IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 005162

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Ingrid Giles
Deceased:	Kathleen Dawn Arnold
Date of birth:	2 January 1993
Date of death:	15 or 16 September 2023
Cause of death:	1a: ACUTE ETHANOL TOXICITY ON A BACKGROUND OF CHRONIC ALCOHOLISM
Place of death:	Heidelberg Victoria 3084
Keywords:	Alcohol toxicity, chronic alcoholism, ethanol, heavy alcohol consumption, alcohol harm reduction, food delivery services, late-night alcohol delivery

INTRODUCTION

1. On 16 September 2023, Kathleen Dawn Arnold[1] was 30 years old when she was located deceased in her bed. At the time of her death, Kathleen lived in Heidelberg with her mother, Jennifer Martin (**Jennifer**).

Background

2. Kathleen was born to parents Jennifer and David Arnold (**David**) and was raised alongside her three siblings. She was described as happy, creative and artistic as a child, and enjoyed singing in a choir with her siblings.

3. However, at nine years old, Kathleen was at the beach and became trapped when a *'sand tunnel collapsed on her'*, subsequently asphyxiating and requiring emergency treatment. Jennifer recalled that Kathleen *'thought she was going to die and was terrified of death'*. She attributes much of Kathleen's mental ill health to this incident: *'I believe this incident and the trauma of it was the beginning of her mental health decline'.*

4. In her early teenage years, Kathleen was diagnosed with an eating disorder and was engaged with Austin Hospital's anorexia programme.

5. During Year 12, Kathleen was reportedly *'going to a lot of parties and binge drinking'.* As she entered her adolescence, Kathleen's alcohol consumption increased, and Jennifer contacted emergency services *'on numerous occasions'.* While intoxicated, Kathleen often demonstrated erratic and suicidal behaviours.

6. During her twenties, Kathleen received support from numerous clinicians regarding her alcoholism and other diagnoses. Since around 2017, Kathleen was engaged with the Alcohol and Other Drug services at Uniting AOD and Banyule Community Health, which included counselling and attending Alcoholics Anonymous meetings.

7. Between 2012 and 2022, Katheleen had approximately 50 presentations to St Vincent's Hospital and Austin Hospital. The majority of her presentations to St Vincent's Hospital were related to alcohol and drug abuse, her eating disorder, depression, suicidal ideation, complex post-traumatic stress disorder, fibromyalgia and liver cirrhosis.

[1] Referred to throughout this finding as 'Kathleen', unless more formality is required.

8. During this period, Kathleen reported to clinicians that she consumed approximately 1.5 litres of alcoholic beverages per day. It was known that she attempted to conceal her alcohol consumption from those around her. Kathleen's former partner recalled that he *'would often find wine bottles in her bag'*.

9. When speaking to the cause of Kathleen's drinking, Jennifer stated,

> *'Throughout [her] history, she never recovered from the eating disorder and when she was sober, she would binge and purge constantly. Sometimes it would be up to 19 times a day. I don't believe she ever received the treatment for her childhood trauma. Her drinking and eating habits were how she controlled her anxiety. These coping mechanisms ultimately led to her death'.*

10. There were periods in 2015-6 and 2020 where Kathleen was able to stabilise her alcohol consumption. However, on each occasion she returned to consuming alcohol.

11. On 28 April 2022, a Detention and Treatment Order was made by the Magistrates' Court of Victoria under the *Severe Substance Dependence Treatment Act 2010* (Vic). However, on 1 May 2022, the day before Kathleen was scheduled to attend detoxification treatment under the order, she presented to the St Vincent's Emergency Department with a suspected polypharmacy overdose of quetiapine, pregabalin, tapentadol and mirtazapine with alcohol. Further examination demonstrated self-harm scars and lacerations to her forearms. Following her presentation, Kathleen underwent medically assisted withdrawal from substances at Depaul House.

12. On 25 August 2023, approximately 3 weeks prior to her death, Jennifer located Kathleen unresponsive on the floor at home. She had *'foam around her mouth'* and was transported to the Austin Hospital Emergency Department. On arrival, Kathleen had a blood alcohol concentration (**BAC**) of 0.474 g/100mL.

13. A Drug & Alcohol clinician met with Kathleen, who declined their services and stated her intoxication was a *'once off'*. She indicated an intention to cease her alcohol consumption and attend Alcoholics Anonymous meetings.

14. Kathleen often demonstrated suicidal ideation and on 17 occasions between 2013 and 2023, was involuntarily transported by Victoria Police to hospital under the then-applicable *Mental Health Act 2014* (Vic).

15. Evidence indicates that Kathleen attempted suicide on at least one occasion, in 2021, when she consumed an excess quantity of prescription medication and alcohol. According to her former partner, Kathleen was *'annoyed that she had woken up'* and said *'it would be easier if she wasn't around'.*

THE CORONIAL INVESTIGATION

16. Kathleen'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.

17. 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.

18. 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.

19. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Kathleen'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.

20. This finding draws on the totality of the coronial investigation into the death of Kathleen Dawn Arnold 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.[2]

[2] 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.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

21. During the morning of 15 September 2023, Kathleen walked to the local shops and purchased various items, including two bottles of wine. According to Jennifer, Kathleen had been sober from alcohol at that point for approximately four days.

22. At approximately 11:00am, a passer-by noticed Kathleen *'collapsing on the street',* and drove her home. According to Jennifer, she assisted Kathleen to bed and believed that she had consumed one of the bottles of wine. Jennifer poured the other bottle down the sink.

23. Around 5pm, when Jennifer left home, Katheen *'was awake'.* Shortly after 5pm, Kathleen travelled to a nearby store and was captured on Closed Circuit Television (**CCTV**) footage purchasing a bottle of spirits.[3] Around 7pm, Kathleen telephoned her ex-boyfriend. During their conversation Kathleen *'spoke about what she was going to do with her life and the future'.* She did not say anything which indicated to her ex-boyfriend that she was or may have been suicidal.

24. At approximately 8pm, Jennifer returned home, and Kathleen was *'semi-conscious and responsive to [her]'.* She discovered half a bottle of vodka in Jennifer's room, which she confiscated. Jennifer retired to bed, believing that Kathleen would *'sober up'.*

25. The next morning, on 16 September 2023, at approximately 7am, Jennifer awoke and found Kathleen *'unconscious in her bed'.* She contacted emergency services and at the call-taker's direction, started cardiopulmonary resuscitation (**CPR**).

26. Soon afterwards, Ambulance Victoria paramedics arrived at the Arnold residence and found Kathleen was unresponsive. At 7:14pm, paramedics declared Kathleen deceased.

27. At the scene, Victoria Police members did not locate a 'suicide note' or similar document.

IDENTITY OF THE DECEASED

28. On 16 September 2023, Kathleen Dawn Arnold, born 2 January 1993, was visually identified by her mother, Jennifer Martin, who completed a formal Statement of Identification.

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

[3] I note the evidence is not clear regarding what *'bottle of spirits'* Kathleen purchased, and/or whether this was the bottle of vodka which Jennifer later discovered in Kathleen's bedroom.

MEDICAL CAUSE OF DEATH

30. Forensic Pathologist Dr Brian Beer (**Dr Beer**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of Kathleen Arnold on 21 September 2023. Dr Beer considered the Victorian Police Report of Death for the Coroner (**Form 83**), and post-mortem computed tomography (**CT**) scan and provided a written report of his findings dated 9 October 2023.

31. The post-mortem examination revealed hepatic steatosis – colloquially known as *'fatty liver'* – and pancreatic calcification. There was also consolidation in the left lower lung, and other non-specific lung markings.

32. Toxicological analysis of post-mortem samples identified the presence of the following drugs:

Ethanol (alcohol)	0.54g/100mL of blood
	0.62g/100mL of vitreous humour[4]
Nordiazepam	~ 0.02 mg/L of blood
Mirtazapine	~ 0.02 mg/L of blood

33. Dr Beer provided an opinion that the medical cause of death was 1(a) *acute ethanol toxicity on a background of chronic alcoholism.*

34. I accept Dr Beer's opinion.

INVESTIGATION BY LIQUOR CONTROL VICTORIA

35. As early as 2020, Jennifer became aware that Kathleen was ordering alcohol through food and alcohol delivery platforms. In mid-2022, prior to Kathleen's death, Jennifer reached out to her local Member of Parliament (**MP**), who contacted Liquor Control Victoria of the Department of Justice and Community Safety on her behalf.

36. In her statement to the Court, Jennifer wrote:

> *'I have been very disappointed that Kathleen has been able to access alcohol through delivery services. I have expressed my disappointment to a local MP because while*

[4] Vitreous humour is the clear gel that fills the space between the lens and the retina of the eyeball. Generally, toxicological analysis of vitreous humour provides a better indicator of perimortem levels than post-mortem blood.

Kathleen was still connected to the medical equipment in 2020 she was still able to get alcohol delivered. The delivery services would not check her ID and she was visibly unsteady and unwell. Even when connected to medical equipment they would still deliver unless I intervened. Sometimes they would leave the alcohol on our doorstep and deliver outside legislation hours. For example, at 2AM and 4AM in the morning.'

37. An inspector of Liquor Control Victoria (**Liquor Inspector**) investigated the actions of relevant delivery services to identify any breaches of the *Liquor Control Reform Act 1998* (Vic) (**LCR Act**). In March 2022, amendments were made to the LCR Act which placed some restrictions on the delivery of alcohol in Victoria. For example, for off-premises requests for alcohol, a licensee must provide written instructions to delivery drivers, including regarding liquor not being left unattended and identification documents being checked to verify age. These requirements apply to the licensee, and not the relevant delivery platform(s).

38. Section 9A(2)(db) of the LCR Act restricts the volume of takeaway alcohol that a licensed restaurant and/or café can provide subject to an off-premises request – for example, no more than 750 mL of wine. Depending on the specific terms of the licence held, establishments are not permitted to deliver alcohol after 11pm or outside of their ordinary trading hours.

39. In August and September 2023, the Liquor Inspector identified two restaurants from which Kathleen often ordered alcohol and investigated their activities. With respect to the first restaurant, the Liquor Inspector confirmed it had been supplying alcohol to Kathleen and issued them with a warning notice for supplying volumes of alcohol in excess of delivery restrictions under section 9A(2)(db). Regarding the second restaurant, the Liquor Inspector issued two infringements for breaches of its liquor licence – relating to supplying alcohol outside of its licensed hours, and for also supplying volumes of alcohol in excess of delivery restrictions. The Liquor Inspector also issued a warning letter for failing to provide written instructions to delivery drivers as required by section 18C(1)(c) of the LCR Act.

40. In October 2023, the Liquor Inspector identified from Kathleen's bank account statements that she made orders from one particular food delivery platform on a near daily basis. The Liquor Inspector contacted the delivery platform and learned that in the 6-month period from 31 March 2023 to Kathleen's death, she had placed 213 orders across 182 days. Of these orders, 98 of them contained alcohol products, for a total of 319 alcohol-based products. According to the Liquor Inspector, these products included 375 mL bottles of cider and 700 mL bottles of vodka, with the most common purchase being bottles of wine.

41. Information provided by the delivery platform regarding their engagements with Kathleen, including checking of identification, according to the Liquor Inspector, did not constitute any breaches under the LCR Act.

FOOD DELIVERY SERVICES AND ACCESS TO ALCOHOL

42. Throughout my investigation into Kathleen's death, I turned to consider how Kathleen was able to access alcohol regularly and easily via orders to local businesses on delivery platforms. Noting that the supply of liquor to Kathleen has been investigated by Liquor Control Victoria, I do not intend to comment specifically on the legality or otherwise of what occurred in Kathleen's case, which has already been appropriately investigated by Liquor Control Victoria. Instead, I will move to provide general commentary regarding her access to alcohol through delivery platforms.

43. There is emerging recognition that food and alcohol delivery platforms have facilitated a significant increase in the community's ability to access alcohol, and this in turn is contributing to harmful alcohol use. According to the Centre for Alcohol Policy Research at La Trobe University, this development is at least partly a result of the COVID-19 pandemic:

> *'With the growth of internet and other online ordering, the on-premise[s] vs. off-premise[s] distinction in licences has become fuzzier, with many on-premise[s] places permitted with various restrictions to sell alcohol for delivery off-premises. Over the years, the number of licences to sell alcohol has grown substantially, and the advent of online ordering and delivery means that alcohol is substantially more available at any address. Australia has recently experienced a seismic shift in the availability of alcohol as online purchases tripled during the first part of the COVID-19 pandemic (Roy Morgan, 2021). Alcohol industry bodies have predicted continued increases in home delivery and more cheap alcohol in post-COVID Australia (Wine Industry Network, 2022). Importantly, the rise in rapid delivery services, delivering alcohol in the same kind of time-frame as take-away food, represents a fundamental change to the availability of alcohol, as in the past drinking in private premises – where 75% of alcohol is consumed in Australia (Callinan et al., 2016) – was limited to the amount of alcohol already on hand.'*[5]

[5] Centre for Alcohol Policy Research, La Trobe University, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 7*, 19 September 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions, p 3-4.

44. The Centre for Alcohol Policy Research made the following recommendations for how to address these harms:

> *'Any delivery of alcohol to a home or other off-premise[s] locations should be by a carrier who is employed by or under the control of the licence-holder, and subject to the delivery conditions of alcohol license-holders. There should be a delay of at least two hours between online ordering and home delivery, and delivery should not be allowed to an intoxicated person.'*[6]

45. Similar concerns were raised by Alcohol Change Victoria (a coalition of health, clinical and related services and organisations), which called for action to end rapid and late-night alcohol deliveries:

> *'Alcohol is more accessible than ever before, with liquor regulation yet to catch up with technology that has turned every phone into a bottle shop. This matters because late night delivery is associated with alcohol-involved family violence, and rapid delivery is associated with excessive and high-risk alcohol consumption […].'*[7]

46. Alcohol Change Victoria also emphasised that other alcohol-fuelled harms, including suicide and sudden deaths, occur most often in the home at night. Accordingly, it has advocated for changes to the regulatory landscape that would permit alcohol delivery to people between the hours of **10am and 10pm only**, noting that there is evidence that reducing the trading hours of alcohol venues by even one hour results in substantially fewer people being harmed.[8]

47. Alcohol Change Victoria also expressed support for a requirement for rapid alcohol delivery companies to observe a **'safety pause' of two hours** between the time an alcohol order is placed and the time the alcohol is delivered, which, it is argued, would significantly reduce the risk of harm to people using alcohol at home – including by giving people a chance to *'sober up'* before alcohol deliveries arrive – and giving people with alcohol dependence a *'cooling off period'* and opportunity to decide not to consume impulsive alcohol purchases.[9]

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[6] Centre for Alcohol Policy Research, La Trobe University, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 7*, 19 September 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions p 5.

[7] Alcohol Change Victoria, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 166*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions p 15.

[8] Alcohol Change Victoria, *Online sale and home delivery of alcohol: measures to prevent harm in Victorian communities*, 23 March 2023, accessed via https://www.alcoholchangevic.org.au/downloads/position-statements/online-alcohol-sales-and-delivery-position-statement.pdf (**Alcohol Change Victoria Position Statement, March 2023**).

[9] Alcohol Change Victoria Position Statement, March 2023.

48. I consider that the broader circumstances in which Kathleen died tragically illustrate the consequences of Victorians being able to have alcohol delivered to them swiftly, easily, and late at night. I believe this is an area where relatively straightforward reform has the potential to significantly reduce the burden of harms associated with alcohol accessed via delivery provider platforms. A pertinent coronial recommendation will be made in this respect.

THE PREVALENCE OF ALCOHOL-RELATED HARM AND ASSOCIATED PREVENTION STRATEGIES IN VICTORIA

49. In my role as a coroner, I regularly encounter the fatal consequences of alcohol use among the Victorian community. Each year, more than 150 deaths involving the acute toxic effects of alcohol are reported to the Coroners Court of Victoria. At least another 100 deaths reported each year are caused by the chronic effects of alcohol use. However, these deaths represent only a proportion of all alcohol-related deaths, as most deaths resulting from chronic alcohol use are not reportable under the *Coroners Act 2008*, given they are largely classified as deaths that are due to 'natural causes' and therefore, unless they are also 'unexpected', will not usually be reported to the coroner.

50. More broadly, alcohol is a factor in a myriad of deaths in the absence of the complications of chronic consumption. Such circumstances include homicides where alcohol use was implicated; suicides of people who had a history of alcohol use and/or who were alcohol affected; fatal motor vehicle collisions where a driver or other involved person was affected by alcohol; drownings of people intoxicated by alcohol; and many others.

51. To explore what might be done to address the deadly toll of alcohol in the Victorian community, I commenced an analysis of certain of the deaths I am currently investigating in which the person, prior to death, had been engaged in alcohol use for an extended period, and the death was the direct result of alcohol consumption. My hope was that, through examining the circumstances of deaths falling into this broad category, I might be able to identify some commonalities pointing to potential areas for intervention to reduce alcohol-related harms.

52. However, from review of the material, I was unable to identify any meaningful commonalities. The alcohol-related deaths under my investigation were of people who had diverse socio-demographic profiles, patterns of alcohol use, mental health histories, and histories of engagement in treatment for alcohol related harms. They died in diverse circumstances linked to their alcohol use, reflecting the diverse ways tin which alcohol can cause harms across the Victorian community.

53. I then resolved to approach the investigation from a different direction, looking at what inquiries and reviews Victorian and Commonwealth governments had conducted over time to explore how to address alcohol-related harms, in the hope that I might identify any potential prevention opportunities among these. The Coroners Prevention Unit (**CPU**)[10] assisted me to identify relevant initiatives, which included the following:

i. The Parliament of Victoria Drugs and Crime Prevention Committee's Inquiry into Strategies to Reduce Harmful Alcohol Consumption (**Inquiry**), which delivered its final report in March 2006 after two years of consultation and work;[11]

ii. The Victorian Government's Alcohol Action Plan 2008-2013, which was published in May 2008 by the Victorian Department of Health and described specific actions to be taken as well as a broader framework for change to address alcohol misuse in Victoria;[12]

iii. The Victorian Auditor-General's Office report "Effectiveness of Justice Strategies in Preventing and Reducing Alcohol-Related Harm", published in June 2012, which examined the roles of Victoria Police, the Department of Justice and the Victorian Commission for Gambling and Liquor Regulation in preventing and reducing alcohol-related harm in Victoria;[13]

iv. The VicHealth Alcohol Strategy 2019-2023, which was published in August 2019;[14] and

v. The Australian Government Department of Health and Aged Care's National Alcohol Strategy 2019-2028, published in December 2019, which was intended to guide state and territory governments as well as communities and health service providers in their

[10] The CPU was established in 2008 to strengthen the coroners' prevention role and assist in formulating recommendations following a death. The CPU is comprised of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety including by providing data and statistics into the prevalence of certain deaths.

[11] Parliament of Victoria Drugs and Crime Prevention Committee, *Inquiry into Strategies to Reduce Harmful Alcohol Consumption: Final Report*. Volumes 1 and 2, and the Response to the Final Report, published on 23 March 2006. Accessible at: Reports - Inquiry into strategies to reduce harmful alcohol consumption - Parliament of Victoria.

[12] Ministerial Taskforce on Alcohol and Public Safety, *Restoring the balance: Victoria's Alcohol Action Plan 2008-2013*, published May 2008. Accessible at: Victoria's Alcohol Action Plan 2008-2013 - May 2008.

[13] Victorian Auditor-General's Office, *Effectiveness of Justice Strategies in Preventing and Reducing Alcohol-Related Harm*, tabled on 20 June 2012. Accessible at: Effectiveness of Justice Strategies in Preventing and Reducing Alcohol-Related Harm | Victorian Auditor-General's Office.

[14] VicHealth, *Alcohol Strategy 2019-2023*, published 5 August 2019. Accessible at: VicHealth Alcohol Strategy 2019–2023 | VicHealth.

responses to alcohol-related harms. This succeeded the National Alcohol Strategy 2006-2011 (there was no strategy in place during the intervening period 2012-2018).[15]

54. Additionally, noting that the Australian Parliament Standing Committee on Health, Aged Care and Sport is currently conducting an Inquiry into the Health Impacts of Alcohol and Other Drugs in Australia (**the Inquiry**),[16] I considered the submissions received to date, in particular the submission of Alcohol Change Australia.[17] I acknowledge there are many excellent submissions to this Inquiry; I selected the Alcohol Change Australia submission for review because: (i) it specifically addresses alcohol-related harms; and (ii) the member organisations of Alcohol Change Australia include a number of highly respected public health bodies.

55. In reviewing the material, I was struck by the fact that despite these initiatives occurring over a 20-year time span, there was nonetheless a high degree of concordance between them regarding what needs to be done to reduce alcohol-related harms. The following broad areas were consistently identified as requiring action (though not every area was addressed in every document):

i. **Pricing:** Alcohol prices can influence risky alcohol use and associated harms, and changes to pricing may reduce harms.

ii. **Taxation:** Different types of alcohol products are taxed differently at present in Australia, and some taxation arrangements contribute to harmful alcohol use. Changes to how alcohol is taxed may reduce harms.[18]

iii. **Regulation:** The way that alcohol is made available (through sale and service) to the Victorian community is subject to regulatory controls. There are a number of areas (including but not limited to density of venues where alcohol is served or sold, times when alcohol is available, ways alcohol can be purchased, enforcement of regulations

[15] Australian Government Department of Health, *National Alcohol Strategy 2019-2028*, Canberra: Department of Health published December 2019. Accessible at: National Alcohol Strategy 2019–2028 | Australian Government Department of Health and Aged Care.

[16] *See in this regard* Inquiry into the health impacts of alcohol and other drugs in Australia – Parliament of Australia.

[17] Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions.

[18] For completeness, some alcohols (such as beer and spirits) are taxed proportionately to their alcohol content while other alcohols (such as wines) are taxed based on their price. As such, cheaper wine products are taxed less than premium wines, despite that their alcohol concentrations may be the same. Submissions of Alcohol Change Australia identify that *'high-volume, high-alcohol wine (such as cask wine) is often being sold at low prices'* (*see* Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions at page 7).

relating to alcohol service and sale, training requirements for those who serve or sell alcohol, and permitted types of alcohol promotions) where changes to regulation may reduce harms associated with alcohol use.

iv. **Healthcare:** It is critical to ensure that appropriate treatment is available in a timely manner to persons experiencing alcohol dependence or other alcohol-related health problems, and/or who are seeking assistance to reduce or cease alcohol use. This includes early intervention programs to support persons who may be at risk of harmful alcohol use.

v. **Advertising:** There are links between advertising and other alcohol promotion (for example via sponsorships) and harmful alcohol use. Advertising restrictions may be a potent harm reduction initiative, particularly if they result in a reduction in young people's exposure to alcohol product advertising. [19]

vi. **Product labelling:** Alcohol drink containers present opportunities to communicate information about alcohol use and its health impacts.[20]

vii. **Education for young Victorians:** There is a strong imperative to ensure that in schools and other contexts, young people are provided appropriate and effective education in responsible alcohol use and alcohol-related harms.[21]

viii. **Community education:** The negative impacts of alcohol use in the Victorian community may be addressed by taking action to increase general awareness about individual, family and community harms associated with alcohol consumption, and how to prevent or reduce them.[22]

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[19] *See in this regard* Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions page 6.

[20] *See in this regard* Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions page 7-8.

[21] *See in this regard* Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions page 6. This issue is also reflected in the recent finding of Coroner Catherine Fitzgerald in relation to the death of a 16-year-old boy from complications of acute alcohol intoxication – *see in this regard* the Finding into death without Inquest of LG, 12 December 2024. Accessible at: https://www.coronerscourt.vic.gov.au/sites/default/files/New_De-identified_COR%202022%20007423%20Form%2038%20-20Finding%20into%20Death%20without%20Inquest.pdf

[22] *See in this regard* Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions page 7-9.

ix. **Social attitudes towards alcohol:** Certain social attitudes support harmful alcohol consumption, such as the expectation that alcohol is consumed on social occasions and at celebratory events, and tolerance of high consumption levels. If these social attitudes can be changed, harmful alcohol use can be reduced.

56. Recognition of the need for action across these areas appears to extend back even further in time than the period I examined. I note that back in 2006, the Drugs and Crime Prevention Committee were already declaring that:

> *'There is now general agreement in both the national and international literature as to what is the most effective range of responses available to policymakers to address alcohol-related harms.'*[23]

57. This was echoed in the 2024 Alcohol Change Australia submissions to the Inquiry that:

> *'We know what works and it is time to implement a systematic, coordinated and evidence-based approach to reduce harm from alcohol in Australia.'*[24]

58. This 2024 call to action, nearly two decades on from the Drugs and Crime Prevention Committee's final report, led me to examine how the Victorian Government is currently coordinating its efforts to reduce alcohol related harms.

59. In particular, I noted that after the Victorian Government's Alcohol Action Plan 2008-2013 expired, there did not appear to be any follow-up action plan to build on what was trialled, implemented and achieved. This was to my mind unfortunate, given that effecting change in such diverse domains as social attitudes, community education and regulation requires sustained effort. The Drugs and Crime Prevention Committee observed in 2006 that:

> *'In an area as complex as alcohol and other drug policy it is neither possible nor desirable to achieve sustainable and long term change overnight. Incremental or gradual change is not only the most feasible way of moving forward but also the most desirable. As well, it is an approach that recognises community attitudes and the*

[23] Parliament of Victoria Drugs and Crime Prevention Committee, *Inquiry into Strategies to Reduce Harmful Alcohol Consumption: Final Report*, Volume 1. Accessible at: Reports - Inquiry into strategies to reduce harmful alcohol consumption - Parliament of Victoria, page xi.

[24] Alcohol Change Australia, *Inquiry into the health impacts of alcohol and other drugs in Australia - Submission 76*, December 2024, accessed via https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/Alcoholanddrugs/Submissions page 2.

reality of the political and bureaucratic environments in which policy change occurs.'[25]

60. Perhaps efforts to renew the Victorian Alcohol Action Plan were redirected towards the development of the National Alcohol Strategy 2019-2028, which was endorsed by State and Territory governments. However, if this is the case, it raises a further question about what Victoria has done under the auspices of the National Alcohol Strategy 2019-2028, noting the Strategy emphasises the central role of States and Territories in implementation:

> *'Jurisdictional implementation allows for governments to take action relevant to their jurisdiction with a national harm minimisation approach and strategies should reflect local circumstances and address emerging issues and drug types. It is expected that jurisdictions will prioritise actions that are evidence-informed and demonstrated to have the greatest impact on preventing and reducing alcohol-related harms.'*[26]

61. While the National Alcohol Strategy 2019-2028 describes a regular reporting framework to measure Strategy effectiveness and progress,[27] I have been unable to source any publicly-available reports describing Victoria's actions under the Strategy or progress towards goals. Further to this point, my attention was directed to an April 2024 report in which Alcohol Change Australia documented a *'lack of public monitoring or reporting'*[28] relating to the Strategy, and conducted their own analysis of the Strategy to establish that:

> *'There has been minimal or no change in alcohol use and harms across a range of indicators since the Strategy was introduced in 2019.'*[29]

62. I draw no conclusions from this about what actions Victoria has, or has not, taken under the auspices of the National Alcohol Strategy 2019-2028, nor their merits or effectiveness. However, this situation clearly highlights the need for Victoria to lead its own program of work (whether described as a *'strategy'*, an *'action plan'* or otherwise) to address alcohol-related harms in the community. This program of work should describe what specific actions

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[25] Parliament of Victoria Drugs and Crime Prevention Committee, *Inquiry into Strategies to Reduce Harmful Alcohol Consumption: Final Report*, Volume 1. Accessible at: Reports - Inquiry into strategies to reduce harmful alcohol consumption - Parliament of Victoria, page xiii.

[26] Australian Government Department of Health and Aged Care, *National Alcohol Strategy 2019-2028*, published in December 2019. Accessible at: National Alcohol Strategy 2019–2028 | Australian Government Department of Health and Aged Care, page 13.

[27] Ibid at page 32.

[28] Alcohol Change Australia, *A Mid-Point Review of the National Alcohol Strategy 2019-2028: How is Australia tracking on reducing alcohol use and harms?* Published April 2024 and accessible at Alcohol-Change-Australia-report-A-mid-point-review-of-the-National-Alcohol-Strategy-April24.pdf page 2.

[29] Ibid.

are undertaken, the timeframes within which they should be implemented, who is responsible for them, and how they will be evaluated for effectiveness. It should also incorporate public reporting on implementation and evaluation of these actions to address alcohol-related harms. I expect that identifying and prioritising actions to be undertaken within the program of work will be straightforward; as already discussed, there is longstanding consensus on what needs to be done.

63. The Victorian Government announced in April 2024 that it would develop a new 10-year strategy to address alcohol and other drug harms. I understand that early work has already commenced, including stakeholder consultations to inform strategy development.[30] This could potentially be the vehicle for developing the program of work described above, however, as the scope and outcomes of the strategy have not yet been formalised, I cannot confirm whether this is the case. Therefore, a pertinent coronial recommendation will be made in this respect.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Kathleen Dawn Arnold, born 2 January 1993;

    b) the death occurred on 15 or 16 September 2023 in Heidelberg, Victoria, from 1(a) *acute ethanol toxicity on a background of chronic alcoholism*; and,

    c) the death occurred in the circumstances described above.

65. Having considered all of the circumstances, I find that Kathleen Dawn Arnold's death occurred in the context of an extended history of excessive alcohol consumption. I note that Kathleen Dawn Arnold had been engaged with clinicians and other support services with respect to her alcohol consumption and other diagnoses, and that she had been successful in achieving periods of abstinence. However, despite these efforts, she was, very sadly, unable to overcome the addiction that ultimately led to her death.

66. While there is evidence that Kathleen Dawn Arnold experienced previous suicidal ideation including a prior suicide attempt, there is no evidence that she consumed alcohol in the

[30] Victorian Government Department of Health, *'Alcohol and Other Drug Strategy: What we heard overview'*, November 2024. Accessible at: https://www.vaada.org.au/wp-content/uploads/2024/12/AOD-Strategy-What-We-Heard-overview.pdf.

immediate lead-up to her death with the explicit intention of taking her own life, though the circumstances of her alcohol consumption suggest a degree of recklessness in this regard.

67. I note that Kathleen Dawn Arnold faced a range of mental health and other issues, which were longstanding in nature, and which cannot be reduced to simply having easy access to alcohol. Nonetheless, it remains that Kathleen Dawn Arnold was able to and did access alcohol with great frequency via food and alcohol delivery platforms, including in the early hours of the morning, which I consider to have exacerbated her chronic alcohol consumption at points in time where she was likely already intoxicated and compromised in terms of impulse control.

68. Moreover, her easy access to alcohol via these platforms undermined the efforts of her loved ones, her clinical team and Kathleen Dawn Arnold herself to address her ongoing addiction.

69. Having made comments about the prevalence of alcohol-related harm in the Victorian community, I consider that the circumstances of Kathleen Dawn Arnold's death bring into focus a range of prevention opportunities in this sector.

RECOMMENDATIONS

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

1. That the **Secretary of the Victorian Department of Justice and Community Safety** consider amending the *Liquor Control Reform Act 1998* (Vic), along with any required regulations, as appropriate, to prohibit home delivery of alcohol between 10pm and 10am in Victoria.

2. That the **Secretary of the Victorian Department of Justice and Community Safety** consider amending the *Liquor Control Reform Act 1998* (Vic), along with any required regulations, as appropriate, to require a minimum two-hour delay between order and dispatch of alcohol for home delivery in Victoria.

3. That the **Victorian Government**, led by the **Victorian Department of Health**, develop: (i) a new Alcohol Action Plan; or (ii) a program of work (including specific actions, timeframes, accountabilities, and public reporting on implementation and evaluation) to address alcohol-related harms in Victoria.

I convey my sincere condolences to Kathleen's family for their loss and recognise the ongoing and tireless efforts of her loved ones, and her clinical team, to care for and support her.

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:

Jennifer Martin, Senior Next of Kin

David Arnold, Senior Next of Kin

Secretary of the Victorian Department of Justice and Community Safety

Victorian Government

Secretary of the Victorian Department of Health

Secretary of the Australian Government Department of Health and Aged Care

Victorian Alcohol and Drug Association

Alcohol Change Victoria

Alcohol Change Australia

First Constable Jesse Francis, Coronial Investigator

Signature:

Ingrid Giles

Coroner

Date: 11 February 2025

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.