr Kolmus**), then-Director of the HSR, Mr Kolmus made clear that *'mental health training is mandatory for all staff of pension-level*

[33] I note there was initial confusion amongst the HSR and its Officers regarding whether or not Kevin's OSP had been reviewed during May 2021. It is understood that Kevin's OSP was not reviewed as was initially believed, rather, it is apparent that the HSR Officer inadvertently confused Kevin with another resident with a similar name when reflecting on these events.

[34] Ibid.

[35] The Coroners Prevention Unit (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.

[SRS]' and that this requirement includes proprietors that work on site to carry out, direct or undertake the day-to-day operation of the SRS and staff who do not have direct contact with residents, such as cleaners or cooks.

51. The implementation of this requirement arose from a previous coronial finding, handed down in 2015 in which then-State Coroner Ian Gray made a recommendation that the Department of Health and Human Services (the predecessor to the Department of Families, Fairness and Housing) consider mandating mental health training for staff (or at least more senior staff) in SRSs with the training at least sufficient to enable staff to recognise serious threats, interpret threats and take appropriate action.[36]

52. The HSR was not able to locate the directive made by the Secretary of the Department (or their delegate) under section 205(1)(c) of the *Supported Residential Services (Private Proprietors) Act 2010* (Vic) – which formed the legal basis for the mandatory training requirement. However, Mr Kolmus believed the directive was made in early 2016 and that SRS proprietors were informed of the requirement by letter on or around 21 April 2016. To assist proprietors to meet the requirement, the Department offered a free course for all staff of pension-level SRS called *Residents and mental health: Better practice in SRS.* Mr Kolmus believed that mandatory mental health training formed part of compliance activities *'from about the end of the 2016-2017 financial year'*.

53. In March 2021, a representative of the HSR visited The Willows and completed an assessor checklist. The checklist indicated that not all staff had completed the mandatory training at that time. Notably, neither Mr Garrod or Ms Garrod were included on the assessor checklist and so it is unclear whether, as of March 2021, they had completed their training.

54. The CPU was concerned about the lack of emphasis placed on the mandatory training by the HSR. Based on Mr Kolmus' statement, mandatory mental health training ought to have formed part of compliance activity by this time however, this did not appear to be the case for The Willows. The CPU hypothesised it would be reasonable to expect HSR Officers or other delegates investigating The Willows to make efforts to confirm that all staff were appropriately trained in this regard – noting that they had made these efforts for CPR and first aid training during the same visit.

[36] Finding into Death With Inquest into Philip Hewitt (COR 2012 001620) dated 14 May 2015 and accessible on the Court's website at: https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/philipjohnrobertshewitt_162012.pdf.

ALCOHOL AND OTHER DRUG TRAINING AND SUPPORT IN SRS FACILITIES

Alcohol and Other Drug training in SRSs

55. Under the SRS Legislation in effect at the time, SRS staff were not required to undertake training or hold any qualifications for alcohol or other drug support.[37] In a statement provided by then-State-wide Manager of the HSR, Paul Paciocco (**Mr Paciocco**), he stated that SRS needed to only have an adequate number of *'appropriately trained'* staff on duty.[38]

56. In order to be *'appropriately trained'* staff need only hold one of five qualifications listed in the SRS Legislation – a Certificate IV in Alcohol and Other Drugs is one such qualification.[39] Mr Paciocco explained that *'proprietors may wish to consider resident population mix when determining appropriate staff qualifications. For example, if residents need support managing their substance use, a Certificate IV in Alcohol and Other Drugs may be a more desirable qualification, as this would involve training in responding to resident drug use'.*

57. The then-Department of Health and Human Services (**DHHS**) offered free, specialised training workshops for all SRS staff and proprietors delivered by the Aged and Community Care Providers Association. The training was intended to *'provide skills and knowledge to assist and improve the safety and quality of services provided to residents'*.

58. It follows that Alcohol and Other Drug training is not subject to the same mandatory requirements as mental health training – given that substance use disorder is less common than mental ill health in the population. The CPU noted that the DHHS offers a module which provides education on identifying and responding to a drug affected person, should this be considered relevant to staff at a particular SRS (due to its residents needs). While this would have been relevant to staff of The Willows, there is no indication this was undertaken.

The Willows' staff previous responses to Kevin's drug use

59. It is apparent that The Willows staff were aware of Kevin's history of substance use.

60. On 29 March 2021, in an entry into Kevin's record, the author recorded that Kevin returned to The Willows around 9 pm and appeared *'disoriented'* and was *'not making sense when he*

[37] At the time of writing, this requirement has not changed since the SSR replaced the HSR on 1 July 2024.

[38] *Supported Residential Services (Private Proprietors) Act 2010* (Vic) section 64. An *'adequate number'* of staff is set as one support worker per 30 residents (or fraction thereof).

[39] *Supported Residential Services (Private Proprietors) Regulations 2012* (Vic) Regulation 36(1), (2). The other qualifications listed at Regulation 36(2)(a) are Certificate III in Individual Support, Certificate III in Home and Community Care, Certificate III in Disability and Certificate IV in Mental Health.

spoke'. The author asked, *'What drug have you taken?'* and Kevin replied *'Juice'*, referring to *'GHB'* or gamma hydroxybutyric acid. When the next staff member arrived for their shift, the author provided a handover and gave instructions to *'check on Kevin every half hour as [they were] concerned but Kevin did not want [them] to co call a* (sic) *ambulance'.*

61. According to Mr Weekes, The Willows' proprietor, during a previous incident (believed to have occurred around April 2021), SRS staff contacted Victoria Police due to suspected onsite illicit drug use by Kevin and another resident. Mr Weekes recalled, *'one of the boys had a needle in his arm'.*

62. Mr Weekes stated that The Willows policy when residents used illicit substances onsite required staff to inform the then-DHHS, the resident's next of kin/nominated person and obtain drug counselling. Mr Weekes informed the Court that this policy was followed with respect to Kevin and the other resident on this occasion.

63. In Kevin's record, there were several additional instances of his substance use that were recorded by The Willows staff, including when he left the SRS to buy drugs or urinalysis results detected illicit substances. Though unsigned, many of these entries, appear to be in Mr Garrod's handwriting.

Whether The Willows staff were aware of Kevin's substance use on 13 June 2021

64. On the night of 13 June 2021, there is no evidence that Kevin's illicit drug use had occurred onsite. According to Mr Weekes:

> *'If a resident is using drugs outside of the Melton Willows and not coming home or disturb* (sic) *the peace at other places all staff can do is offer support and talk with the person about the danger they will put them self* (sic) *in. Staff can inform next of kin or nominated person and support worker or allied health of there* (sic) *concerns as well as the Department of Families, Fairness and Housing.*

65. In a statement dated 16 December 2021, Mr Garrod reflected on the evening of 13 June 2021:

> *'Kevin left and went to a smoke shop just around the coroner from The Willows.*
>
> *Kevin came back about an hour later, as Kevin was helping in the kitchen to prepare his meals, he said he was hungry so [his personal trainer] told him to grab a meal and go sit in the lounge. Kevin did this and as he was eating he just fell asleep whilst sitting there. Kevin's face was pretty much in his meal.*

I woke up Kevin up and I told him I'd help him to bed. ***Kevin was really sweaty, I thought he might have used something, but I didn't know what****'* (emphasis added).

66. Mr Garrod went on to explain that he helped Kevin to undress and administered his medication.

67. However, in a supplementary statement Mr Garrod provided on 24 July 2025, some four years after the event, his recollection had changed:

> *'On the night of the 13th of June 101, Kevin's behaviour was not the same when he used drugs previously, that night he was sweating and sleepy, where previously when he used drugs he was more talkative, when he used drugs you normally couldn't shut him up, the night of the 13th it was different, he didn't walk past everyone and go to his room, he came into the dining room and was hungry. I saw he sweaty* (sic) *but just thought that was from the walk at the time, because he hated walked. I didn't seek any advise* (sic) *about his medication at the time because* ***I didn't think he had used drugs at the time'*** (emphasis added).

68. It is not possible to reconcile Mr Garrod's statements, however, it is apparent that Kevin was demonstrating out of character behaviours on the evening of 13 June 2021 - including that he appeared overly sedated and was perspiring excessively.

69. In Mr Weekes' statement, he did not address the situation when the health and wellbeing of a resident using drugs is at risk. Mr Paciocco of the HSR touched upon the issue and stated that *'depending on the situation, [staff] would have a responsibility to apply first aid (if required), contact relevant emergency services (if required) and the resident's relevant support worker'*. This obligation will arise if the resident *'presents as ill/injured'* or the *'illness or injury'* is reported to staff.

70. The CPU considered the evidence of Mr Garrod, and the procedures outlined by Mr Weekes and Mr Paciocco. While the evidence did not indicate that Kevin was in acute need of first aid or emergency service attention at the time he went to bed, he was acting uncharacteristically and clearly struggling. On previous occasions when staff became aware of Kevin's substance use, they implemented 30-minute observations, and thus the CPU commented that while staff had previously taken action to ensure Kevin's safety, there were no similar strategies put in place on the night of his death.

MEDICATION MANAGEMENT PRACTICES AT THE WILLOWS

71. As mentioned, at the time of Kevin's death, The Willows was being investigated by the HSR for compliance breaches in relation to medication management. Some but not all of these issues had been resolved by the time of Kevin's death in June 2021.

Issues associated with medication management identified by the CPU

72. The CPU identified several issues associated with The Willows' medication administration.

73. The first matter the CPU identified was that despite Kevin's presentation on the evening of 13 June 2021, Mr Garrod proceeded to administer his evening medications which included multiple strong psychoactive drugs. Mr Garrod was not a qualified health professional and could not be expected to have a substantive knowledge of the prescribed medications. However, Mr Garrod should have been aware that Kevin was taking an evening psychiatric medication that warranted regular monitoring by a mental health clinic as it was recorded in his OSP. In this context, observing Kevin to be so sleepy he fell asleep in his dinner and needed assistance to go to bed, it was reasonable to expect Mr Garrod to seek advice before administering the evening medication.

74. The CPU considered that if, as Mr Garrod had originally stated, he believed that Kevin had ingested some sort of substance, this would have been even more reason to seek advice before administering the evening medication. At the time, the HSR expected that a '*staff member administering the medication should consult with the treating health practitioner or a pharmacist in relation to any concern about the appropriateness of a medication before administering the medication or substance.'* However, there is no evidence that Mr Garrod turned his mind to consider whether Kevin was well enough to receive his medication.

75. The second issue related to improper records and arose from what appeared to be a practice of someone other than Mr Garrod signing the medication record. Mr Garrod was equivocal in his statements of 2021 and 2025 that he gave Kevin his medication, however, the medication chart of 13 June 2021 was signed by *'CG'* – presumably Ms Cherie Garrod (**Ms Garrod**), Mr Garrod's wife and colleague who was working at The Willows on 13 June 2021. In Mr Garrod's supplementary statement of June 2025, he did not respond to the Court's question on this issue.

76. The CPU concluded that, it appeared that the medication management issues were unresolved at the time of Kevin's death and that evidence of unsafe practices persisted despite the protracted engagement of the HSR since 2020.

Inconsistent evidence regarding medication practices at The Willows

77. It is worth noting that in the copy of Kevin's Medication Administration Record provided by the Coronial Investigator as an exhibit to the Coronial Brief,[40] the medication chart showed the initial *'CG'* for the morning of 14 June 2021 – when Kevin was found unresponsive and later declared deceased. No staff from The Willows indicated in their statements that Kevin was administered his medication that morning, but the record was signed.

78. A duplicate of Kevin's Medication Administration Record was provided as an annexure to a statement of the HSR in February 2023. However, in this copy, the initials *'CG'* appear to have been corrected using correction tape/liquid paper and the word *'deceased'* written over the top. The HSR stated that this record was provided to it by The Willows on 28 July 2021 or 10 August 2021.

79. It is not possible for me to reconcile these records, and it appears that Kevin's Medication Administration Record was signed *'CG'* in advance of the morning dose of 14 June 2021. It also appears that after a copy of the record was given to my Coronial Investigator but before a copy was given to the HSR, the *'CG'* entry was made. This is a concerning practice.

80. It remains unclear to me whether Mr Garrod was authorised to administer medications at the time of the fatal incident. The HSR indicated that by 1 June 2021, all Willows staff authorised to administer medication had completed relevant in-house training but it is unclear if Mr Garrod was included in this group as he was not listed on the qualifications checklist completed by the regulator at the March 2021 inspection. Mr Garrod's June 2025 statement was unclear on the matter as he stated.

> *'**At the time of Kevin's death I had no formal qualifications**, I was being trained "on the job" by my supervisor Tammy Kovachevic, to work with Kevin specifically to make sure Kevin got the care he needed'*

But subsequently appeared to contradict this claim by saying:

> *I was authorised to give Kevin his medication by Tammy, as I **had done my medication handling course and I held that formal qualification.** That qualification is renewed on a regular basis'* (emphasis added).

[40] The coronial brief was submitted by Senior Constable Brittany Webster on 2 March 2022.

81. I am unable to state with certainty whether Mr Garrod had completed a formal medication handling course or in-house training at the time of the fatal incident and was therefore authorised to administer medication to Kevin on 13 June 2021.

82. I have been unable to reconcile the inconsistencies in the evidence regarding medication management at The Willows and I am left with the impression that statements and material which they have provided during my investigation are unreliable.

KEVIN'S INTERIM SUPPORT PLAN AND ONGOING SUPPORT PLAN

83. SRS residents' needs are outlined in Interim Support Plans (**ISP**) and Ongoing Support Plans (**OSPs**). As has been discussed in this finding, the HSR Officers identified during an inspection on 26 October 2020 that Kevin's ISP had not been developed into an OSP within the required 28 days.

84. ISPs and OSPs play a key role in facilitating optimal support between SRS staff and residents across a variety of needs. Mr Paciocco stated that resident ISPs should reference individual *'health and personal support needs'* such as *'physical and mental health support, drug and alcohol support amongst many other potential requirements'*. Regarding alcohol and other drug support, the ISP may include the *'recording and coordination of any support services that the resident is in receipt of'*.

85. When asked specifically about the use of ISPs and OSPs in the context of substance use, Mr Paciocco stated the SRS proprietor should *'cause for the appropriate level of support to be provided to the resident'*. Mr Paciocco explained this *'may include contacting a resident's support worker/health service staff/treatment organisations and coordinating that support for the resident'.* These changes should be recorded in the individual's OSP. If the SRS proprietor is unable to secure *'appropriate healthcare'* for the resident, they must notify the Secretary of the Department of the resident's needs.

86. Once the ISP is developed into an OSP, Mr Paciocco explained the OSP must *'be reviewed and updated every six months at a minimum'* and *'if a resident's health and support needs change, then the OSP must be adjusted to reflect those changes'*. I note that the HSR Officers also noted that resident OSPs were not being reviewed and updated as required.

87. It is apparent that Kevin's condition and *'health and support needs'* had changed around March and April 2021 when he experienced a re-emergence of his PTSD symptoms, became

non-compliant with his medication (clozapine), relapsed in his substance use and underwent an inpatient psychiatric admission.

88. Even though Kevin was discharged on 28 April 2021, his OSP was not updated for another six weeks, on 7 June 2021, one week before his death. It is unclear why this delay occurred. The updated OSP listed Kevin's medical practitioners including his GP clinic, clozapine management clinician and alcohol and other drug support clinician. However, there was no listed frequency of contact with Kevin's alcohol and other drug support clinician as would be expected in the OSP, particularly in light of a recent relapse of substance use.

89. The OSP indicated that Kevin had *'a past history of substance abuse which is carefully monitored by his NDIS worker Mark'* who had *'encouraged Kevin to keep on the right track'* and stated, *'he hasn't had a relapse since February'.* This is inconsistent with evidence that SRS staff were aware that Kevin had used illicit substances on 20 March and 1 April 2021, provided a positive drug screen on 31 March 2021 and had likely used illicit substances on several occasions in early April.

90. In contemplation of his recent discharge from hospital, the CPU commented it would have been reasonable for The Willows staff to have involved Kevin's alcohol and other drugs support clinician in developing his revised OSP upon discharge, to ensure that his return to the SRS was best supported by updated strategies for staff to ensure his safety if he did continue to use illicit substances.

INTERACTIONS BETWEEN THE HUMAN SERVICES REGULATOR (AND ITS SUCCESSOR) AFTER KEVIN'S DEATH

91. On 15 June 2021, the day after Kevin's death, The Willows notified the HSR. The HSR requested Kevin's OSP, medication chart and the first aid and CPR qualifications of Cherie Garrod. According to Mr Kolmus, these documents were compliant.

92. On 17 and 20 August 2021, an individual (**the complainant**) emailed the HSR setting out their concerns in relation to the care and management (including in relation to the administering of medication) of a resident of Melton Willows (who was not Kevin) among other issues. The complainant did not raise any concerns specific to Kevin.

93. Around September 2021, the complainant subsequently reported that Kevin died due to a *'drug overdose'* and that there was illicit drug paraphernalia located in his bedroom immediately after his death. After receiving this complaint, the HSR contacted Victoria Police

to ascertain whether this was correct. Victoria Police emailed the HSR on 1 October 2021 and, amongst other things, wrote:

> *'Regarding what the [complainant] has stated I'm unaware if they are speaking regarding a previous time police attended. FRV [Fire Rescue Victoria] were first on the scene followed by ambulance, nil CAT [Crisis Assessment and Treatment] team in attendance and nil syringes at the scene. I did not collect any syringes nor were there any located. No one spoke to my partner or myself suggesting there was any sort of foul play. I have yet to hear back from the coroners regarding the cause of death'.*

94. In late August 2021, the HSR received a 'Notification for Investigation' from the Community Visitor. Community Visitors are Victorian Governor in Council appointed for three years terms and have significant powers of entry and inspection. They can visit unannounced and write a brief report following their visit to facilities regarding their interactions with staff, what documents they inspected, issues of concern and good practices observed. Community Visitors play a vital role in safeguarding the rights and wellbeing of people with a disability.[41]

95. The Notification for Investigation contained several allegations from the complainant including some about Kevin's death. These included an allegation that 'a few days before Mr Maloney's death, he appeared sleepy and substance affected, and the facility lacked concern for his welfare'. The complainant also alleged that *'unqualified staff are administering medication to residents'*.

96. According to the Notification for Investigation, the Community Visitors conducted a phone visit to The Willows on 10 August 2021 and spoke with an employee who advised there was an active medication administration policy at The Willows and offered to provide a copy to the Community Visitors. As of May 2023, this document had not been sent to the Community Visitors.

97. The staff member told the Community Visitors that *'the Coroner determined that Kevin's death was the result of a cardiac arrest associated with an enlarged heart'*. This is not correct, and it is unclear how The Willows came to this conclusion prior to Dr Archer completing the post-mortem examination and determining Kevin's medical cause of death.

CONCLUSIONS OF THE CPU

[41] See more information on Community Visitors on the website of the Office of the Public Advocate here: https://www.publicadvocate.vic.gov.au/opa-volunteers/community-visitors.

98. From its review of the circumstances of Kevin's death, the CPU provided me with its conclusions as follows:

a) Given Kevin presented with a higher than usual level of need on the evening of 13 June 2021, it is reasonable to expect that Mr Garrod would have taken some action address his increased need:

i. It was reasonable for Mr Garrod to have informed the sleep-over staff of events that occurred on 13 June 2021 so they could have made checks on Kevin throughout the night as had been done on a previous occasion, and,

ii. It was reasonable to expect that Mr Garrod would have considered whether Kevin ought to have received his nighttime medication given his uncharacteristic behaviour on 13 June 2021 and to have sought advice from more qualified staff who could have considered further escalation to a health professional.

b) Kevin's OSP did not reflect his recent deterioration in March and April 2021 and there was a significant delay in updating it after his discharge from hospital,

c) It is reasonable to expect that a resident prescribed psychotropic medication and who is known to use illicit substances would have a documented plan of management, guided by relevant clinical service providers, as part of their SRS Ongoing Support Plan (OSP),

d) While there was a mandatory condition at the time of Kevin's death that all SRS staff undertake baseline mental health training, it is unclear whether this was met including by Mr Garrod, and this requirement was inadequately assessed by the HSR,

e) It was not possible to causally link The Willows' compliance breaches with Kevin's death, but it was apparent that the SRS was struggling to meet the standards expected by the HSR at that time,

f) In the context of The Willows being identified as non-compliant in December 2020, the safeguarding provided by the HSR appeared to lack timeliness and comprehensiveness as several matters remained unresolved when the SSR commenced its oversight on 1 July 2024.

THE NEW REGULATORY FRAMEWORK: THE SOCIAL SERVICES REGULATOR

99. The *Social Services Regulation Act 2021 (Vic)* and the *Social Services Regulations 2023 (Vic)* (together the **SSR Legislation**) established a new framework for social services regulation in Victoria. Under this framework, on 1 July 2024, the Social Services Regulator (**SSR**) replaced the role of the HSR.

100. SSRs are now required to meet six prescribed standards (**the SSR Standards**). Those relevant to the circumstances of Kevin's death are Safe Service Delivery and Safe Workforce. The *'Safe Service Delivery Standard'* seeks to ensure that services are safely provided based on assessed needs and includes having:

a) Systems and processes in place to identify and manage risks of harm to service users,

b) Staff who possess the knowledge and skills to assess service user needs and risks to safety,

c) Staff receive information, education or training on risks of harm to service users,

d) Systems and processes in place to make sure service users' needs are regularly reviewed,

e) Staff monitor the health and wellbeing of service users and put in place intervention strategies as needed; and,

f) Policies and processes in place on how the provider supports service users' health and wellbeing.

The *Safe Workforce Standard* aims to ensure that services are delivered by a workforce with the knowledge, capability and support to provide safe services with care and skill and includes having:

a) Systems and processes to identify, meet and track workforce training needs,

b) Staff receive ongoing training and professional development relevant to their role; and,

c) Regular review of training needs to support safe service delivery.

101. Given that the SSR Standards apply to a broader range of services than SRSs, they are less specific than the SRS Legislation. However, the SSR has produced Fact Sheets containing guidance to SRS proprietors in relation to specific issues including medication management, staffing requirements and managing support plans.

102. The *'Managing Medication'* Fact Sheet generally aligns with the regulatory framework that was in place at the time of Kevin's death, regarding the storage, distribution and administration of residents' medication. Staff administering medication are required to have processes in place so that if persons administering medication have any concerns about the appropriateness of a medication, they must consult the treating health practitioner or pharmacist before proceeding. However, this relies on the administering party turning their mind to the appropriateness and/or safety of the medication, and even in the circumstance where Kevin appeared unwell, there is no evidence that Mr Garrod considered contacting a senior staff member who could assess the need to escalate the matter to a health professional.

103. The *'Staffing Requirements'* Fact Sheet sets out requirements similar to the previous regulatory framework but has reduced the mandatory requirement for mental health training to apply to only the proprietor, personal support coordinators and other persons in a day-to-day management position (recalling that the requirement previously applied to all SRS staff). In this regard, I note that mental health crises can occur at any time of day or night and that limiting baseline training to certain staff in leadership or management roles has the potential to place residents at risk unless there is a trained staff member nearby, or is a strong culture of feeling able to seek advice from senior staff when support workers are concerned about a client.

<u>The Willows compliance with the Six Standards following Kevin's death</u>

104. Given that the SSR replaced the HSR, I sought a statement from the SSR to ascertain whether (and when) The Willows became compliant with the new regulatory framework, with a particular focus on medication management and staff training, and whether the outstanding compliance issues remained.

105. Mr Paciocco, the Manager of Regulatory Compliance and Enforcement of the SSR (previously the State-wide Manager of the HSR) explained that *'the [previous] Compliance Notices had been closed off'* before the SSR was established.

106. On 4 November 2024, the SSR inspected The Willows and identified four breaches. Concerningly, The Willows was not compliant in developing, implementing and providing evidence of safe service delivery policies and procedures that *'identify and reduce the risk of harm to services users in the provision of social service'*, was not compliant with regards to its medication administration including to *'ensure that resident's medication is stored, administrated and recorded in accordance with legislative obligations'*, and was not

compliant in providing completed training records for relevant staff involved in the administration of medication.

107. The SSR issued improvement notices. Mr Paciocco stated that by 16 July 2025, The Willows was wholly compliant with several of the Improvement Notices through remained only partially compliant with others. At the time of Mr Paciocco's statement, 18 July 2025, he expected an amendment Improvement Notice to be issued to The Willows to address the specific maintenance-related compliance issues.

108. It is comforting that The Willows is nearing full compliance, however, it would be remiss of me to not emphasise that it has taken almost five years since the then-HSR identified their non-compliance with several elements of the regulations (as they then operated), particularly on key areas including medication management and staff training.

109. While I acknowledge that the transfer from the HSR to the SSR will have caused some delays, there is no indication that the HSR took any action regarding The Willows' compliance between May 2023 and July 2024 despite several outstanding deficiencies.

110. The new SSR Standards appropriately place the protection and safety of social services users at the centre of service delivery, but I note that there is an absence of any factsheet or guidance on effective handovers. Such a document could provide service-specific guidance to SRSs focused on the promotion of safety though effective transfer of information. More specifically, SRSs could be obligated to have processes in place to ensure the communication of key information about residents between shifts and guidance for staff in how to appropriately respond to changes in service user needs (including escalation processes). While the Managing Support Plans Fact Sheet indicates OSPs must be updated six-monthly (or sooner if a resident's health and personal support needs change), it was evident that when Mr Maloney was found to be unusually drowsy the night before the fatal incident, a key safety measure would have been for staff on the next shift to be made aware of this in real time. In the SRS context, ensuring important information is transferred between shifts is likely to be a safeguarding strategy that will have similar functional benefits to clinical handovers in health care settings. A handover Fact Sheet should also remind providers of the obligation to have processes in place to guide staff on the escalation of any concerns to senior staff.

111. I will make an apposite recommendation in this regard.

FINDINGS AND CONCLUSION

112. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[42] Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

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

    a) the identity of the deceased was Kevin Thomas Maloney, born 17 February 1982;

    b) the death occurred on 13 or 14 June 2021 at The Willows Assisted Living 16 McKenzie Street, Melton Victoria 3337, from 1(a) *mixed drug toxicity (heroin, venlafaxine, alprazolam, pregabalin)* with a contributing factor of 2 *WHO Class III obesity*; and,

    c) the death occurred in the circumstances described above.

114. I have considered the advice provided by the Coroners Prevention Unit and accept and adopt its conclusions.

115. I find that The Willows demonstrated poor practices relating to medication management and administration to its residents. On the basis of Kevin's presentation on the evening of 13 October 2021, at which time he appeared unwell, the support worker ought to have escalated the matter to a more senior member of staff to consider whether it was appropriate to seek advice from a health professional.

[42] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'.

116. Three of Kevin's prescribed medication contributed to his death however, I do not consider that The Willows staff ought to have appreciated the synergistic effect of these medications and their capacity to cause central nervous system depression (particularly when combined with certain illicit substances – such as heroin) and the evidence before me (principally that any dose of heroin can be fatal) does not support a finding that Kevin's death could have been prevented if he had not been administered these medications.

117. My investigation has been complicated by often conflicting evidence and material given by The Willows, specifically related to staff recollections about Kevin's substance use on the evening of 13 June 2021, whether support workers interacted with Kevin on the morning of 14 June 2021, staff qualifications and the provision of records which appear to have been altered after Kevin's death.

118. I will direct that this finding is distributed to the Victorian Disability Worker Commission for their information.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

(i) With a view to improve public health and safety, I recommend that the **Social Services Regulator** develop an additional Fact Sheet to provide guidance to Supported Residential Service (**SRS**) providers on handovers. Such a document may be a standalone document or may be incorporated into an existing factsheet and should provide service-specific guidance to SRSs focused on the promotion of safety though effective transfer of information.

(ii) With a view to improve public health and safety, I recommend that consideration be given by the **Social Services Regulator** to developing additional guidance for SRS providers on their obligations under the Social Services Standards and how to meet expected outcomes particularly with respect to the communication of key information about residents between shifts and how to appropriately respond to changes in service user needs (including escalation processes).

(iii) With a view to improve public health and safety, I recommend that the **Social Services Regulator**, following consultation with key stakeholders in the area, include mental

health training as a priority training area for personal support coordinators with the view to ensure there are appropriate emergency and escalation protocols in place and so that personal care coordinators are adequately equipped to provide suitable care if and when mental health issues arise.

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

ORDERS AND DIRECTIONS

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

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

Ms Julie Hayes, Senior Next of Kin

Melton Willows Supported Residential Service

The Social Services Regulator

The Department of Families, Fairness and Housing, c/- Lander & Rogers

The Victorian Disability Worker Commission

Melbourne Health

Senior Constable Brittany Webster, Coronial Investigator

Signature:

Coroner Leveasque Peterson

Date: 19 January 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.