IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 004213

REDACTED FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: JM

Delivered On:	9 December 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne, Victoria
Hearing Dates:	10 and 11 October 2013
Findings of:	CORONER K. M. W. PARKINSON
Representation:	Ms Erin Gardner for Department of Human Services; and Ms Natalie Blok for Young People's Legal Rights Centre Inc ('Youthlaw')
Police Coronial Support Unit Assisting the Coroner	Leading Senior Constable John Kennedy

I, K. M. W. PARKINSON, Coroner having investigated the death of

JM

AND having held an inquest in relation to this death on 10 and 11 October 2013

AT MELBOURNE

Find that the identity of the deceased was JM

Born on 23 May 1992

And the death occurred on 28 August 2009

At Western Hospital, 148-160 Gordon Street, Footscray, Victoria.

from:

1A. COMBINED DRUG TOXICITY (HEROIN, ALPRAZOLAM AND DIAZEPAM)

In the following circumstances:

1. An inquest was held into the death of JM who died at the Western Hospital on 28 August 2009. Leave was granted to an incorporated body, Youthlaw to appear as an Interested Party pursuant to s56 of the Coroners Act 2008.

2. The evidence included statements of witnesses who have been called to give evidence and statements from a number of persons who have not been called. The brief also includes medical and clinical records and reports. Correspondence was also received from JM's father, setting out a number of his concerns in relation to the circumstances of JM's death. I have also been assisted in this case by extensive and comprehensive written submissions filed by the Department of Human Services ('DHS') and the Young People's Legal Rights Centre ('Youthlaw') at the conclusion of the proceeding.

3. Whilst I do not refer to all of the material before the court, I have considered all of this material in coming to my finding in this matter.

4. The following witnesses were called to give evidence: Ms Sharon Desmond, Group Manager, Drug and Alcohol Services, Western Health; Psychiatrist Dr Catherine Greenwood-Smith-Smith, ORYGEN Youth Health; Youth Justice Worker Ms Vicki Wilkinson, DHS; Child

Protection Worker Mr Paul Girardi, DHS and Senior Child Protection Worker Ms Susan Vickers, DHS.

5. The Coroner is required to the extent possible to establish the cause of the death and the circumstances in which it occurred. In this context, factors which may have contributed to the death were examined in the inquest. I turn to consider these matters.

BACKGROUND AND CIRCUMSTANCES

6. JM was born on 23 May 1992 and was 17 years old at the time of her death. She resided with her father in Victoria.

7. JM had a history of substance abuse, including alcohol and illicit drugs. JM's use of illicit drugs included heroin. She had also been diagnosed with mental illness including depression. JM had a history of extensive involvement with drug and alcohol services, including DASWEST, mental health care providers, including ORYGEN Youth Health, Western Health and clinicians at DHS Child Protection.

8. DASWEST is a drug and alcohol support service operating out of the Western Health Service. They provide young people with treatment and counselling services in relation to substance abuse. ORYGEN Youth Health is primarily a mental health support service, however they offer multi-disciplinary support for young people whose mental health is further compromised by substance use.

9. JM had been a client of DHS Child Protection from 7 years of age. On 25 June 2008, JM became subject to a Supervision Order, a protective order made pursuant to the *Children Youth and Families Act 2005* (Vic) in the Protection Division of the Children's Court of Victoria. This order was extended on 4 March 2009 and continued in operation. JM was placed in the day to day care of her father. A number of conditions were attached to the order and these included:

- JM and her father accept visits from and co-operate with DHS;

- JM and her father jointly and JM individually, accept support services as agreed with the DHS;

- JM was to live with her father; and
- JM was to continue to see DASWEST, ORYGEN Youth Health and Headspace as directed by the Department.

10. I have extracted these orders as they become pertinent in the context of assessing the level of supervision and assistance available to JM before, during and after her release from youth detention.

11. Youth Justice first became involved with JM in May 2008. The course of JM's involvement with Youth Justice is set out in the statement of Ms Vicki Wilkinson in which a lengthy and comprehensive program of youth justice and child protection interventions is evidenced. Ms Wilkinson stated:

> "From the commencement of my involvement with JM, mental health, domestic violence with her boyfriend, drug and alcohol abuse (particularly prescription medication), and anger management presented as the key areas of concern. These concerns continued until her death, and were the focus of work undertaken by both the Youth Justice and Child Protection Divisions of the Department. .. Supports in place prior to my involvement for JM included Anglicare-Adolescent Specialist Support Service (ASSS), WestCare-Early School Leavers program (ESL) and DasWest-Youth Drug & Alcohol Outreach Team. .. Due to her high risk behaviours, JM had been placed on the High Risk Youth schedule of the Department's Child Protection division prior to my involvement." [1]

12. During 2008, referral was made by Youth Justice to various support programs including DASWEST drug and alcohol counselling and Orygen Youth Mental Health Services. Youth Justice also reports frequent failures to attend at appointments even when JM was on bail or when court hearings were pending. It was not uncommon for JM to simply fail to attend and Youth Justice workers accommodated many such instances by rescheduling appointments or by attending upon JM at various locations.

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[1] Exhibit 8 - Statement of Ms Vicki Wilkinson dated 11 July 2011 at paragraphs 6, 7 and 9.

13. The course of JM's involvement with Child Protection is set out in the statements of Ms Susan Vickers[2] and Mr Paul Girardi[3]. Child Protection worker Mr Paul Girardi also gave evidence as to his involvement and attempts to manage JM's complex problems. Owing to the complexity of JM's case both he and Senior Child Protection clinician, Ms Susan Vickers jointly managed and shared responsibility for the supervision and assistance provided to JM. Mr Girardi described a very troubled and traumatised young woman who at times could be extremely violent and difficult to engage. His evidence was of extensive attempts at engagement and the putting in place of various support and assistance for both JM and her father.[4]

14. The course of JM's involvement with ORYGEN, which commenced with an inpatient admission on 23 July 2008 after referral by the Adolescent Forensic Health Service and continued until her death, is set out in the statement of Dr Greenwood-Smith.[5] A lengthy and complex mental health and substance abuse treatment program is evidenced. This included a number of inpatient admissions and a comprehensive treatment program.

15. Dr Greenwood-Smith stated that as she did not appear to be engaging with a clinic based service she was referred to the Youth Outreach Service. During her 12 months of care with the Intensive Mobile Outreach Service, JM continued to have difficulties with "engagement and collaboration with the suggested management, including medication and therapeutic interventions".

16. JM was diagnosed with Post Traumatic Stress Disorder; Cannabis Dependence; Inhalant abuse; Benzodiazepine abuse; Borderline Intellectual Disability; Antisocial Personality Disorder; and Borderline Personality Traits. Dr Greenwood-Smith also commented that there was some concern that JM had shown symptoms of hypomania, a feature of Bipolar II Disorder, however she stated that after assessment this was thought to be most likely due to episodes of substance intoxication, including intoxication with benzodiazepines.

17. Dr Greenwood-Smith identified the risks associated with JM's presentation which she described as both acute and chronic. Her evidence as to these risks was consistent with those

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[2] Exhibit 16 – Statement of Ms Susan Vickers dated 5 July 2011.

[3] Exhibit 4 – Statement of Mr Paul Girardi dated 5 July 2011.

[4] Transcript 11 October 2013 at page 214 to 216.

[5] Exhibit 2 – Statement of Dr Catherine Greenwood-Smith dated 16 December 2011.

identified by all those services involved with assisting or supervising JM. Dr Greenwood-Smith described the risks as follows:

> "*Risk to self:* JM had episodes of deliberate self harm and suicidal ideation. The latter was not a prominent risk with JM, her deliberate self harm was primarily without suicidal intent, and used mainly to manage distress. Risk of deliberate self harm was a low to moderate chronic risk and would increase when JM was seeking substances or intoxicated.
>
> *General Vulnerability:* to exploitation, and being a victim of physical assault was moderate. Static factors related to this were her borderline intellectual functioning and association with a peer group with offending behaviours and aggression. Acute factors included substance intoxication and her level of impulsive aggression to others. Risk of misadventure due to substance intoxication was frequently high due to her very harmful patterns of substance abuse.
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> *Risk to others:* including family/peers, members of the public and clinicians, was deemed to be chronically high. This was judged on her history of assaulting others and ongoing episodes of interpersonal violence, impulsivity, substance abuse and lack of remorse."

18. The treatment and interventions adopted by ORYGEN included ongoing outreach both before and when she was in custody at Parkville, individual therapeutic work including substance abuse interventions. Dr Greenwood-Smith reported that there was a brief admission to DASWEST (Drug and Alcohol Service) unit for detoxification, in mid December 2008, however JM discharged herself before completing the program.

19. The evidence is that JM frequently missed appointments. On some occasions the failure to attend resulted in a crisis in JM's mental health and substance use and consequent admission and intervention, however on many occasions the service was able to manage the situation by rescheduling and modifying treatment programs.

20. The course of JM's involvement with Drug and Alcohol treatment services at DASWEST is contained in the statement of Ms Sharon Desmond[6]. JM was involved with the service at various times from March 2007 to the date of her death. The DASWEST service also had a similar experience to that of other services, in attempting to provide treatment and assistance to JM.

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[6] Exhibit 1 – Statement of Ms Sharon Desmond dated 16 August 2011.

21. Each of the services referred to above had initially been engaged by either DHS protective service or juvenile justice sectors.

Events leading to Youth Detention

22. On 27 March 2009, JM was charged with breaching her YSO and with further offending. JM was remanded in custody as bail was refused. Ms Wilkinson had extensive involvement with JM in this period and liaison with every supervisory and treatment service associated with JM's care. In the period 27 March 2009 to the date of JM's death on 28 August 2009, Ms Wilkinson had arranged, managed or attended meetings with JM or in relation to her care and supervision on at least 30 occasions.

23. Youth Justice Worker Ms Wilkinson's evidence was that during the period of the remand JM was angry with her, because she (Youth Justice) would not support any application for Bail. Ms Wilkinson had explained to JM that she could not support a bail application in the first periods of remand due to her inability to comply with bail conditions, her continued offending and due to JM's own safety (largely relating to drug use) and that of the community.

24. In the remand period a number of measures were taken to attempt to address the substance abuse and mental health issues. The period of remand also provided an opportunity for JM to remain substance free and for mental health assessment to take place in this context. Counselling and treatment continued whilst JM was on remand.

25. On 30 April 2009, JM was bailed with a requirement to re-appear at the Children's Court of Victoria on 8 July 2009. Bail conditions included reporting to police, residing with father, curfew, obey all lawful directions of Youth Justice; attend and comply with YJ program and weekly urine screens. In the bail period, JM continued to miss appointments for drug and alcohol and mental health services and with Ms Wilkinson on at least eight occasions. These included:

- failure to attend a scheduled care team meeting and making no contact on 4 June;
- failure to attend drug and alcohol counselling on 9 June;

- failure to attend a Youth Justice meeting and making no contact on 11 June;
- attending 1 1/2 hours late for a Youth Justice supervision meeting on 18 June, becoming abusive and threatening and leaving the meeting when counselled in relation to non attendance and positive urine screens;
- failure to attend an appointment with Drug and Alcohol services youth outreach Mr Michael Anderson; and
- there was also a non-association provision with which JM failed to comply.

26. On 8 July 2009, JM was sentenced by the Criminal Division of the Children's Court of Victoria to six months detention at a Youth Justice Centre for breaching a Youth Supervision Order and committing offences including assault and aggravated burglary. She was admitted to Parkville Youth Residential Centre ('Parkville').

27. As can be seen from this background, there was necessarily some intersection between the protective and criminal jurisdictions and youth justice and child protection workers, when it came to providing services and supervision in relation to JM.

28. During her detention at Parkville, JM is reported to have been co-operative with Youth Justice and Child Protection workers. She was seen by forensic medical and mental health clinicians and her medication regime was adjusted during this time. She was noted by staff at Parkville to be positively planning for the future and she presented as engaging well with all of the clinicians.

29. JM was also reviewed by ORYGEN before, during and after her time in Parkville, including by case worker Ms Megan Wilson and treating Psychiatrist, Dr Catherine Greenwood-Smith.

30. On 23 July 2009, JM had been discharged from the ORYGEN program as she was sentenced to six months in custody and she had not shown a willingness to commit to the program or its objectives. She also had a history of not attending for appointments. In her discharge plan, JM was reviewed and found to have no suicidal ideation nor did she display any evidence of depression.

31. During the course of the planning for youth parole, ORYGEN revisited JM and she (JM) made certain commitments to genuine participation in the program, which resulted in ORYGEN accepting further case management upon her release.

32. The evidence before the court is that there was discussion amongst all relevant clinicians as to the planning for JM's release from custody on parole and the services and supervision required. This involved the relevant support services who would be engaged in assisting JM upon her release, DASWEST, ORYGEN, Youth Justice and Child Protection. A parole planning meeting was also held on 5 August 2009 at Parkville at which meeting both JM and her father was present. JM's proposed release date of 24 August 2009 was discussed at that meeting.

33. A parole plan[7] was submitted to the Youth Parole Board by the Youth Justice worker, Ms Wilkinson recommending JM's Parole. Initially there was concern expressed by the Youth Parole Board as to the absence of a Training or Education regime post release. JM agreed that she would participate in a course at TAFE and enrolment was pursued on her behalf. This program was an addition to the Parole plan and an additional parole plan submitted[8].

34. The parole plan was accepted by the Youth Parole Board on 3 August 2009 and parole was granted effective from 24 August 2009 to a scheduled end date of 22 November 2009.[9] JM signed the order prior to her release on 24 August 2009 and the evidence is that the terms of the order were explained to her by the Youth Justice Worker and also by the presiding member of the Youth Parole Board.

35. Conditions of the Parole Order included not breaking the law, supervision by a parole officer, reporting to the parole officer as and when directed and attending upon substance abuse counselling and general counselling as and when directed by her parole officer.

36. The detail of the services and relevant timeframes was not spelt out in the Parole Order conditions, however it is apparent that JM was well aware of her obligations after she was granted parole. This is evidence not only from the minutes of the parole meeting, but also

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[7] Exhibit 9 – Parole Plan dated 27 July 2009.

[8] Exhibit 10 – Parole Plan amended dated 17 August 2009.

[9] Exhibit 11 – Parole Order, Youth Parole Board dated 3 August 2009.

from her conduct after release in telephoning her parole supervisor to provide reasons why she would not be attending scheduled appointments. It cannot be said that JM was unaware of her obligations or that there was any room for confusion as to the timing or location of the meetings with support or supervisory services.

37. Whilst it appears that on the release date, the support services were not individually notified of the time that JM had been released, the parole planning meetings had provided sufficient indication of imminent release date and appointments had been made with the mental health service provider and arrangements made for JM to resume contact with DASWEST. Appointments had also been scheduled with the parole officer, Ms Wilkinson.

THE EVENTS IN THE PERIOD MONDAY 24 AUGUST 2009 TO THURSDAY 27 AUGUST 2009

38. It is appropriate to recount in some detail the course of events after JM's release as they provide insight into the difficulties that protective, juvenile justice and other clinicians and JM's father experienced in trying to assist and protect JM.

39. At 11.00 a.m. on Monday 24 August 2009, JM was released from Parkville. JM was met by her father and had in her possession $50 in cash and a cheque representing earnings during her period in detention. She was discharged with prescriptions for Sodium valproate 500mg orally twice daily and Olanzapine 5mg orally twice daily. The indications for prescribing were Olanzapine for distress and anxiety associated with Post Traumatic Stress Disorder and Borderline Personality Disorder and Sodium valproate initially for Bipolar II Disorder, continued for distress and anxiety associated with Post Traumatic Stress Disorder and Borderline Personality Disorder when diagnosis was revised the latter.[10]

40. Her father drove JM to a pharmacy in Brunswick to obtain the medication. They were then to drive home, however at JM's request her father dropped her at a friend's flat in Footscray.

41. JM's father reported that JM returned home on the first night of her release (24 August) at around 6.00 p.m. with a bag of toiletries. He was unclear where she had obtained these items, as to his knowledge she did not have available to her sufficient funds for their purchase. JM

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[10] Exhibit 2 - Statement of Dr Catherine Greenwood-Smith at page 7.

left immediately after dropping these items home. She returned to the house at around 9.45 p.m., informing her father that she had been at a tattooist.

42. JM's father reported that JM appeared to be "out of it" and suspected that she was substance affected. JM proceeded to her room and her father went to check on her a short while later, observing that she was breathing heavily and had fallen asleep with food still in her mouth, which he took steps to clear.

43. On Tuesday 25 August 2009 (the second day after release), her father reported that JM woke around 9.30 a.m. and left the house, taking his mobile phone with her. She informed her father that she was attending a meeting with Ms Megan Wilson, her Case Worker at ORYGEN. JM did not attend this appointment.

44. JM returned home at approximately 5.30 p.m. however immediately left the residence again, returning later at around 10.15 p.m. At that time, her father again reported that JM appeared to be substance affected and observed what appeared to be puncture marks on her arm, which she explained as having been due to blood tests taken by a clinician. He reported that she fell asleep in the kitchen whilst eating. JM's father woke her and JM went to her bedroom. Her father stayed awake to check on JM and observed that she was again breathing heavily.

45. On Wednesday 26 August 2009 (the third day after release), JM attended a flat in Braybrook occupied by her ex-boyfriend, an adult male, some years older than JM, with whom the DHS was aware JM had some time earlier been involved in a relationship.

46. Her ex-boyfriend reported that JM appeared to be substance affected and behaving in an unusual manner. He also reported that JM told him that she had consumed a large quantity of Xanax tablets. JM left his residence sometime between the late afternoon and early evening that day.

47. JM's father reported that JM returned home around 10.15 p.m. that evening (the third day after release) and he observed her to be "seriously affected by drugs". He noticed that she was unkempt and that her shirt was stained with a substance he was unable to identify. JM had a shower and then sat with her father to have something to eat.

48. On Thursday 27 August 2009, JM again attended her ex-boyfriend's residence. He located her that morning at the residence of another friend who lived in the same block of units. JM was observed to have syringes in her shoulder bag. He reported that they both consumed some Xanax tablets and that JM confided in him that she had been using heroin for the past couple of months.

49. Her ex-boyfriend stated JM then requested that he accompany her to purchase some heroin. He declined and he stated that JM left without him, returning approximately 40 minutes later. On her return, JM is reported to have informed him that she had consumed half a gram of heroin, before she fell asleep on the couch.

50. Later that day, at around 4.25 p.m., JM was observed by another resident of the flat, to be asleep on the couch, snoring and lying 'in an uncomfortable looking position'. Those present at the flat were unable to rouse her. Later that evening, JM was observed to be 'frothing from her mouth' and was unresponsive. Her ex-boyfriend attempted to resuscitate JM. Emergency services were called at 8.47 p.m. Paramedics arrived around 8.52 p.m. and reported that at their arrival JM was in cardiac arrest.

51. She was resuscitated, intubated and transferred to the Western Hospital Footscray, where she was admitted and transferred to the Intensive Care Unit at 7.00 a.m. on the following day, 28 August 2009.

52. The medical deposition stated that a CT Brain showed diffuse brain swelling. There was no neurological improvement over the period of the admission. At 5.45 p.m. on 28 August, a meeting was held with JM's family and a decision was made to withdraw life support. JM died at 7.10 p.m. on 28 August 2009.

53. An examination was undertaken by Forensic Pathologist Dr Noel Woodford of the Victorian Institute of Forensic Medicine. Dr Woodford commented:

> "External examination of the body shows needle puncture wounds in both antecubital fossae. There are no injuries of a type likely to have caused or contributed to death. According to the medical deposition, an opinion as to the cause of death was "opiate overdose leading to cardiorespiratory arrest". Examination of a

postmortem CT scan shows bibasal lung consolidation. The brain appears swollen."[11]

54. Toxicological analysis of ante-mortem samples identified Morphine at 4.8mg/L; 6-monoacetylmorphine at 0.11mg/L; Alprazolam at ~0.1mg/L; Diazepam at ~0.1mg/L; Olanzapine at trace levels and Delta-9-tetrahydrocannabinol at ~5ng/mL.

55. The presence of 6-monoacetylmorphine, a metabolite of heroin indicates recent heroin use. The toxicologist reported that heroin is converted to morphine within minutes of injection and that 6-monoacetylmorphine is the intermediate compound in the conversion of heroin to morphine.

56. Dr Woodford reported that a reasonable medical cause of death was Combined Drug Toxicity.

57. JM's father stated that to his knowledge his daughter did not have a history of using heroin and that it was his belief that the heroin was administered by another person, either with or without her consent. The investigating member had earlier investigated this issue when raised with him by JM's father, and was asked by the Coroner to review this matter. He reported that there was no evidence that any other person administered the heroin and that his investigations in this regard did not reveal any further available line of inquiry.

58. There is evidence that JM had previously used heroin, as she had advised the youth justice workers of this matter when she was in Parkville.[12] Whilst the assistance of another person to inject can never be entirely excluded from the scenario of intravenous drug use, there is no evidence which would entitle a conclusion that any other person was involved in the death.

SUPERVISION OF THE PAROLE ORDER AND TERMS OF PAROLE

59. Conditions were placed upon the parole order including that JM attend as directed for treatment and assessment upon drug and alcohol counselling and mental health clinicians. She was also required to report as directed to her parole supervisor. At the time of the parole order being made the existing protective orders set out herein remained in place.

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[11] Exhibit 18 – Report Dr Noel Woodford dated 28 September 2009 and attached toxicology report.

[12] Exhibit 2 – Statement of Dr Greenwood-Smith.

60. The parole plans included mental health assessments and interventions to be provided by ORYGEN; drug and alcohol treatment programs to be provided by DASWEST and support in the community to be overseen and undertaken by both Youth Justice workers and by Child Protection workers.

61. Prior to JM's release, appointments were made for attendance at ORYGEN with Ms Megan Wilson on 25 August 2009[13], a parole supervision meeting with Ms Wilkinson on Monday 31 August 2009[14] and as to DASWEST youth outreach team, where the arrangement with JM was that she would contact Mr Michael Anderson after her release on parole.[15]

62. In the period after the parole JM did not comply with the conditions of the parole.

63. The evidence of Dr Greenwood-Smith is that on Tuesday 25 August 2009 JM did not attend her appointment. She later called her case manager Ms Megan Wilson and was noted to have slurred speech. Ms Wilson thought JM may have been substance affected. She reminded JM of her appointment the following day at the ORYGEN clinic at Parkville.

64. JM did not attend the appointment on Wednesday 26 August 2009. She sent a text message to the clinician advising that she could not attend as her father was unable to drive her to the clinic.

65. Ms Wilson made a scheduled telephone contact with JM on Thursday 27 August 2009. In that telephone conversation, JM's speech appeared slurred and her responses were slow. The ORYGEN appointment was again rescheduled to Tuesday 1 September 2009. Ms Wilson also noted that she made a call to Ms Wilkinson to advise of the conversation.

66. At 4.28 p.m. on Thursday 27 August 2009, Ms Wilson sent an email to all care team members advising of the events and her belief that JM may be substance affected. The email noted that JM had missed appointments on Tuesday 25 August and Wednesday 26 August and that in speaking to her on Tuesday (25 August) and Thursday (27 August), Ms Wilson had formed

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[13] Exhibit 2 – Statement of Dr Greenwood-Smith.

[14] Exhibit 8 – Statement of Ms Vicki Wilkinson.

[15] Exhibit 4 – Statement of Mr Paul Girardi dated 5 July 2011.

the view that JM may have been drug affected. The email also advised care team members that JM was having contact with her ex-boyfriend.

67. The email further advised that the appointments with JM had been rescheduled for 1 September 2009. Addressed recipients of the email were Ms Wilkinson; Mr Paul Girardi; Mr Michael Anderson and Ms Susan Vickers.

68. Ms Wilkinson's evidence is that she did not recall speaking to Ms Megan Wilson on 27 August 2009 and it is possible that the call was taken by another case worker. She received the email and decided that the appropriate course would be to follow up with JM the following day (28 August). The email was not received by Mr Girardi until 28 August as he was out of the office during the afternoon.

69. It appears that Mr Michael Anderson, the DASWEST drug and alcohol youth outreach clinician with whom JM had formed a strong engagement, did not receive the email relating to possible resumption of substance use, as he worked part time and was not at work on 27 August 2009.

70. It is apparent that, despite the instituting of a number of support and supervisory services, almost immediately after JM was released from the Youth Justice facility she recommenced substance use.

71. Her substance use was not reported to the supervising clinicians and whilst the treatment provider at ORYGEN had some sense during the course of telephone calls made by JM that she may have been substance affected, she was not in a position to make any assessment without direct contact.

72. To compound the difficulty, JM was failing to attend any assessment or treatment appointments and in view of her past history of compliance, this was not a matter which immediately put the clinicians on alert as to a possible acute problem.

73. In the period between 24 August to her collapse on 28 August, JM appeared substance affected to her father on three occasions. This information was not communicated to the Youth Justice Workers supervising JM's parole.

74. However I am satisfied that even had this information been communicated, the opportunity for intervention, including even locating JM for assessment or apprehension, would not have been likely to have been available. This is because JM was attending at various locations, some known and some not known to the Youth Justice and Child protection workers and was spending limited time at her home address. It is also because the time-frames were just too short for any action to be taken and implemented, either by way of taking steps to revoke parole or otherwise.

75. Whilst communication may have not have been ideal as between clinicians, it is clear that the timing of the catastrophic events overtook any reasonable opportunity for intervention by either child protection or youth justice workers.

76. It is equally clear that JM's failure to attend at appointments was not reasonably of itself to be understood by the clinicians as evidence of an unusual or escalating situation, as JM's history had been one of similar conduct over a long period.

77. Whilst it is submitted by Youthlaw that outreach services (involving home attendance) would have been the appropriate approach to assessing and supervising JM's initial parole period, it is by no means apparent that this service or even an escalation of supervision, would have been effective to prevent the outcome in this case.

78. In the initial period of youth parole, it is reasonable to expect some compliance on attendance and substance abstinence by the young person. JM had emphasised her intention to meet her parole obligations and it appears that an assessment was made that it was in JM's best interest to accord her the opportunity for some level of independent decision making.

79. The only alternative in JM's case to trusting her word as to intended compliance with the parole orders and abstinence from substance use, would have been to detain her in custody and after release to have immediately revoked her parole.

80. Whilst the revocation of parole was an available option, the culmination of events meant that there was very little time available to the Youth Justice workers to be able to intervene to make or to progress an application to the Youth parole board.

81. They became aware of JM's possible decline into further substance use only after the email of 4.27 p.m. on 27 August 2009. They did not have communication with JM's father until after JM was hospitalised. They were not advised by JM's father in the intervening period that JM was substance affected.

82. It is apparent that all of the clinicians involved with JM over a significant period of time had gone to great lengths in an attempt to assist her with her substance use, mental health and behavioural issues.

CONCLUSION AS TO CAUSE AND CONTRIBUTION TO DEATH

83. The issue which was being grappled with by the clinicians, including the Youth Justice parole supervisors, was the balance to be struck between asserting the discipline of the parole order and its conditions and retaining a line of communication and involvement with a very troubled young woman.

84. This is the effect of the evidence of Ms Wilkinson and Mr Girardi. I accept that this was a significant matter in JM's case management. The alternative would have been to take immediate action to revoke the parole and to arrange for JM to return to custody.

85. It appears on the evidence available that the DHS clinicians were doing everything within their professional practice limitations and the available resources, to plan for a successful parole in order to avoid a return to custody and to attempt to allow JM to exercise some level of independence and self-discipline. In this context the clinician's decisions to continue along the proposed path of intervention and to allow JM the opportunity to prove that she was capable of complying with her commitments upon the parole being granted, was a reasonable decision for clinicians to make.

86. The Department and its officers, both protection and juvenile justice, took all reasonable steps to provide services and assistance to JM and I am satisfied that the breakdown in communication as to missed appointments occurring as it did on 27 August 2009, was not a causal or contributing factor to the death.

87. This breakdown in communication occurred at a point at which intervention would have been unlikely to have resulted in any different outcome for JM. This is because JM had already used the heroin on that day, before the email communication was sent and even had the email been seen that day, was unlikely to have been easily located by workers from any of the services.

88. The evidence does not support a conclusion that any act or omission on the part of any of the DHS, JJU or other clinicians involved with JM's care or supervision after her release from juvenile detention, caused or contributed to the death.

89. I am satisfied that the care and supervision provided by DHS protective and Juvenile Justice workers and other clinicians was reasonable and appropriate.

90. I am not satisfied that there were any systemic failures which might be reasonably said to have caused or contributed to the death.

91. The failure of those present in the flat to respond to the evolving emergency when JM appeared to be 'crashed out' on the couch and was unable to be roused, is evidence of a troubling lack of common sense, care and concern. I am unable however to determine whether earlier intervention, that is around 4.30 p.m. on 27 August 2009 would have likely resulted in a different outcome for JM.

92. I find that JM had injected heroin shortly before her cardio-respiratory collapse on 27 August 2009.

93. I find that this substance in combination with the other substances caused the cardio-respiratory collapse which resulted in her death on 28 August 2009.

94. I find that there is no evidence that any other person assisted JM in the injecting of the heroin or other substances which led to her collapse.

95. I find that JM died on 28 August 2009 and that the cause of her death was Combined Drug Toxicity including Heroin.

COMMENTS

Pursuant to section 67(3) of the *Coroners Act* 2008, I make the following comment(s) connected with the death:

1. YouthLaw submitted that they believed there were three areas of concern in the supervision planning for JM's parole:

    - the absence of an agreed crisis response plan and specific conditions in the parole planning process;
    - lack of clarity of the roles, "leader" and communication strategy within care team; and
    - the absence of formal Departmental policy and procedure dealing with post-release clients.[16]

2. I have considered Youthlaw's submissions and the proposed recommendations in respect to DHS development and amendment of policies and procedures, undertaking reviews, developing protocols outlining roles and responsibilities and conducting annual reviews of such policies and procedures.

3. Ms McKinnon[17], DHS Director of Statutory and Forensic Services provided a comprehensive report as to new procedures that were adopted by DHS subsequent to JM's death, which were described as providing:

    > "improved professional consultation, improved collaboration between program areas, a new child protection operating model, better targeted staff training, enhanced practice requirements and strengthened health service provision and exit planning for young people in custody".

[16] YouthLaw Written Submissions dated 1 November 2013, pages 16 – 22.

[17] Exhibit 17 – Statement of Ms Mary McKinnon dated September 2013 and attachments.

4. In relation to the latter Ms McKinnon outlined the manner in which the new procedures would operate and the new mechanisms for supervision and support available. She stated[18]:

> "Professional oversight and secondary consultation services for youth justice workers in the community and within custodial settings have been areas of focus in recent years. In December 2012 eight dedicated Youth Justice Senior Practice Advisor (YJSPA) roles were created across the department to promotes state wide quality and consistency in youth justice practice. These positions are intended to provide a high level of decision making support for community based youth justice teams and provide consultation and facilitation in high risk cases where a number of programs and agencies are involved. Of note YJSPA tasks include reviews of client parole plans, including consideration of a young person's suitability for parole, oversight of parole progress reports and case management in partnership with the youth justice community based programs."

5. In relation to the issue of parole planning and parole order contents Ms McKinnon stated:

> "There are several practice instructions relating to parole planning and supervision of youth justice clients serving their sentence in the community on a parole order, specifically the *Parole planning* instruction revised May 2011 and attached to this statement and marked as exhibit MM14. The instruction provides comprehensive advice on the purpose, objectives and principles of planning required to inform the Board's decision to parole a young person, including assistance that will be provided to the young person to re-establish themselves in the community. Also attached to this statement and marked MM15 is the *Parole order practice instruction* which was revised in April 2011. This instruction outlines the expectations of young people on parole, including observing special conditions on their parole orders, statutory supervision processes and requirements for case management, case planning, warnings for failure to comply and interaction processes with the Boards."

6. As Youthlaw submitted:

> "These changes assist to clarify roles as between those who have primary responsibility and who have overall responsibility; and specifying tasks for the key worker for the young person in the custodial unit such as organising relevant health referrals prior to release and notifying external agencies of the release date."

7. In this context it appears that the Department of Human Services has undertaken an extensive program of review and adjustment of procedures particularly in relation to release planning and post release supervision, which is likely to provide a more comprehensive oversight and practice support for clinicians.

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[18] Exhibit 17 paragraphs 28 and 65.

8. Whilst unlikely to have altered events in this case, it may be appropriate in future cases where a young person is in such a precarious situation, with a history of failing to comply with conditions of bail and other orders, to recommend to the Youth Parole Board, that specific clinicians, treatment regimes and appointments be specified in the parole order; and then to ensure that clear and firm advice be given to the parolee by the supervising parole officer (JJU worker), that in the event that all of these conditions are not met, application for revocation will be made.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

1. In view of the matters discussed and the extensive additions and changes to practice and procedure adopted by the Department of Human Services there are no recommendations which may be usefully made in this case.

PURSUANT TO SECTION 18(2) OF THE *OPEN COURTS ACT 2013,* I ORDER THAT THE FOLLOWING NOT BE PUBLISHED ON THE INTERNET

Compliance with the suppression order any identifying material including the name, residential address or suburb of JM is required.

Any material identifying the name, residential address or residential suburb of JM or JM's parents must not be published.

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

The family of JM;

The Interested Parties;

The Investigating Member.

Signature:

CORONER K. M. W. PARKINSON
Date: 9 December 2013