



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2025 008178

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge Liberty Sanger, State Coroner
Deceased:	WQB
Date of birth:	[REDACTED]
Date of death:	23 or 24 November 2025
Cause of death:	1(a) Mixed drug toxicity (tapentadol, methylamphetamine, estazolam, oxycodone, alprazolam, diazepam, aripiprazole, olanzapine, promethazine)
Place of death:	[REDACTED] [REDACTED]
Keywords:	Family violence; exposure to family violence as a child; adolescent use of family violence; link between family violence and mental illness

INTRODUCTION

1. On 24 November 2025, WQB was 27 years old when he was found deceased at a Motel in a northern suburb of Melbourne, Victoria.

BACKGROUND

2. WQB was the youngest son of PHV and TRD with an older sister KJH. He was born overseas and moved to Australia with his family in 2000 or 2001¹. PHV reported that WQB started losing interest in school after he transferred to a different school in Grade Five. PHV noted that at that time, he and TRD were “*having near arguments*”. When WQB reached Grade Nine, he “*had lost interest completely [in school] and was aloof*”.
3. KJH first observed WQB’s mental health issues when their parents separated and noted that the separation had a “*big impact*” on WQB. He isolated himself and refused to talk about his feelings. KJH noted that this was also when WQB started damaging property and perpetrating family violence against the family. WQB stayed with TRD and his sister during this period, however occasionally TRD had to call the police, and WQB would be removed from the family home.
4. WQB had a history of substance misuse. KJH explained that WQB’s coping mechanism was to use drugs. Consequently, he experienced several overdoses in the months and years prior to his death. KJH noted that this cycle of substance misuse prevented him from being able to maintain employment.
5. WQB’s diagnoses included severe depression, substance use disorder, borderline personality disorder, and obsessive compulsive disorder (OCD). In late-2024, WQB’s treating clinicians considered a diagnosis of schizophrenia versus substance-induced psychosis.
6. Prior to his death, WQB resided at a Community Care Unit (CCU)², managed by Northern Health. Shortly before his death, WQB was removed from the CCU due to his escalating behaviour and was not welcome to return. After his final hospital admission, WQB stayed at a local motel, after declining the hospital’s attempts to provide him with accommodation. WQB’s mental health history and treatment is explored in further detail below.

¹ The available evidence reports arrival in either 2000 or 2001.

² The CCU is a rehabilitation service which provides supported accommodation together with comprehensive multidisciplinary care. The primary aim of a CCU admission is to support consumers with mental illness to develop the skills required for independent living while benefiting from a stable and supportive residential environment.

THE CORONIAL INVESTIGATION

7. WQB'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.
8. 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.
9. 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.
10. Victoria Police assigned Senior Constable Samantha McCartin to be the Coronal Investigator for the investigation of WQB's death. The Coronal 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.
11. This finding draws on the totality of the coronial investigation into the death of WQB 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.³

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

Identity of the deceased

12. On 1 December 2025, WQB, born [REDACTED], was visually identified by his sister, KJH.
13. Identity is not in dispute and requires no further investigation.

³ Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Medical cause of death

14. Forensic Pathologist Dr Joanne Ho from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 26 November 2025 and provided a written report of her findings dated 25 February 2026.
15. The post-mortem examination revealed findings consistent with the reported circumstances.
16. Toxicological analysis of post-mortem samples identified the presence of:
 - a) Tapentadol⁴;
 - b) Methylamphetamine and its metabolite amphetamine⁵;
 - c) 3,4-Methylenedioxy-N-Methylamphetamine (**MDMA**)⁶;
 - d) Estazolam⁷;
 - e) Oxycodone⁸;
 - f) Alprazolam⁹;
 - g) Diazepam and its metabolites nordiazepam, temazepam and oxazepam¹⁰;
 - h) Clonazepam metabolite 7-aminoclonazepam¹¹;
 - i) Aripiprazole¹²;
 - j) Olanzapine¹³;
 - k) Desmethylvenlafaxine¹⁴;

⁴ Tapentadol is an analgesic indicated for moderate to severe pain.

⁵ Methylamphetamine is the N-methyl derivative of amphetamine and has no legitimate therapeutic use in Australia.

⁶ MDMA is a synthetic amphetamine derivative used for its euphoric and entactogenic effects.

⁷ Estazolam is used for the short-term management of insomnia.

⁸ Oxycodone is a semi-synthetic opiate narcotic analgesic related to morphine used clinically to treat moderate to severe pain.

⁹ Alprazolam is a triazolobenzodiazepine derivative indicated for some depression symptoms, panic attacks, panic disorder and agoraphobia.

¹⁰ Diazepam is a benzodiazepine indicated for anxiety, muscle relaxation and seizures.

¹¹ Clonazepam is indicated for the treatment of seizures.

¹² Aripiprazole is an antipsychotic drug.

¹³ Olanzapine is an antipsychotic drug. It is also indicated for mood stabilisation and as an anti-manic drug.

¹⁴ Desmethylvenlafaxine is indicated for major depression.

- l) Levetiracetam¹⁵;
 - m) Promethazine¹⁶; and
 - n) Cocaine metabolite ecgonine methyl ester¹⁷.
17. Dr Ho explained that the tapentadol was detected at a level consistent with excessive and potentially fatal use. The combination of drugs detected could cause death in the absence of other contributing factors.
18. Dr Ho provided an opinion that the medical cause of death was *1(a) mixed drug toxicity (tapentadol, methylamphetamine, estazolam, oxycodone, alprazolam, diazepam, aripiprazole, olanzapine, promethazine)*.
19. I accept Dr Ho's opinion as to the medical cause of death.

Circumstances in which the death occurred

20. On 14 November 2025, CCU staff observed a deterioration in WQB's presentation. He denied the use of substances, however he had an unsteady gait and appeared confused at times. His behaviour escalated to pacing, irritability, picking up a pot plant and entering staff-only areas. CCU staff determined to place him on an Inpatient Assessment Order (**IAO**) in the early hours of 15 November 2025.
21. CCU staff observed WQB eating leaves. He expressed a belief that staff were recording him and he behaved aggressively towards staff. Due to safety concerns, staff disengaged and retreated from WQB, resulting in a temporary loss of visual contact with WQB. During this time, WQB absconded from the CCU, so staff immediately contacted emergency services.
22. At the relevant time, Ambulance Victoria had a 'Code Orange' in place. This delayed the provision of police and paramedics to the search for WQB. Police later located WQB and transported him to the Northern Hospital Emergency Department (**ED**) at about 1.30pm that afternoon. When WQB realised that he was on an IAO and may be admitted to hospital, he absconded from the ED again. ED staff immediately contacted police.

¹⁵ Levetiracetam is an antiepileptic used for the control of partial onset seizures.

¹⁶ Promethazine is an anti-histamine.

¹⁷ Cocaine is abused for its stimulant properties.

23. After absconding the ED, WQB returned to the CCU where he allegedly behaved aggressively, threatened staff and yelled. He reportedly threw rocks at nursing staff, smashed the front door glass, damaged a staff member's car, made sexually inappropriate and abusive comments to staff, and sent sexually explicit messages to the CCU phone. He threatened to return with a "*big one*".
24. That night at about 6.00pm, WQB sent a series of text messages to TRD stating that he intended to attend her home to smash her windows. At some point that evening, WQB attended TRD's home and smashed a window located on the second floor using a rock. At about 6.30pm, WQB sent a series of text messages to PHV advising that he intended to attend his home and damage the window. WQB attended PHV's home at about 6.40pm and damaged a large window with a rock. WQB left both properties before police could locate him. Police determined to apply for Family Violence Intervention Orders (FVIOs) against WQB to protect TRD and PHV.
25. Police located WQB later that night and returned him to the ED at about 9.45pm. Clinicians administered medication and noted the need for a likely admission. A consultant psychiatrist reviewed WQB on 16 November 2025 and noted an impression of drug-induced psychosis with florid psychotic symptoms and paranoia. WQB denied using cannabis, however admitted to using tapentadol three days' earlier. Clinicians placed him on an Inpatient Temporary Treatment Order (ITTO) and admitted him to the Adult Mental Health Inpatient Unit. Upon admission, WQB presented as drowsy. By the end of the day, WQB's psychotic symptoms had settled.
26. A psychiatrist reviewed WQB again on 17 November 2025. His behaviour had improved, his speech was normal and his paranoia had decreased, although he reported ongoing pseudo-hallucinations. His insight was assessed as fair, while his judgment remained impaired. The psychiatrist formed the view that WQB was experiencing an acute relapse of psychotic symptoms in the context of ongoing substance use.
27. From 17 to 19 November 2025, WQB's mental state improved and he no longer expressed paranoia, psychotic beliefs or hallucinatory behaviours. His interactions with nursing staff were largely appropriate, with occasional irritability and ongoing anxiety about his discharge plan.
28. On 19 November 2025, the Heidelberg Magistrates' Court issued interim FVIOs against WQB to protect TRD and PHV. The FVIO prohibited all contact and communication with TRD and

PHV. WQB's treating clinicians contacted TRD, who advised them of the FVIO and advised that he could not return to her home.

29. The CCU staff met with WQB on the ward on 19 November 2025. CCU staff undertook a lengthy review and informed WQB that he was unable to return to the CCU due to his recent threatening behaviour towards staff and neighbours, and his repeated failure to engage in treatment for his substance misuse. The CCU staff advised that they would liaise with the inpatient social work team to assist WQB to find suitable accommodation, and to connect him with community mental health treatment for ongoing support once discharged.
30. Shortly after his meeting with the CCU staff, WQB's behaviour escalated significantly. This included aggression towards staff, kicking doors and damaging property. Staff attempted to de-escalate him several times without success, then administered intramuscular droperidol and a brief period of exclusion. Following the period of seclusion and administration of droperidol, a psychiatrist reviewed WQB. The psychiatrist noted an absence of psychotic symptoms. WQB did not express any suicidal or homicidal ideation and did not present with any withdrawal symptoms from his recent substance use. WQB asked to be discharged from hospital and threatened to further damage property if he was not released.
31. Staff initially planned to continue WQB's admission to enable the social work team to work with him and secure accommodation. However, in the context of WQB's threats to staff, his overall improvement to his baseline condition, the fact that he no longer met the threshold for involuntary treatment and his requests to be discharged, WQB discharged himself against medical advice on 19 November 2025.
32. The plan upon discharge was for WQB to be referred to the Community Mental Health Team (CMHT) and the Acute Community Intervention Service (ACIS). Staff offered support to arrange accommodation, however WQB declined and advised that he preferred to obtain housing himself via Haven Home Safe. Upon discharge, clinicians provided a five-day supply of his regular medications which included olanzapine, desvenlafaxine and naltrexone.
33. After discharge, on 19 November 2025, WQB attended the CCU to collect his belongings. He reportedly presented as irritable and declined assistance from staff to pack his belongings. CCU staff provided him with a taxi voucher to take him to his motel.
34. WQB checked into a Motel on 20 November 2025. That day, CCU staff attempted to call WQB to confirm his accommodation and to proceed with his CMHT referral. WQB did not

- answer the call. Later that day, a clinician at the inpatient unit attempted to call WQB to enquire about his accommodation and to connect him with community mental health services, however he did not answer.
35. The next day, WQB attended a nearby Police Station where he was served with the FVIOs to protect his parents. The attending member did not note any issues or concerns with WQB's presentation, and he appeared to understand the FVIO conditions. That day, inpatient unit staff made numerous attempts to call WQB, however he did not answer their calls and did not return their voicemails or messages.
 36. On the afternoon of 22 November 2025, WQB sent a message to KJH, asking to catch up for a coffee. KJH was unavailable and declined the offer. She noted that her messages with WQB were originally positive. WQB stated that he would "*turn things around and grow up. Leave behind the drugs and be future focused*". However, WQB later asked KJH if she had taken their father to the airport and when she replied that she had not done so, WQB's messages became abusive.
 37. WQB stated that he was going to take an overdose of drugs and sent a photo of some pills, Ziplock bags and a business card for a Motor Inn. He told KJH that he was due to stay at the Motor Inn until Monday (24 November 2025).¹⁸ This was the last conversation between WQB and KJH.
 38. On the evening of 23 November 2025, WQB attended the Motel reception where he was staying and spoke with a staff member. He requested more toilet paper. The staff member did not observe anything out of the ordinary about WQB's presentation. This was the last time WQB was seen alive.
 39. On 24 November 2025, the Motel staff thought that WQB had checked out, as scheduled. A staff member entered WQB's room and observed him lying on the bed. She assumed that he was asleep, so she immediately left the room and notified her manager. The manager attended WQB's room to check on him. The manager determined that WQB was not breathing and promptly called Triple Zero.
 40. Paramedics attended the scene and confirmed WQB was deceased. Police also attended the scene and investigated WQB's death. Police observed that WQB had a rolled up \$10 note in

¹⁸ It is unclear why WQB told KJH that he was staying at the Motor Inn when the evidence establishes that he was staying at the Motel.

his hand. Police did not observe any injuries or signs of an assault in the room. Police located four empty packets of tapentadol and five empty Ziplock bags with remnants of a white crystal substance (believed to be methylamphetamine). Police did not identify any suspicious circumstances or evidence of third-party intervention in connection with the death.

FURTHER INVESTIGATIONS

41. Due to the circumstances of WQB's death, with a recent discharge from hospital and loss of his stable accommodation, I directed further material from Northern Health, the operators of CCU and the Northern Hospital. I also directed further information about WQB's history of family violence, both as a perpetrator and victim-survivor.

Family violence history

42. As noted above, WQB had a history of perpetrating family violence against his parents as an adolescent and adult. However, according to Victoria Police records, WQB was reportedly exposed to family violence between his parents. The first recorded incident of family violence occurred when WQB was about nine years old in 2010.¹⁹ The report alleged a previous history of physical assaults, regular arguments, and escalating verbal abuse by PHV towards TRD.
43. As an adolescent and adult, WQB was documented as a perpetrator of family violence in at least 15 incidents from 2016 until November 2025 (the most recent incidents). The affected family members (**AFMs**) were recorded as his sister, mother and father.
44. Exposure to family violence is a form of child maltreatment,²⁰ and evidence suggests that its prevalence is increasing, with young people aged 16-24 years old reporting exposure to family violence at a rate of 43.8%.²¹

¹⁹ Coronial Brief, Victoria Police LEAP records, 327-332.

²⁰ Davina M Haslam et al. 'The Australian Child Maltreatment Study (ACMS), a national survey of the prevalence of child maltreatment and its correlates: methodology' (2023) 218 *Medical Journal of Australia* 218 S5-S12.

²¹ Haslam D et al, The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report. (Australian Child Maltreatment Study, Queensland University of Technology, 2023) 3.

45. Adults who have experienced childhood maltreatment are at increased risk of developing a mental health disorder²² and substance misuse issues,²³ and childhood maltreatment is also associated with a higher risk of self-harm and suicide in young people.²⁴
46. Childhood exposure to family violence can shape a child's understanding and experience of relationships, including what comes to be perceived as familiar or normative.²⁵ Adolescents who use violence (as WQB did) are also likely to be victim survivors.²⁶ Research suggests that men who choose to use interpersonal violence often have a history of trauma rooted in adverse experiences during their formative years.²⁷
47. Trauma can influence the formation of core beliefs that normalise, justify or enable a person's decision to use violence. While trauma is not a direct cause of family violence, nor does it excuse the decision to engage in violent behaviour, it is important to recognise that traumatic experiences, including childhood exposure to family violence, can influence the likelihood that an individual will choose to use violence later in life. This pathway to violence is gendered. For example, research shows that without intervention, boys' exposure to violence perpetrated against their mother or female caregiver can lead to a higher risk of partner violence later in life.²⁸
48. To effectively prevent family violence and family violence related deaths, it is therefore important that systems are resourced to address drivers of violent behaviour before they manifest in adulthood. To that end, multiple coroners have made and supported

²² Davina M Haslam et al. 'The Australian Child Maltreatment Study (ACMS), a national survey of the prevalence of child maltreatment and its correlates: methodology' (2023) 218 *Medical Journal of Australia* 218 S5-S12; Family Safety Victoria, [MARAM Practice Guides: Foundation Knowledge Guides](#) (February 2021) 93.

²³ Family Safety Victoria, [MARAM Practice Guides: Foundation Knowledge Guides](#) (February 2021) 67.

²⁴ Haslam D et al, The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report. (Australian Child Maltreatment Study, Queensland University of Technology, 2023) 23; Suicide Prevention Australia, 'Adverse Childhood Experiences and Suicide' (November 2025), <<https://www.suicidepreventionaustralia.org/wp-content/uploads/2025/11/Adverse-Childhood-Experiences-and-Suicide-report-FINAL.pdf>>; Angelakis I, Gillespie EL, Panagioti M. 'Childhood maltreatment and adult suicidality: a comprehensive systematic review with meta-analysis' (May 2019) *Psychol Med* 49(7) 1057-1078; Lawrence, D.M., et al. 'The association between child maltreatment and health risk behaviours and conditions throughout life in the Australian Child Maltreatment Study' (2023) 218 *Medical Journal of Australia* S34 -S39.

²⁵ Mathews, B., et al. 'Association Between Childhood Maltreatment and Adult Intimate Partner Violence Victimization: Findings From a National Survey in Australia' *Journal of Interpersonal Violence* (2025); Evans, K. E., Schmidt-Sane, M. M., Bender, A. E., Berg, K. A., & Holmes, M. R. 'Children's exposure to intimate partner violence and acceptance or appraisals of IPV: A systematic review' *Journal of Family Violence* (2022) 37(8), 1301–1319; Our Watch, [Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia](#) (2nd ed, 2021) 122.

²⁶ Family Safety Victoria, [MARAM Practice Guides: Foundation Knowledge Guides](#) (February 2021) 95.

²⁷ Family Safety Victoria, [MARAM Practice Guides: Foundation Knowledge Guides](#) (February 2021) 46.

²⁸ Vlasis, R. (April 2025). *Working with adult users of domestic and family violence who have a trauma background*; Our Watch, [Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia](#) (2nd ed) (2021) 49-50.

recommendations regarding primary prevention of family violence.²⁹ These recommendations include that:

*The Victorian Government urgently increase the total quantum of primary prevention funding, and prioritise longer term funding across the primary prevention system, including multi-year funding for organisations leading prevention activities, and stable, ongoing funding for Respect Victoria*³⁰

And that:

The Federal Government commit to long term funding for the development and maintenance of critical infrastructure for the primary prevention of violence against women and family violence as well as for those agencies that play a key role in influencing the quality, reach, impact and coordination of prevention activities at a national level, as outlined by Our Watch³¹ in Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia.³² These include:

- *Our Watch (to provide independent national leadership on primary prevention)*
- *Australia's National Research Organisation for Women's Safety (ANROWS) (to deliver the National Community Attitudes towards Violence against Women Survey and the prevention elements of the national research agenda)*
- *Australian Bureau of Statistics (to deliver the Personal Safety Survey)*
- *Workplace Gender Equality Agency.*³³

49. With respect to the primary prevention of child maltreatment, recommendation two of the inaugural Australian Child Maltreatment Study found:

*We must accelerate a public health approach, with a focus on primary prevention and secondary prevention. We can and must invest more, and invest more wisely, in universal prevention at the population level, and to target interventions to subpopulations at high risk.*³⁴

²⁹ See, for example, [Finding into death without inquest – Thi Minh Nguyen](#); [Finding into death without inquest – Ms HRZ](#); [Finding into death without inquest – Shirley Kidd](#).

³⁰ Similar recommendations are made by the FVRIM and Respect Victoria in the following reports - FVRIM, [Monitoring Victoria's family violence reforms Primary prevention system architecture](#) (Report, 2022) 38-40; Respect Victoria, Progress on Preventing Family Violence and Violence Against Women in Victoria: First Three-Yearly Report to Parliament (Report, September 2022) 11-16.

³¹ Our Watch is the national leader in the primary prevention of violence against women and their children in Australia.

³² Our Watch, Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia (2nd ed, 2021) 100-6.

³³ Ibid 110.

³⁴ Haslam D, Mathews B, Pacella R, Scott JG, Finkelhor D, Higgins DJ, Meinck F, Erskine HE, Thomas HJ, Lawrence D, Malacova E. (2023). The prevalence and impact of child maltreatment in Australia: Findings from the Australian

50. Finally, Action 10 of Australia’s framework for the primary prevention of violence against women emphasises the need to reduce the long-term impacts of exposure to violence and prevent further exposure through various measures, including by taking action to:

*Strengthen early intervention mechanisms for children and young people that aim to address the gendered impacts of exposure to violence against women and promote alternative models of healthy, equitable and non-violent relationships, characterised by respect and equality, and not limited by gender norms and stereotypes’.*³⁵

51. Noting WQB’s exposure to family violence as a child, and his decision to use violence as an adolescent and adult, I note my strong support and endorsement for these recommendations.

Procedural fairness response

52. As a matter of procedural fairness, the Court wrote to PHV and provided him with an opportunity to respond to my proposed findings, including a discussion of the family violence that WQB was allegedly exposed to as a child. PHV did not respond.

Mental health treatment

Mental health history

53. As noted above, WQB had a significant history of mental health treatment, commencing from the age of 14. His first presentation to the Northern Hospital ED occurred in March 2017 when he was brought to the hospital under section 351 of the (then) *Mental Health Act 2014* (Vic). His first psychiatric admission at Northern Health occurred in May 2017. This two-week admission was in the context of intoxication and a suicide attempt. During the admission, WQB was diagnosed with severe depression with cluster B personality traits and prescription medication abuse.
54. From 2017 to 2024, WQB largely received treatment from community mental health services across the Northern and North West Area Mental Health Services. WQB experienced about 20 admissions to inpatient units across the Northern and Broadmeadows Hospitals. He also experienced other inpatient admissions to other hospitals including the Royal Melbourne

Child Maltreatment Study: Brief Report. Australian Child Maltreatment Study, Queensland University of Technology, 35.

³⁵ Our Watch, [Change the Story: A Shared Framework for the Primary Prevention of Violence Against Women in Australia](#) (2nd ed, 2021) 86.

Hospital, St Vincent's Hospital and the Orygen Inpatient Unit. He also presented to various EDs across the northern and western suburbs of Melbourne.

55. WQB's treatment during this period included both voluntary and involuntary treatment. Most of his presentations occurred in the context of suicidal ideation, intoxication, substance-induced psychosis/psychotic symptoms or physical health complications secondary to substance misuse. WQB's engagement with treatment was largely superficial and his compliance with treatment fluctuated over time.
56. By late-2024, WQB was living in boarding/rooming houses after being evicted from his mother's home. In December 2024, WQB was admitted to the CCU. Upon admission, the CCU provided WQB with services to support his mental health and develop his activities of daily living. Some of the supports included psychological counselling, links to long-term accommodation services, links to employment services, social work and occupational therapy. He also received support for his substance misuse, although he continued to misuse substances.
57. WQB's engagement with services at CCU was variable and tentative (at times). He cycled through periods of substance use, which increased the risk posed to himself, primarily through misadventure. Episodes of substance use were associated with multiple instances of acute psychosis, typically in the context of intoxication, followed by periods of paranoid ideation.

ED presentations and hospital admissions during CCU admission

58. From December 2024 to November 2025, WQB experienced several ED presentations and hospital admissions. This included:
 - a) 16 January 2025 – WQB was transported to hospital by ambulance due to deteriorating symptoms of psychosis.
 - b) 27 April 2025 – WQB presented to the ED following an intentional polypharmacy overdose, however left the ED prior to formal discharge. The ED clinician called WQB who advised that he felt “okay”.
 - c) 30 April 2025 – WQB was brought to the ED again in the context of “recreational” polysubstance use. He was admitted to the Short Stay Unit (SSU). He was discharged home the next day after a brief period of assessment in the SSU.

- d) 25 May 2025 - WQB presented to the ED following another drug overdose, allegedly involving 54 dexamphetamine tablets. He was admitted to the SSU; however, he left the SSU on 27 May 2025.
 - e) 12 September 2025 – WQB was transported to the ED by ambulance due to methamphetamine use. He presented as highly erratic with multiple falls. He was admitted to the Intensive Care Area (ICA) involuntarily under an Assessment Order (AO). The AO was later revoked, and he was discharged back to the CCU on 17 September 2025.
 - f) 8 October 2025 – WQB was found unconscious and gasping for breath in his bedroom. Paramedics attended and treated him at the CCU. Later that day, he was found unresponsive again. Paramedics attended again and resuscitated him. Paramedics transported WQB to St Vincent’s Hospital, Melbourne where he was admitted to the Intensive Care Unit. On 13 October 2025, WQB was transferred to the Northern Hospital for inpatient psychiatric care. Following a period of improvement, WQB was discharged back to the CCU on 20 October 2025.
 - g) 6 November 2025 – WQB was transported to hospital by ambulance after experiencing a tonic-clonic seizure. Clinicians determined the seizure was likely provoked by substance misuse. WQB wanted to leave hospital, and as he did not meet the threshold for involuntary treatment, he discharged against medical advice on 7 November 2025.
59. In October 2025, CCU staff noted the escalation in WQB’s substance use, ED presentations and increased episodes of aggression and inappropriate behaviour towards CCU staff. While WQB was admitted to the inpatient unit on 18 October 2025, CCU spoke to him about the need to participate in treatment and adhere to clearly defined expectations. He agreed to comply with the expectations and was permitted to return to the CCU.

Decision to discharge WQB from the CCU

60. Northern Health explained that consumers residing at the CCU are expected to engage with the therapeutic program, maintain behaviours consistent with the safety and wellbeing of the unit and sign a residency agreement on admission. The conditions of admission to the CCU advise that consumers may be required to leave the CCU outside of a planned discharge in circumstances including:

- a) Failure to engage with the therapeutic program (including group activities and allied health interventions);
 - b) Substance use on CCU premises;
 - c) Substance use that negatively impacts behaviour of the consumer, or the safety and wellbeing of others;
 - d) Aggression or violence towards property, staff or other consumers;
 - e) Significant disruption to the CCU program or therapeutic environment; or
 - f) Clinical deterioration such that the consumer is too unwell to be safely managed within the CCU setting.
61. Prior to admission to the CCU, WQB signed a copy of the Residency Agreement, which outlined the terms above.

Support with accommodation

62. As noted above, WQB declined all offers of assistance to obtain accommodation upon his discharge from the Northern Hospital. He was also unwilling to stay in hospital any longer and could not be compelled to do so.
63. Northern Health stated that if WQB was willing to stay on the ward, their usual practice is for the patient to undergo a comprehensive assessment by the social work team. This would have informed discharge planning, including identifying and sourcing appropriate accommodation options. Northern Health noted that due to WQB's history of substance misuse and aggression, he may not have been accepted by Northern Health's current housing partners. However, the social work team would have worked with WQB to determine other available accommodation pathways.
64. Additionally, Northern Health would have supported discharge by providing short-term accommodation funding, up to two weeks, together with practical supports. Practical supports could include provision of toiletries, a mobile phone and SIM card, and/or supermarket vouchers. The team would have also arranged referrals to ongoing supports to specialist housing support services, ACIS and the Housing Pathways Team for follow-up. Unfortunately, WQB's unwillingness to engage meant that these options could not be pursued.

65. Northern Health noted that about 18 months ago (late-2024 or early-2025), the Northern Health Mental Health Division established the Housing Pathways Team (**HPT**). The HPT was established in response to Recommendation 25.3 of the *Royal Commission into Victoria's Mental Health System*, which highlighted the critical need to improve access to, and coordination of, housing support for people living with chronic and enduring mental illness.
66. Northern Health noted that homelessness is associated with poor health outcomes, prolonged inpatient stays, and challenges in achieving recovery-oriented goals. The establishment of the team was intended to address systemic gaps in the interface between mental health services and housing systems, particularly for patients experiencing homelessness or housing insecurity.
67. Since its implementation, the HPT has focused on three key areas:
- a) Direct consumer support – providing specialised consultation and coordination to assist consumers in navigating complex housing systems and accessing appropriate accommodation options.
 - b) Sector partnership development – strengthening collaboration with key external stakeholders, including community housing providers, homelessness services and government agencies to improve referral pathways, reduce barriers and support more equitable allocation of housing resources.
 - c) Workforce capability building – increasing the capacity and confidence of clinical staff to identify and respond to housing instability through advice, secondary consultation and knowledge sharing.
68. Northern Health noted that this model has supported improvements to care coordination and service linkages and that the service is working to expand the program by identifying additional partnership options. Northern Health stressed that these pathways are only as effective as a consumer's willingness to engage with them. Sadly, WQB was unwilling to engage with these processes and opted to find his own accommodation.

FINDINGS AND CONCLUSION

69. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
- a) the identity of the deceased was WQB, born [REDACTED];

b) the death occurred on 23 or 24 November 2025 at [REDACTED], from mixed drug toxicity (tapentadol, methylamphetamine, estazolam, oxycodone, alprazolam, diazepam, aripiprazole, olanzapine, promethazine); and

c) the death occurred in the circumstances described above.

70. Having considered all the circumstances, I am satisfied that WQB intentionally took his own life. I note WQB's complex mental health history including numerous suicide attempts and chronic suicidal ideation. I also note the messages he exchanged with his sister prior to his death, depicting a large quantity of drugs and disclosing an intention to end his life.

71. While it was unfortunate that WQB was unable to return to the CCU following his last hospital admission, it is clear that CCU staff did all they could to support him during his near-12-month admission. Unfortunately, WQB was unwilling or unable to comply with the conditions of his admission, and it would have put other consumers and staff at risk if he were to return. While WQB was offered support with accommodation, he repeatedly declined the offers and reported that he wanted to obtain his own. At the time of his final discharge from hospital, his condition had improved and did not meet the threshold for involuntary treatment. As he was a voluntary patient, he was free to leave and could not be compelled to stay in hospital any longer.

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

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

TRD, Senior Next of Kin

PHV, Senior Next of Kin

Northern Health

Senior Constable Samantha McCartin, Coronial Investigator

Signature:



Judge Liberty Sanger, State Coroner

Date: 22 September 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.
