



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 006530

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Inquest into the death of: NJC

Findings of: AUDREY JAMIESON, Coroner

Delivered on: 18 March 2026

Delivered at: Coroners Court of Victoria
65 Kavanagh Street, Southbank, Victoria 3006

Hearing dates: 18 March 2026

Representation: Emily Eriksen, Department of Families, Fairness and
Housing

Counsel assisting the Coroner: Anna Pejnovic, Coroners Court of Victoria

I, AUDREY JAMIESON, Coroner, having investigated the death of NJC¹
AND having held a Summary Inquest in relation to this death on 18 March 2026
at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank, Victoria 3006
find that the identity of the deceased was NJC
born on 9 December 2003
died on 5 December 2021
at Nagambie Lakes Regatta Centre, 66 Loddings Lane, Victoria, 3608
from:

1(a) DROWNING

in the following summary circumstances:

NJC was 17 years old when he drowned in Lake Nagambie. At the time of his death, NJC lived in kinship care with his sister hnp and her children. He was subject to a Care by Secretary Order which was to expire on his 18th birthday.

BACKGROUND CIRCUMSTANCES

Child Protection involvement

1. Child Protection were involved with NJC and his family from 23 October 2017, when he was 14 years old, until the time of his death. NJC was the subject of six reports to Child Protection, with protective concerns for NJC identified as:
 - a. NJC's exposure to family violence between his parents;
 - b. NJC's exposure to substance use of his parents;
 - c. NJC's inconsistent experience of parenting and exposure to untreated mental health of his parents;

¹ This Finding has been de-identified by order of Coroner Audrey Jamieson which includes an order to replace the name of the deceased and other persons related to or associated with the deceased, with a pseudonym of a randomly generated letter sequence for the purposes of publication.

- d. Physical and emotional abuse experienced by NJC inflicted by his father, including assaults and threats to kill NJC;
 - e. NJC's mother's inability to manage his perceived aggressive behaviours; and
 - f. Inability of both parents to act protectively and ensure appropriate and adequate supervision of NJC.
2. On 9 February 2020, NJC was located by Victoria Police having absconded from his home in the months prior. Child Protection workers met with NJC and made an assessment that his parents could not undertake the necessary steps to care for him and keep him safe, and that he was at an unacceptable risk of harm.
 3. Child Protection issued a Protection Application by Emergency Care² and NJC was placed on an Interim Accommodation Order³ (IAO) in the care of his sister, HNP.
 4. A kinship assessment conducted on 3 April 2020 identified that NJC was settled and was no longer displaying aggressive behaviours. It was recommended that he remain in HNP's care.
 5. On 5 October 2020, a Care by Secretary Order (CBSO)⁴ was made to remain in effect until the eve of NJC's 18th birthday.
 6. HNP was provided with an instrument of authorisation to make certain decisions for NJC under section 175B of the *Children Youth and Families Act (2005)*. The instrument allowed her to make routine decisions for NJC including social events and overnight stays.

² Section 241(1)(a) of the *Children, Youth and Families Act 2005* provides for Protection Application by Emergency Care. The decision to proceed with an application by Emergency Care is guided by the risk assessment based on the age, stage and development of the child. A Protection Application is issued by Emergency Care in the most serious of circumstances where a child has suffered significant harm or is at risk of significant harm and the child's parent/s are unable or unwilling to protect them.

³ An IAO is an order that provides for where a child who is subject to a Protection Application will reside until the Protection Application is determined by the court.

⁴ A CBSO confers parental responsibility for the child on the Secretary to the department to the exclusion of all other persons. Parental responsibility means Child Protection is responsible for the day-to-day decision-making for a child. This includes the placement arrangements for the child, such as where the child attends school, or meeting their health needs. Decision-making is informed by ongoing professional judgement and enacted through case planning processes.

7. A Kinship Part C⁵ assessment was completed on 26 May 2021, which identified ‘... *no concerns regarding NJC and any risk-taking behaviours, no concerns regarding his mental health or physical health and development.*’
8. The Kinship Part C assessment highlighted that NJC’s health, development and wellbeing needs were being met through his placement with HNP. She was able to meet his basic needs, as well as the emotional support he required to manage and address his trauma history.
9. HNP and NJC moved to Bendigo in June 2021, and NJC’s case was transferred to the Child Protection North Division Loddon Area. Day-to-day case management was contracted⁶ to Anglicare Victoria.
10. NJC’s goals following the expiration of the CBSO were to remain with HNP while he completed his schooling, and then move in with his friends, start an apprenticeship in a trade such as carpentry and eventually move to Western Australia to work in the mines with his cousin.

Medical history

11. NJC had a complex history with significant childhood trauma. He experienced depression and anxiety in his early teens and had reported two previous suicide attempts. He had previously seen psychologists but reportedly did not enjoy speaking to them and refused to see one after he moved to Bendigo. He had previously been prescribed sertraline but reportedly ceased taking it as it made him feel worse. He took melatonin for poor sleep.
12. NJC had also previously been a frequent user of alcohol and cannabis. HNP did not allow him to smoke at her house but believed that he would smoke when he visited friends and family in Ballarat.

⁵ A formal 12-month review of long-term kinship care arrangements. The aim of the Part C assessment is to assess the child’s progress, wellbeing, development and whether or not the placement offers stability and enables the child to thrive.

⁶ Case contracting is a formal arrangement in the form of a written agreement, between Child Protection and a Community Service Organisation funded to deliver community-based child, family and out-of-home care services, for the provision of case management for a child subject to a protection order. Contracting arrangements are designed to enable the most appropriate agency to support implementation of a child’s case plan.

THE CORONIAL INVESTIGATION

Jurisdiction

13. The death of NJC was a reportable death under section 4 of the *Coroners Act 2008* (Vic) (“the Act”) because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from accident or injury. In addition, NJC’s death was reportable under section 4(2)(c) of the Act as he was, immediately before his death, a person placed in custody or care.
14. Pursuant to section 52(3) of the Act, a Coroner must hold an inquest if the deceased was, immediately before their death, a person placed in custody or care.

Purpose of a coronial investigation

15. The purpose of a coronial investigation of a reportable death is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.⁷
16. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. The circumstances in which death occurred refer to the context or background and surrounding circumstances but are confined to those circumstances sufficiently proximate and causally relevant to the death, and not all those circumstances which might form part of a narrative culminating in death.⁸
17. The broader purpose of any coronial investigation is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the prevention role.⁹

⁷ Section 67(1) of the Act.

⁸ This is the effect of the authorities – see for example, *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

⁹ The “prevention” role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act 1985* where this role was generally accepted as “implicit”.

18. Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.¹⁰ These powers are effectively the vehicles by which the Coroner's prevention role can be advanced.¹¹
19. The Coroners Court of Victoria is an inquisitorial jurisdiction.¹² Coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.¹³

Sources of evidence

20. This Finding is based on the totality of the material produced by the coronial investigation into the death of NJC. That is, the Court File and Coronial Brief of evidence compiled by Leading Senior Constable Jason Woosnam.
21. The Brief will remain on the Court File, together with the Inquest transcript.¹⁴ In writing this Finding, I do not purport to summarise all the material and evidence but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

¹⁰ See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations, respectively.

¹¹ See also sections 73(1) and 72(5), which requires publication of coronial findings, comments and recommendations and responses respectively; sections 72(3) and 72(4), which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

¹² Section 89(4) of the Act.

¹³ Section 69(1) of the Act. However, a Coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1) of the Act.

¹⁴ From the commencement of the Act, that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

Standard of proof

22. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*¹⁵. These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

- the nature and consequence of the facts to be proved;
- the seriousness of any allegations made;
- the inherent unlikelihood of the occurrence alleged;
- the gravity of the consequences flowing from an adverse finding; and
- if the allegation involves conduct of a criminal nature, weight must be given to
 - the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

IMMEDIATE CIRCUMSTANCES OF DEATH

23. On the evening of 2 December 2021, HNP picked NJC up from a friend's house in Ballarat. She could smell cannabis and could tell that he had been smoking.

24. On 3 December 2021, NJC travelled to Seymour with HNP to attend the wedding of their sister XTQ. They dropped their belongings at XTQ's house, before attending the ceremony at a property called Barong on the Water (**Barong**) in Nagambie. Barong is located on the edge of Lake Nagambie, and the property has private access to the lake.

¹⁵ *Briginshaw v Briginshaw* (1938) 60 C.L.R. 336 esp. at 362-363: “*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters, “reasonable satisfaction” should not be produced by inexact proofs, indefinite testimony, or indirect inferences...*”.

25. After the ceremony, NJC and HNP attended the reception at Northern Republic in Euroa. According to HNP, NJC had '*a couple*' of drinks with dinner. While at the reception, NJC told XTQ that he was not going to smoke cannabis during the weekend out of respect for her, and '*would not drink too much*'. Following the reception, a bus took them back to XTQ's home where they stayed the night.
26. The next day, on 4 December 2021, NJC asked HNP for permission to attend a family lunch. He planned to stay at XTQ's house that evening. HNP gave him \$50 in case he needed to purchase anything, told him to behave, and that she would speak to him later. According to HNP, NJC was so happy to be able to spend more time with family.
27. XTQ's friend Charlie picked NJC up from XTQ's house and drove him to Barong. On the drive, Charlie recalled that JNC was talking to himself and laughing. While at Barong, XTQ had a few Great Northern mid-strength beers but did not recall NJC consuming any alcoholic drinks.
28. Approximately 20 guests then attended at the Nagambie Rowing Club for lunch. XTQ bought NJC one glass of Great Northern mid-strength beer to have with lunch. She did not see him purchase any himself. After around an hour, some of the group returned to Barong to continue celebrating.
29. At Barong, the group ate, drank and celebrated. NJC, XTQ and her friend Polly walked down to the lake so that Polly's dog could swim. At the lake, NJC commented that he could swim across the lake and tried to make a deal with XTQ that if he did so, she would too. XTQ replied '*no deal*', and the group returned to the house.
30. NJC then changed out of his wedding clothes into shorts and a t-shirt. XTQ did not think anything of this as that was what he regularly wore. She did not think he would go for a swim as it was '*certainly not swimming weather*'.
31. XTQ observed NJC walk down to the edge of the lake and sit in a chair. XTQ and her friend Eileen then witnessed NJC finish a can of Jack Daniels bourbon and cola and enter the water. XTQ and Eileen walked to the water to watch him as a safety precaution. According to XTQ, NJC was a capable swimmer who had swum across St Georges Lake in Creswick, which

was around three or four times the width of Lake Nagambie where they were situated at Barong.

32. Once XTQ and Eileen reached the edge of the lake, NJC was around twenty metres away from the bank. XTQ yelled to NJC '*come back now*' and noticed he was bobbing under the water. She again yelled '*come back in now*', to which NJC yelled back '*I can't*'. XTQ called Triple Zero.
33. Eileen immediately entered the water and swam towards NJC. When she approached him, she noticed he was coughing and had red eyes and snot coming from his nose. He was '*thrashing around*'. Eileen held on to his head and told him to '*float his legs up*', which he did for a moment before thrashing around again. She held NJC under the armpit and moved him towards a buoy, before NJC pushed her away. Eileen yelled for help, and NJC told her '*I'm done*', before sinking under the water. XTQ's friend Mikaela entered the water and assisted Eileen. She tried to search for NJC, to no avail.
34. At around 5:10pm, Victoria Police arrived at the scene. First Constable Talia Mabey immediately entered the water and swam towards Eileen and Mikaela, instructing them to return to the bank. First Constable Mabey remained in the water for 15-20 minutes attempting to locate NJC, before returning to the bank herself.
35. Victoria Police Search and Rescue divers arrived and began searching for NJC, though they were unsuccessful that evening.
36. On the morning of 5 December 2021, they recommenced their search. NJC's body was located at around 9am, approximately 450 metres from the Nagambie Lakes Regatta Centre at a depth of around two metres.
37. The Search and Rescue diver who located NJC noted that the location where he was found was made up of soft mud and was clear of any plants or objects.

INVESTIGATION PRECEDING THE INQUEST

Identification

38. On 5 December 2021, NJC, born 9 December 2003, was visually identified by his sister, HNP, who completed a Statement of Identification.
39. The identity of NJC is not in dispute and requires no further investigation.

Medical cause of death

Post mortem examination

40. On 6 December 2021, Forensic Pathologist Dr Hans de Boer from the Victorian Institute of Forensic Medicine (VIFM) performed an autopsy on the body of NJC. In preparing his report, Dr de Boer reviewed a post-mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death (Form 83), information from the Department of Health and Human Services and the VIFM contact log. Dr de Boer provided a written report of his findings dated 14 December 2021.
41. The post mortem CT scan showed a swollen brain and hyperinflated lungs. The external examination findings were consistent with the known history and there was no evidence of an injury of the type likely to have caused or contributed to death.
42. Dr de Boer commented *drowning does not result in specific findings at post mortem examination, although some findings can suggest or support the diagnosis. In this case, the hyperinflated lungs are supportive findings. Given the lack of specific autopsy findings, a diagnosis of drowning is therefore heavily reliant on contextual information.*

Toxicology

43. Toxicological analysis of post mortem blood samples identified the presence of ethanol (0.04g/100mL) and delta-9-tetrahydrocannabinol (~ 7ng/mL).

Forensic pathology opinion

44. Dr de Boer ascribed the medical cause of death as 1 (a) drowning.

THE INQUEST

First Directions Hearing

45. Practice Direction 5 of 2020 *Directions Hearings and Mandatory Inquests* provides that in all cases where an inquest must be held, a Directions Hearing will be convened within 28 days of the death in order to confirm the coronial investigator, fix the date of delivery of the coronial brief, and provide any other directions as appropriate.
46. Accordingly, a Directions Hearing was held on 15 December 2021. Leading Senior Constable (LSC) Premala Thevar of the Police Coronial Support Unit appeared to assist me. Ms Cassandra Nolan appeared on behalf of the Department of Families, Fairness and Housing, and Mr Greg King appeared on behalf of Anglicare Victoria.
47. LSC Thevar provided a summary of the known circumstances, and the return date for the Coronial Brief was set for 14 April 2022.

Expert opinion

48. Following the receipt of the Coronial Brief, I commissioned Professor Edward Ogden to provide an expert report addressing, *inter alia*, NJC's alcohol and cannabis consumption prior to his death and the effect these substances would have had on his decision-making and ability to swim.
49. Prof Ogden is a qualified medical practitioner with over 45 years of clinical experience, currently specialising in addiction medicine. At the time of providing his report, Prof Ogden was the Deputy Director (Addiction and Forensic Medicine) in the Centre for Human Psychopharmacology at Swinburne University of Technology, Addiction Medicine Consultant at Austin Health, Addiction Medicine Specialist for Goulburn Valley Health and Adjunct Senior Lecturer at the University of Melbourne.

50. The questions posed to Prof Ogden are repeated below, and his responses summarised.

- a. *What do the levels of alcohol and THC suggest about NJC's consumption? Is it possible to determine when NJC may have used cannabis and if so, when would you estimate this to have occurred?*

Assuming the measured post-mortem blood alcohol concentration was a true indication of NJC's blood alcohol concentration at the time of his death, then he must have consumed more alcohol than the statements in the coronial brief indicate.

It is not possible to determine with certainty when he last smoked cannabis without knowing whether he was a frequent or infrequent smoker. In heavy smokers of cannabis, the concentration of THC in blood can persist for several days after last use.

If NJC were an infrequent user of cannabis, Prof Ogden estimated that NJC probably smoked cannabis in the period between 30 minutes and 3 hours before his death.

If NJC was a regular heavy user of cannabis, he may have had low levels of THC in his blood all the time. However, the level of THC detected in his blood was significant. In Prof Ogden's opinion, it is more likely than not that NJC was affected by cannabis at the time of his death.

- b. *How would the alcohol and THC, separately and in combination, have impacted NJC's behaviour at the time of the incident? E.g. his decision-making, ability to assess the risks of swimming, ability to think clearly when he found himself in trouble in the water.*

Alcohol, even at low levels, can impair judgment and decision-making abilities and can cause a person to make poor choices. The alcohol may have resulted in NJC having a false sense of confidence and bravado and likely impaired his judgment and ability to properly assess the risks of swimming across the lake. His ability to think clearly was likely impaired so that when he found himself in trouble, he was more likely to panic.

Cannabis impairs perception and judgment increasing the risk of disorientation, and increased anxiety and agitation. The cannabis likely contributed to NJC being disoriented in the water, and more likely to panic when he found himself in trouble.

The combination of alcohol and cannabis probably impaired NJC's awareness, judgment, sense of balance, ability to perceive risk and ability to respond to an urgent situation. He would have more readily panicked when in trouble and become disoriented, causing him to be unable to respond effectively when Eileen attempted to help him.

- c. *How would the alcohol and THC, separately and in combination, have impacted NJC's physical ability? E.g. his ability to swim and keep himself afloat.*

NJC's family described him as a capable swimmer; however his blood alcohol concentration would have caused a degree of impairment. Further, at 17 years old he may have been more prone to the impairing effects of alcohol than an older person. He may have experienced disorientation, impaired coordination and disturbed balance, affecting his ability to swim, and may have experienced fatigue and lessened endurance due to the sedating effects of alcohol. It may also have caused him to panic.

Cannabis impairs the ability to perform accustomed tasks by habit. For a person who is impaired by cannabis and panicking in the water, there is no possibility to think rationally about how to get out of trouble (such as float) or listen to instructions when rescue is attempted.

When alcohol and cannabis combined, the impairing effects are intensified, making it even more challenging to perform the precise movements and maintain balance in the water required to swim effectively.

In combination, the alcohol and cannabis would have impaired NJC's motor coordination, balance and cognitive functioning that is likely to have made swimming much more difficult for him.

The sedating effects of the combination of alcohol and cannabis would probably have contributed to NJC having reduced stamina and endurance, which may in part explain why he got into difficulty whilst swimming. It may also explain why he was so overcome with exhaustion once he got into difficulty that he was unable to comply with Eileen's instructions as she attempted to rescue him.

51. Prof Ogden also provided some general commentary on the effect of alcohol and cannabis on human performance, and the role of both substances in drowning. Addressing the role of alcohol in drowning, Prof Ogden stated:

*Reviewing 48 papers on drownings on behalf of the Royal Life Saving Society of Australia, Hamilton and colleagues noted that almost 50% of fatal drownings were alcohol related. A study by Calverley and colleagues found that alcohol has been clearly associated with an increased risk of drowning with young Australians oblivious to, or ignoring the risks of consuming alcohol and swimming.*¹⁶

52. Addressing the role of cannabis in drowning, Prof Ogden said:

One Australian study examined the coronial data on 476 young men who drowned in coastal waters in Australia in the 15 years from July 2004 to June 2019. The relative risk of drowning after using cannabis was estimated to be increased by a factor of 2.25 times.

Second Directions Hearing

53. I convened a second Directions Hearing on 1 September 2023. Senior Constable Thevar again appeared to assist me. Cassandra Nolan appeared on behalf of the Secretary to the Department of Families, Fairness and Housing, and Laura D'Amico (Hall & Wilcox) appeared on behalf of Anglicare Victoria.

¹⁶ Calverley, H.L.M., L.A. Petrass, and J.D. Blitvich, "They don't think it will ever happen to them": Exploring factors affecting participation in alcohol-influenced aquatic activity among young Australian adults. *Health Promot J Austr*, 2021. 32 Suppl 2: p. 229-237.

54. I indicated to parties that I considered the circumstances of NJC's death were adequately addressed by the expert report of Prof Ogden, who provided a reasonable explanation for NJC's bravado in entering the lake, and how he came to be in trouble in the water.
55. I further indicated that in the absence of submissions to the contrary, I was minded to finalising the matter by way of summary inquest, subject to the possibility of there being some adverse comment or criticism in relation to NJC's supervision leading up to his death.

Submissions following second Directions Hearing

56. Following the Directions Hearing, the Department of Families, Fairness and Housing filed a number of documents to address the *appropriateness of the Children's Court Order in place and the supervision of NJC's kinship placement*. The documents filed by DFFH included a statement of Damian Worley, Director, Child Protection, Loddon Area, and statement of Rebecca Holdman, Principal Practitioner, Child Protection, Central Highlands Area.
57. Anglicare Victoria filed submissions addressing how *Anglicare was satisfied NJC's care and wellbeing was satisfactory up until the last few days of his life, and just prior to his 18th birthday*.
58. Additionally, NJC's mother wrote to the Court expressing concerns regarding the care provided to him, particularly by Child Protection in Ballarat. She said *DHS Ballarat neglected his mental health and addiction in which I believe ended his life*. She also said that HNP should not have left NJC in the care of XTQ and her friends, and that XTQ should not have let him stay the day after the wedding.

Summary inquest

59. Having reviewed the available evidence, the concerns raised by NJC's mother and the submissions of DFFH and Anglicare Victoria, I determined that this matter would be appropriately finalised by way of a Summary Inquest and Form 37 *Finding into Death with Inquest*. Interested parties were informed of my determination by way of a formal notice for a Summary Inquest to be held on 18 March 2026.

THE ADEQUACY OF SUPERVISION

60. Despite the fatal incident being so close to NJC's eighteenth birthday, the fact that NJC died while subject to a CBSO necessitates that I scrutinise the efficacy and appropriateness of the supervision afforded to him by his kinship carer HNP and the services overseeing his placement proximate to his death – Child Protection North Division Loddon Area and Anglicare Victoria.
61. I acknowledge JNC's mother's concerns regarding the care afforded to him by Child Protection in Ballarat. However, I do not consider that this period of care is sufficiently proximate to his death for it to be appropriate for me to investigate it further or make comments or findings as to the appropriateness of the care provided. Nor do I consider it appropriate to 'go behind'/interrogate the decision of Child Protection to initiate proceedings in NJC's matter, ultimately resulting in the making of the Care by Secretary Order.
62. The evidence indicates that NJC had a good relationship with HNP and he was well supported in her care. Both NJC and HNP had at times expressed to case workers that their relationship was not always the greatest, but they loved each other. The conflicts they experienced did not appear out of the ordinary for a sibling relationship.
63. The Kinship Part C assessment completed 26 May 2021 identified no issues with NJC's placement. He reported feeling settled, supported and comfortable living with HNP. It was assessed that *'this placement for NJC remains stable and appropriate with no concerns for his safety and wellbeing in the care of his sister HNP.'*

Child Protection

64. Mr Worley's statement explained the process of case-contracting. He said that the objective is to provide *the most appropriate and effective case management to the child and their family by minimising the number of professionals involved in the day-to-day life of the child and their family while also maximising the expertise, capability and strong relationships of the community service organisation with the child and family.* He explained that Child Protection retains the ultimate case planning responsibility and makes all significant decisions about the child.

65. Mr Worley considered that the decision to contract NJC's case to Anglicare was appropriate because Anglicare had greater capacity to build a relationship with NJC and HNP and were able to support the planning for his transition from care.
66. Case notes indicate that there was contact with NJC at least fortnightly. The case management proximate to his death was impacted by Public Health pandemic restrictions, including, relevantly, that face-to-face contact with families could only occur where emergency responses were required. Accordingly, during the lockdown periods of 15 to 27 July 2021 and 5 August to 21 October 2021, meetings with NJC occurred via telephone or video conference instead of face-to-face.
67. Care Team meetings with NJC, his Anglicare supports, his Child Protection Case Manager and Team Manager, and HNP, were held at least every eight weeks.
68. Contact with NJC appropriately increased over July and August 2021 in response to NJC's behaviours escalating as he appeared to struggle with lockdown and remote learning. He had been leaving HNP's home to go to Ballarat, where he said he was visiting his friends and father. On another occasion, he threatened to run in front of a car following an argument with HNP.
69. As a result, 'Placement in jeopardy' meetings were held. It appears that the situation was resolved and NJC and HNP remained committed to the placement, and there were no ongoing issues. Notes from a meeting on 17 August 2021 state:

'It was identified at the beginning of the meeting that NJC and HNP had had the chance to discuss what has been going on and how things will look moving forward in the placement. HNP made it clear that she is happy to continue to have NJC in her care, which HNP was happy with'
70. The final Care Team meeting for NJC was held on 26 November 2021, where it was discussed that Child Protection and his Anglicare case manager would cease to be involved with him after he turned 18, but he would receive continued support from Anglicare's Better Futures program. NJC planned to remain in HNP's care while he explored study or work options.

71. Mr Worley opined that the level of contact with NJC was appropriate for a young person in a stable kinship placement preparing for independence. He said that the case notes for the period of 18 June to 4 December 2021 indicated a collaborative approach to monitoring between Child Protection, Anglicare and HNP. He said *the file indicates a true partnership between Child Protection and the contracted agency.*
72. Overall, Mr Worley considered that NJC's placement with HNP was appropriate and met his needs. His presentation seemed to improve over the course of the placement, and he appeared to be an independent, future-focussed young person with clear goals.
73. Ms Holdman, Principal Practitioner at Child Protection, Central Highlands Area, addressed in her statement an earlier assertion by Child Protection that there were no case notes for NJC for the period 17 November 2020 to 27 May 2021, before he moved to Ballarat and his care was transferred to the North Division Loddon Area.
74. Ms Holdman advised that a review of the Department's Client Relationship Information System (**CRIS**) revealed that NJC's file was accessed by a Child Protection practitioner on one occasion between 17 November 2020 and 26 April 2021. However, only one case note was completed, on 17 November 2020 when a Practitioner contacted HNP. The case note indicated that NJC was doing well, with no concerns.
75. Ms Holdman noted that between 27 April 2021 and 26 May 2021, there were 27 case notes on the CRIS file pertaining to supervision of NJC's placement and assessments undertaken to ensure that he and HNP received practical supports to maintain the placement, inclusive of referrals to services which were to continue past his 18th birthday.
76. Ms Holdman made enquiries of staff members who were allocated NJC's case during that period and advised that they did not have any recollection of the work they did and were unable to locate any other material that may assist.

Anglicare

77. Anglicare explained that under the Kinship program, its key function is to support the young person and not provide day-to-day care. They provide support with education, health, cultural connections, family contact, peer relationships and leisure activities.
78. Anglicare was contracted to assist in NJC's case management and support his education, placement, medical and dental check-ups. NJC was also part of the Anglicare Better Futures program, which supports young people transitioning from out of home care.
79. NJC was supported by a Kinship Care Case Manager and Better Futures Case Worker. They initially found it difficult to engage with NJC as he was reserved and guarded, though after building rapport they developed a positive relationship with him.
80. As the delegate of NJC's guardian, Anglicare were obligated to have monthly sightings of NJC. His Kinship Care Case Manager was required to maintain fortnightly contact with him, via phone or face-to-face. He had 10 contacts with NJC – three were face-to-face, four were phone calls and three were Care Team meetings. Anglicare acknowledged that the pandemic restrictions in place at the time impacted the ability for more face-to-face meetings.
81. Part of the Kinship Care Case Manager role was to note NJC's location and to seek permission from Child Protection if he was to be away from home for more than two nights. HNP assisted with this and reported to the Kinship Care Case Manager whenever NJC left for Ballarat.
82. The Kinship Care Case Manager had no concerns about NJC prior to his death. NJC appeared to be in a good place mentally, was feeling well, and was positive about the support he received.
83. As part of the Better Futures program, the Better Futures Case Worker provided supports to NJC including by arranging driving lessons, funding a gym membership, buying him a new phone so he could better connect with services including Centrelink and referring him to the Jobs Victoria Employment Services program.

84. His impression was that of all the young people in his case load, NJC was very mature for his age and was very motivated on his future and achieving his goals. He was excited to work with NJC on these.
85. The Better Futures Case Worker's last meeting with NJC was on 26 November 2021. He recalled that NJC had a realisation that he would '*not always be young*'. He had been reflecting on his past drug and alcohol use and said that this was something he had done when he was younger but was now looking at his future. He believed that NJC was future-focussed and in a '*really good space*'.
86. Anglicare were aware that NJC had previously been a user of cannabis, but he had explained to them that he had not used it in the year prior to his death as he did not like how it made him feel. Similarly, Anglicare were aware he had consumed alcohol prior to their engagement with him but had no evidence to indicate he had done so in the time they provided care.
87. Anglicare ultimately submitted that NJC presented as being well, future-focussed and drug and alcohol free in all of their interactions with him, right until their last contact one week before his death. They stated:

NJC's consumption of alcohol and drugs during the weekend of the wedding and his insistence on swimming across the lake were an unpredictable, unfortunate and tragic accident that was not foreseeable by Anglicare and which unfortunately Anglicare could not have prevented.

COMMENTS

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

1. The making of the CBSO and the decision to place NJC in HNP's care was not the subject of my inquiry into NJC's death. However, the available evidence clearly suggests that it was appropriate to do so. It is evident that NJC was doing well in HNP's care; that he was healthy, motivated and future-focussed young man.

2. Caring for a young person with a complex background of trauma would have come with its challenges. I commend HNP for providing a stable and loving home to NJC, particularly in circumstances where she herself was relatively young and had three children of her own to raise. It appears that she not only met his physical needs but provided a safe space and the emotional support he required to address his complex trauma background.
3. NJC displayed some challenging behaviours which, to an extent, would not be unexpected or shocking for a person nearing the age of 18 and finding their independence, including leaving unannounced to stay with his father or friends in Ballarat. In these circumstances, HNP appropriately kept Anglicare/Child Protection informed.
4. HNP was authorised under section 175B of the *Children Youth and Families Act* to make decisions for NJC about social events and overnight stays within Victoria. She was therefore entitled and allowed to make the decision to allow him to stay with XTQ the night after her wedding. This did not require the approval of Anglicare or Child Protection.
5. I consider that it was appropriate for NJC to attend XTQ's wedding in the company of HNP, and on the knowledge available to her at the time, it was appropriate for HNP to allow him to attend the family lunch the following day with the plan of staying with his sister overnight.
6. I acknowledge that XTQ purchased NJC a beer at the Nagambie Rowing Club. In any other circumstance – that is, where a Care by Secretary Order or similar did not apply – to do so for someone that was four days from turning eighteen would not be outside of social norms. I also note that it was her wedding weekend, and the evidence suggests that he drank more than the one beer that she purchased for him.
7. Lastly, I consider it necessary to comment on the lack of file notes for the period of November 2020 to May 2021, even though this was not proximate to NJC's death. Although I have not reviewed Child Protection's policies and requirements for making file notes, the completion of a single file note in that time would surely fall short of what is expected and I would suggest would not meet community standards for an organisation that is the legal guardian of vulnerable young people. I acknowledge that from May 2021 onwards, there were regular file

notes made, and whatever issues were occurring for the previous months appear to have been rectified.

FINDINGS AND CONCLUSION

Having applied the applicable standard to the available evidence, I make the following Findings pursuant to section 67 of the *Coroners Act 2008* (Vic):

1. I find that NJC, born 9 December 2003, died on 5 December 2021 at the Nagambie Lakes Regatta Centre, 66 Loddings Lane, Nagambie, Victoria 3608.
2. AND, I find that at the time of his death, NJC was subject to a Care by Secretary Order and living in kinship care with his sister and was accordingly ‘a person placed in custody or care’ for the purposes of the *Coroners Act 2008*.
3. AND, I find that the care and support provided to NJC by his kinship carer HNP, Anglicare and Child Protection proximate to his death was appropriate and met his basic needs and physical and emotional wellbeing.
4. AND, having regard to all the circumstances – including that it was XTQ’s wedding weekend, that NJC was four days from turning eighteen and that he had provided assurances about his drinking and smoking that weekend that they were entitled to accept – I make no adverse comments about the supervision provided by HNP or XTQ on the weekend of his death.
5. AND, I accept and adopt the medical cause of death ascribed by Dr Hans de Boer, and I find that NJC died from drowning.
6. AND, I accept the expert evidence proffered by Professor Edward Ogden and I find that NJC’s consumption of alcohol and cannabis proximate to his death likely impaired his judgment and ability to properly assess the risks of swimming across the lake, and gave him a false sense of confidence and bravado to do so.
7. AND, I find that the combination of alcohol and cannabis likely impaired NJC’s motor coordination, balance and cognitive functioning making swimming more difficult, and may have caused panic resulting in him being resistive to rescue.

8. AND, I sincerely commend Eileen, Mikaela and Sergeant (then First Constable) Talia Mabey for their efforts to rescue NJC, which came at risk to their own wellbeing.
9. AND FURTHER, in conclusion, I find that NJC's death by drowning was the result of misadventure.

I convey my sincere condolences to NJC's family, friends and supports for their loss.

PUBLICATION OF FINDING

To enable compliance with section 73(1) of the *Coroners Act 2008 (Vic)*, I direct that the Findings will be published on the internet.

DISTRIBUTION OF FINDING

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

NJC's mother

NJC's father

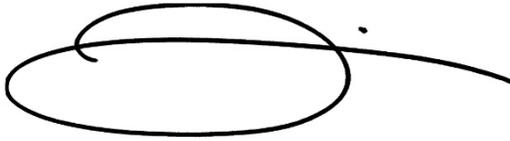
Department of Families, Fairness and Housing

Hall and Wilcox on behalf Anglicare Victoria

Commission for Children and Young People

Leading Senior Constable Jason Woosnam

Signature:



AUDREY JAMIESON
CORONER



Date: 18 March 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 inquest. 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.
