



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2021 000780

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

Section 67 of the Coroners Act 2008

Deceased: Elizabeth Jean Hanlon

Delivered on: 19 June 2026

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

Hearing date: 17 June 2026

Findings of: Deputy State Coroner Paresa Antoniadis Spanos

Counsel assisting the coroner: Grace Horzitski, Senior Coroner's Solicitor

Representation: No appearances

Key words: In care, SDA, borderline personality disorder, dignity of risk, behaviours of concern, pulmonary thromboembolism, deep venous thrombosis, probable promethazine overdose

INTRODUCTION

1. On 10 February 2021, Elizabeth Jean Hanlon (**Ms Hanlon**) was 38 years old when she died in hospital following a promethazine overdose. At the time, Ms Hanlon lived in Cranbourne.

INVESTIGATION AND SOURCES OF EVIDENCE

2. This finding draws on the totality of the coronial investigation into the death of Ms Hanlon including evidence contained in the coronial file comprising her medical records, the e-medical deposition from Monash Health, and the inspection report and toxicology report from the Victorian Institute of Forensic Medicine (**VIFM**), statements from Ms Hanlon's family and her general practitioner, and statements and records from the support services who assisted Ms Hanlon.
3. All of this material, together with the inquest transcript, will remain on the coronial file.¹ In writing this finding, I do not purport to summarise all the material and evidence but will only refer to it in such detail as is warranted by its forensic significance and the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION AND INQUEST

4. The purpose of a coronial investigation of a 'reportable death'² is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.³ Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury. However, if a person satisfies the definition of a person placed in care immediately before death, the death is reportable even if it appears to have been from natural causes.⁴

¹ From the commencement of the *Coroners Act 2008 (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. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

² The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria a reportable death includes deaths that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; and, deaths that occur during or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure, have reasonably expected the death (section 4(2)(a) and (b) of the Act). Some deaths fall within the definition irrespective of the section 4(2)(a) characterisation of the 'type of death' and turn solely on the status of the deceased immediately before they died – section 4(2)(c) to (f) inclusive.

³ Section 67(1).

⁴ See the definition of 'person placed in custody or care' in section 3(1) of the Act.

5. Ms Hanlon's death falls within the definition of reportable death because her death was unexpected and unnatural and while a person placed in custody or care by virtue of residing Specialist Disability Accommodation (SDA).^{5 6 7 8}
6. Section 52(2)(b) of the Act requires me to hold an inquest into a death if the deceased was, immediately before death, a person placed in custody or care.
7. The 'cause of death' refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the 'circumstances in which death occurred' refers to the context or background and surrounding circumstances but is 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.⁹
8. The broader purpose of any coronial investigations 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.¹⁰
9. 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

⁵ Specialist Disability Accommodation (SDA) is National Disability Insurance Scheme (NDIS) funded housing designed for people with extreme functional impairment or very high support needs.

⁶ On 11 October 2022, the Coroners Regulations 2019 came into effect. Sub-regulation 7(1)(d) provides that a 'person placed in custody or care' now includes "a person in Victoria who is an SDA resident residing in an SDA enrolled dwelling".

⁷ 'SDA resident' has the same meaning as in the *Residential Tenancies Act 1997* (Vic) and captures a person who with a disability who receives, or is eligible to receive, funded daily independent living support; and who is residing, or proposes to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

⁸ 'SDA dwelling' also has the same meaning as in the *Residential Tenancies Act 1997* and is defined by section 498BA of that Act as an 'SDA enrolled dwelling' or any other permanent dwelling that provides long term accommodation and where daily independent living support is provided to one or more residents with a disability funded by a specified entity or program. An 'SDA enrolled dwelling' in turn means a permanent dwelling that provides long-term accommodation for one or more SDA resident and enrolled as an SDA dwelling under the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2016* (Cth) as in force from time to time or under other rules made under the *National Disability Insurance Scheme Act 2013* (Cth).

⁹ 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).

¹⁰ 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'.

health or safety or the administration of justice.¹¹ These are effectively the vehicles by which the coroner's prevention role can be advanced.¹²

10. 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
11. The main focus of the coronial investigation and inquest was the circumstances leading to Ms Hanlon's death, including the appropriateness of the assistance provided to her by her support services.

IDENTITY OF THE DECEASED

12. On 10 February 2021, Elizabeth Jean Hanlon, born 23 June 1982, was visually identified by her mother, Dale Hanlon, who signed a formal Statement of Identification to this effect.
13. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

14. Senior Forensic Pathologist, Dr Michael Burke, from the VIFM, conducted an examination on 15 February 2021 and provided an amended written report of his findings dated 12 January 2023.
15. The post-mortem examination revealed pulmonary thromboembolism, deep vein thrombosis (DVT), ischaemic heart disease, bronchopneumonia, and chronic asthma.
16. Dr Burke advised that pulmonary thromboemboli refer to ante-mortem 'blood clots' which form in the peripheral circulation, dislodge and travel within the blood stream to impact within the lungs. This results in obstruction to blood flow and vasomotor changes.
17. Risk factors for the development of DVT and subsequent pulmonary thromboembolism are stasis of blood flow, damage to the endothelial lining of blood vessels, and changes in blood

¹¹ See sections 72(1), 67(3) and 72(2) regarding reports, comments, and recommendations respectively.

¹² See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (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.

¹³ Section 69(1). 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).

coagulation. The situation of being admitted to the intensive care unit, intubated and sedated/paralysed, would be viewed as a risk factor for the development of DVT.

18. Dr Burke explained that if an individual were to develop DVT and subsequent PE after suffering a major heart attack, this would be viewed as a natural event. On the other hand, such a complication following treatment for a fractured leg is clearly an un-natural event. In Ms Hanlon's situation, the DVT, and subsequent pulmonary thromboembolism, has occurred in the setting of a drug overdose and is thus an un-natural event.
19. Routine toxicological analysis of ante-mortem samples collected on 10 February 2021 detected aripiprazole,¹⁴ fentanyl,¹⁵ hydroxyrisperidone,¹⁶ laudanosine,¹⁷ nordiazepam,¹⁸ midazolam,¹⁹ olanzapine,²⁰ paracetamol.²¹ Promethazine was not detected. Dr Burke noted that as Ms Hanlon was admitted to hospital on 25 January 2021, the toxicology detected was non-contributory.
20. Dr Burke provided an opinion that the medical cause of death was "*1(a) Pulmonary thromboembolism*" secondary to "*1(b) Deep venous thrombosis*" due to "*1(c) Promethazine overdose*".
21. I accept Dr Burke's opinion.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

Background

22. Ms Hanlon's mother, Dale Hanlon, noted that her daughter was born prematurely at 30 weeks. She was later diagnosed with hearing loss at a young age and assessed as being slow in her development, including walking and speech. She was subsequently diagnosed with an intellectual disability and received support from various services.

¹⁴ Aripiprazole is an antipsychotic drug.

¹⁵ Fentanyl is a synthetic opioid with 50 to 100 times the analgesic potency of morphine, rapid onset (two to three minutes) and short duration of action (0.5 to 1 hour). It is used in surgical anaesthesia, chronic pain and breakthrough cancer pain.

¹⁶ Risperidone is an antipsychotic drug effective against the positive and negative symptoms of schizophrenia. 9-hydroxyrisperidone (paliperidone) is a metabolite.

¹⁷ Atracurium is a non-depolarising neuromuscular blocker indicated for general anaesthesia to aid tracheal intubation, muscle relaxation for surgery and mechanical ventilation. Laudanosine is a metabolite.

¹⁸ Diazepam is indicated for anxiety, muscle relaxation and seizures. Nordiazepam, temazepam, and oxazepam are metabolites. Adverse effects of diazepam include confusion, incoordination, physical dependence, sedation, and seizures in withdrawal. Overdose can cause ataxia, drowsiness, and muscular weakness.

¹⁹ Midazolam is used as a preoperative medication, antiepileptic, sedative-hypnotic, and anaesthetic induction agent.

²⁰ Olanzapine is an antipsychotic drug.

²¹ Paracetamol is an analgesic drug.

23. In high school, Ms Hanlon attended Warrnambool Special Development School where she thrived. She got her first job at Safeway at 16 years of age.
24. Dale Hanlon recalled that when her daughter turned 18 years of age, she stopped taking her medication and stated she was an adult and wanted to make her own decisions. However, Dale Hanlon noted her daughter did not have the mind of an 18-year-old. The following year, Ms Hanlon moved in with her then boyfriend, which appears to have been a significant turning point in her life.
25. Her mother noted that once Ms Hanlon move to Morwell, she became involved with a group of people who took advantage of her and introduced her to drug use. She experienced seizures as a result of her subsequent drug use and also started coming to the attention of the police. Her mother stated: “

She was very aggressive towards police and people. I believe that she has always been like this from a child, and she didn't know how to regulate her emotions so she would become aggressive.

26. Ms Hanlon was arrested when she was about 22 years of age for drug offences, criminal damage, and assault. At some point she was transferred from the Dame Phyllis Frost Centre to the Thomas Embling Hospital, and it was at about this time she was diagnosed with epilepsy and schizophrenia.
27. Following her release, Ms Hanlon moved to Cranbourne with her mother where she completed a TAFE course and received assistance from disability and mental health services. According to Dale Hanlon, over the following several years, Ms Hanlon did well and her mental health stabilised although she had several psychiatric admissions.
28. However, in about 2009, Ms Hanlon began to act out, her behaviour deteriorated, and she ran away with a friend. Dale Hanlon recalled:

The years after this Elizabeth's behaviour continued to get worse after this. She would run on the road, stand at bridges do dangerous behaviours that led to her ending up in the psychiatric ward.

29. Ms Hanlon's mother reported that her daughter overdosed for the first time in 2014, resulting in an admission to Dandenong Hospital. Following discharge, Ms Hanlon continued to exhibit

frequent high-risk behaviours, such as running into traffic, that resulted in further admissions to psychiatric facilities.

30. Since 2018, Ms Hanlon was supported by the National Disability Insurance Scheme (NDIS). While awaiting NDIS-funded accommodation, she moved homes several times due to incidents associated with her behaviour.
31. In 2019, the Victorian Civil and Administrative Tribunal (VCAT) granted a guardianship order appointing the Public Advocate as Ms Hanlon's guardian to make decisions about where she lived and the services she needed.²²
32. At this time, Ms Hanlon had a nine-month admission (November 2019 to August 2020) to Monash Health's Psychiatric Inpatient Unit and their Transitional Support Unit to establish diagnostic clarity, support her safety, and manage her complex behaviours. During the admission, there were numerous incidents on the ward including self-strangulation, cutting, eating inedible items (plastic cutlery), purging, smoking, items brought on to the ward which resulted in significant conflict with staff when she was searched and the items removed, allegations of sexual assault against staff involved in limit setting and restraint, and lunging at staff members. In November 2019, Ms Hanlon threatened to kill a staff member, forcefully broke an exit sign cover and raised it at the staff member.
33. Obtaining post-discharge accommodation for Ms Hanlon was challenging. The treating team considered transferring Ms Hanlon to a Secure Extended Care Unit (SECU)²³ or SDA. Ms Hanlon was not accepted to a SECU and by May 2020, her NDIS Support Coordinator had made application to ten SDA/NDIS Medium Term Accommodation facilities with no success.
34. On 24 August 2020, Ms Hanlon moved to Life Health Services at 8 Rock Daisy Drive, Cranbourne, in supported independent living accommodation. According to Bhawana Bhawana, Care Manager, Ms Hanlon was provided with 24-hour care in the house and the community. Support workers encouraged Ms Hanlon to engage in different activities such as walks, activities at the park, painting, colouring, shopping, and taking her to cat cafes and salons. Ms Bhawana noted that Ms Hanlon mainly preferred to do things by herself without

²² Order renewed on 3 July 2020, due for reassessment on 30 September 2021.

²³ Secure Extended Care Units are located in hospitals and provide inpatient treatment and rehabilitation for people with severe mental illness; residents are generally unable to live independently.

being supervised. She would participate in house chores such as meals preparation, and cooking, but routinely declined healthy food options. Ms Bhawana also stated:

... she preferred to go for walks unaccompanied by staff. Whenever Elizabeth got upset she would immediately go for a walk. Due to her disability, Elizabeth would shout aloud, assault staff both verbally and sometimes physically, she would lock herself in her bedroom and tell staff to keep off while saying that there are voices telling her to kill herself while at time she would be quiet continuously for 3-4 hours and would not respond to staff prompting...

In some instances when Ms Hanlon got upset, she always tried to self-harm herself, by jumping in front of moving vehicle, cutting herself or medication overdose whenever such an incident occurred, ambulance was called and in some cases the police. In all these incidents neither we or the emergency services didn't find any illicit substances. Even during the final incident there were no wrappers or any packages to show what Elizabeth claimed to have taken.

35. Ms Bhawana indicated that Ms Hanlon received regular support from a behaviour specialist, case manager, psychologist, and occupational therapist.
36. In addition to the above, Ms Hanlon's medical history also included depression, borderline personality disorder, appendicitis/appendectomy, type 2 diabetes mellitus, polycystic ovary syndrome, asthma, provoked bilateral pulmonary embolism (**PE**)/ DVT with apixaban (ceased). At the time her death, Ms Hanlon's usual prescribed medications included duloxetine, sodium valproate, and Ventolin.

Events leading to Ms Hanlon's passing

37. On the afternoon of 25 January 2021, Ms Hanlon locked herself in her bedroom after returning from an outing with her carer at about 2.25pm. When her carer unlocked Ms Hanlon's door, she observed Ms Hanlon using a Stanley knife to cut herself and contacted emergency services.
38. Victoria Police members subsequently attended at about 3.13pm, finding Ms Hanlon in her bedroom still in possession of the knife and attempting to cut herself. Ms Hanlon handed the knife to the police members when requested. At this time, she informed the members that she had taken 50 Phenergan (promethazine) 25mg tablets. Within a short time, Ms Hanlon's

condition deteriorated and Ambulance Victoria paramedics were requested to attend. They transported Ms Hanlon to Casey Hospital.

39. According to Dr Anton Zadoya, Intensive Care Unit (ICU) Specialist, Ms Hanlon developed decreased level of consciousness and hypoxia (low level of oxygen in the blood) whilst in the emergency department. Aspiration pneumonia was suspected based on chest x-ray changes with atelectasis and ground glass opacities in both lungs.
40. Ms Hanlon was transferred to the ICU the next day for monitoring of decreased conscious state and treatment of hypoxia due to aspiration pneumonia. Due to Ms Hanlon's deterioration (worsening hypoxia) she was intubated (put on a breathing machine). PE was suspected and she was started on therapeutic anticoagulation with clexane (blood thinning medication).
41. On 27 and 28 January 2021 Ms Hanlon's condition deteriorated due to hypoxia. A bronchoscopy was performed to look for infective and inflammatory causes of hypoxia which did not show abnormalities.
42. A CTPA (computed tomography scan pulmonary angiogram) conducted on 29 January 2021 confirmed no clots, but showed changes in the lungs, likely infective or inflammatory. Accidental findings also included hepatic steatosis and cardiomegaly. Antibiotics were upgraded and infusion of paralysis medication was added. Informal bedside transthoracic echocardiography (ultrasound of the heart) was performed showing normal cardiac function. Therapeutic dose of anticoagulation was changed to prophylactic dose.
43. On 1 February 2021, Ms Hanlon's condition deteriorated due to fevers, low blood pressure, and worsening hypoxia. Sepsis and septic shock were suspected so the antibiotics regimen was upgraded. A pelvic and speculum exam was performed in the view of finding a source of sepsis. An informal bedside transthoracic echocardiogram (TTE) was done and showed normal cardiac function.
44. On 2 February 2021, an ultrasound was performed of the right and left lower limbs which did not show signs of DVT. Results from genital swab confirmed *Candida glabrata* infection. Topical antifungal medication was started, as per discussion with infectious diseases (ID) team. ID team advised against systemic antifungal treatment.
45. On 3 February 2021, formal transthoracic echocardiography was performed which showed normal cardiac function, saline bubble study was mildly positive (one out for four injections)

for left to right shunting (likely not significant as per discussion with echocardiography technician).

46. Between 3 and 7 February 2021, Ms Hanlon showed some improvement, with resolution of hypoxia and shock, so antibiotics were de-escalated. A decision was made to decrease volume status and improve lung function with frusemide infusion and planned extubation (liberation from breathing machine).
47. On 7 February 2021, results from blood culture confirmed bacteraemia resembling *Staphylococcus* (later confirmed as contaminant) and yeast species in urine sample. Consultation with ID team prompted broadening of antibiotic cover.
48. On 8 February 2021, there was concern about Ms Hanlon not waking up appropriately after discontinuation of sedation. CT scan of the brain was conducted and showed no abnormalities.
49. On 9 February 2021, Ms Hanlon deteriorated suddenly due to worsening hypoxia, tachycardia, new ECG changes, and troponin elevation. Her condition was discussed with cardiology, who suggested this was type 2 myocardial infarction. Therapeutic anticoagulation was initiated as PE was suspected.
50. On 10 February 2021, Ms Hanlon's condition had deteriorated further with worsening multiorgan dysfunction including cardiovascular and respiratory failure. The Alfred Health ECMO (extracorporeal membrane oxygenation) team was called for advice and assessment. Urgent ultrasound of lower limbs conducted and confirmed bilateral below knee DVT without evidence of above knee extension. Urgent formal transthoracic echocardiography was performed which showed dilation of right ventricle with moderately reduced contraction. Decision was made to use thrombolysis. Antibiotics and antifungal medication were escalated in the view of potential sepsis.
51. On 10 February 2021, the ECMO retrieval team assessed Ms Hanlon and documented their opinion on the case as 38-year-old, with complex history and prolonged ICU stay, deterioration due to vasodilatory shock and right heart failure. The cause of deterioration was determined to likely be multifactorial, although sepsis seemed likely, and acute PE may also have occurred. It was determined that Ms Hanlon was too unstable for transfer for CTPA. She was documented as receiving high dose of vasopressors and inotropes. Transthoracic echocardiogram showed normal biventricular function, moderately dilated right ventricle.

52. After multiple discussions between ICU and ECMO team it was determined that ECMO would not be an effective treatment and was not supported by best practice guidelines. Ms Hanlon was determined to be too unstable to transfer to the Alfred Hospital. The ECMO team suggested to continue current supports and antibiotics.
53. The General Medicine team also documented and confirmed that Ms Hanlon had significant deterioration. In the view of dilated right ventricle and refractory hypoxemia, the cause of which was not clear, ECG changes, and troponin elevation raised suspicion to right ventricular infarct. There was also possibility of undiagnosed pulmonary hypertension. Ms Hanlon was empirically thrombolysed and clinicians deemed she had a poor prognosis.
54. Multiple meetings and discussions were held with Ms Hanlon's immediate family. Family members were made aware of her underlying significant deterioration, development of multiorgan failure, and poor prognosis. Ms Hanlon continued to deteriorate and, despite all the therapies and multiorgan support, passed away at 7.54pm on 10 February 2021.

FAMILY CONCERNS

55. In her statement, Dale Hanlon was concerned that Ms Hanlon was able to shop unsupervised and buy the medication with which he had overdosed.
56. She later wrote to the Court indicating Ms Hanlon's neighbour, Ian Hogg, had approached the family with concerns that he observed staff not paying attention to Ms Hanlon, ambulances frequently attended, Ms Hanlon was often "*stoned*", Ms Hanlon would be taken to see her boyfriend and would then return home the next morning, staff did not supervise what Ms Hanlon purchased when shopping, and he was asked to help settled Ms Hanlon at times.
57. To assist my investigation, I obtained a statement from Mr Hogg which did not repeat many of the concerns he reportedly conveyed to the family. However, he noted that Ms Hanlon often sat alone at the front of the house smoking, ambulances attended about every two weeks, and that she was able to access things with which she could hurt herself.
58. In her statement, Ms Hanlon's sister, Erin Hanlon, stated that Ms Hanlon disclosed to her that she was using marijuana and consuming alcohol in the lead up to her death. She questioned how this could happen when Ms Hanlon had carers with her all day. She also queried how Ms Hanlon was able to access Phenergan, why Ms Hanlon was allowed to visit friends unsupervised, and why she had ceased her blood thinning medication.

REVIEW OF CARE

59. In light of the concerns raised, I obtained advice from the Coroners Prevention Unit²⁴ (CPU) about the care Ms Hanlon received in the months preceding her death.
60. By way of background, the CPU noted that in the second half of 2020, a successful application was made for Ms Hanlon to be accommodated at an SDA in Cranbourne operated by Life Health Services.²⁵
61. Extensive planning was undertaken by Monash Health prior to discharge, inclusive of frequent contact with the NDIS Support Coordinator and inviting NDIS support workers (SW) to take Ms Hanlon on outings including to a community-based disability support service (Blairlogie). Shayna Franklin, Behaviour Support Specialist from Exaudy Care,²⁶ had several visits with Ms Hanlon to commence developing a post-discharge behaviour plan.
62. A comprehensive discharge plan was subsequently provided to the SDA that incorporated plans for managing Ms Hanlon's medications, medical issues, intellectual disability, and behaviours of concern and listed all services involved in her care.
63. In August 2020, with extensive community supports in place, Ms Hanlon moved into the SDA. She was the sole occupant with two SWs rostered at all times who received training from the Behaviour Support Specialist in October 2020 and thereafter received updates following the Behaviour Specialist's weekly sessions with Ms Hanlon.²⁷ Ms Hanlon was also seen weekly by Monash Health clinicians (a community mental health case manager and a psychologist).
64. While living at the SDA, Ms Hanlon continued to experience self-harm episodes including cutting, self-strangulation, punching objects, walking in front of moving cars, and swallowing

²⁴ The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

²⁵ Life Health Services is registered with the National Disability Insurance Scheme Quality and Safeguards Commission to provide a range of services including accommodation, support with daily and household tasks, development of life skills, assistance with transport and support for individual to be more involved in the community.

²⁶ Exaudy Care is a National Disability Insurance Scheme provider that offers various services including behaviour support.

²⁷ Ms Hanlon's National Disability Insurance Scheme Plan that commenced 9 July 2020 (prior to discharge from Monash Health) included 20 hours of specialist behavioural support and 15 hours for Behaviour Management Plan and staff training. Ms Hanlon was discharged to the SDA in August 2020 and her NDIS Plan that commenced 24 September 2020 had a further 12 hours of specialist behavioural support and 12 hours for Behaviour Management Plan and staff training. The NDIS Plan that commenced 12 November 2020 provided for 50 hours of specialist support and 30 hours for the Behaviour Management Plan and staff training.

mothballs and what she stated to be cyanide tablets. The Instacare case notes also indicated that Ms Hanlon's shopping trips were increasingly triggers for escalation in her behaviour with the specific triggers being wanting to shop independently and the SWs wanting to check her shopping.

Mental health diagnoses and behaviours of concern

65. The CPU noted that during her interactions with mental health services, Ms Hanlon had received diagnoses of schizophrenia, post-traumatic stress disorder, and depression. The diagnosis of schizophrenia was amended to borderline personality disorder following a review by a clinician from Spectrum in March 2020.²⁸
66. Ms Hanlon had significant difficulty with emotional regulation and limited functional coping skills. She struggled to comply with requests and would respond aggressively (including to staff) if her perceived needs were not promptly met or she was unable to do as she wished. Known triggers for Ms Hanlon were feelings of not being in control or having a choice, not being able to smoke cigarettes, believing she was being monitored, unwanted change, lack of privacy, feeling ignored or unheard, her relationship with her mother, requests being denied, losing things or people she cared about, broken promises, and people asking her multiple questions. When upset, Ms Hanlon was known to make self-harm and suicide attempts, withdraw and refuse to communicate with staff, refuse food and damage property (for example, breaking windows, setting fire to blankets, spraying deodorant on smoke detectors to set off fire alarms). She often had difficulty in making safe choices in terms of men she had met online, staying out overnight, alcohol/cannabis usage and financial matters.
67. Prior to moving to the SDA, the NDIS funded National Occupational Therapy²⁹ to assess Ms Hanlon and advise on the most appropriate housing and care options to meet her needs. The assessment was undertaken in January 2020 and the ensuing report recommended:
 - (a) provision of around-the-clock care on a 1:1 ratio, expanding to 2:1 when Ms Hanlon was unwell;
 - (b) staff to be specifically trained mental health SWs with additional training/induction to manage her triggers and implement a behaviour management plan; and

²⁸ Spectrum is a statewide service in Victoria that specializes in working with people with personality disorders and complex trauma. With diagnostic clarity, the treating psychiatrist gradually ceased Ms Hanlon's antipsychotic medication.

²⁹ National Occupational Therapy is part of National 360 who provide allied health services to clients of all ages across Australia via a range of health and disability funding streams.

- (c) staff to have experience with self-harming behaviours and how to intervene, as well as the ability to evaluate objects that entered the home for potential risk.

68. In June 2020, occupational therapists from Monash Health conducted a new assessment post clarification of Ms Hanlon’s diagnosis from schizophrenia to borderline personality disorder. The occupational therapists had worked with Ms Hanlon for some time and were familiar with her triggers and strategies for managing the behaviours of concern. In their report, they raised concerns about placing Ms Hanlon in a highly restricted environment, isolated from other people, as it may exacerbate her behaviours of concern. They further opined Ms Hanlon did not require overnight support as she was able to undertake functional tasks and could instead be managed by a SW (eight hours per day) to encourage positive behaviour rather than provide direct assistance. They indicated that consistency (low staff turnover) and familiarity were key factors in enabling SWs to establish rapport with Ms Hanlon which would in turn support her safety. As noted, at the time of the fatal incident, Ms Hanlon had two SWs rostered at all times, however, their level of training and experience in supporting people with behaviours of concern is unknown. The Monash Health occupational therapists also noted that Ms Hanlon’s *“risk will never be completely mitigated.”*
69. In addition to the SWs, Ms Hanlon was supported by a range of community-based services from Monash Health and a Behaviour Support Specialist (Shayna Franklin) funded by the NDIS during the lead-up to the fatal incident. This care team met fortnightly with the House Manager under the guidance of the NDIS Support Coordinator. The team included Ms Franklin, Sheena Draai (Mental Health Case Manager at Monash Health), Lisa Bertone (Psychologist at Agile Comprehensive Care Initiative (ACCI), Monash Health), and Bianca Parsons (Occupational Therapist at Recovery in Mind³⁰). There was also regular consultation with Ms Hanlon’s appointed guardian.
70. Given the high frequency of Ms Hanlon’s presentations to emergency departments for mental health issues, Monash Health implemented a Comprehensive Service Plan³¹ which outlined the agreed response to Ms Hanlon and the conditions under which she could be admitted to a psychiatric unit. The aim of this plan was to encourage Ms Hanlon to take responsibility for

³⁰ Recovery in Mind provide recovery focused, trauma informed care to individuals experiencing mental illness. Ms Parsons was well known to Ms Hanlon as she had been the treating occupational therapist during most of the 2020 episode of care at Monash Health.

³¹ A Comprehensive Service Plan would better enable Monash Health to assist in the treatment of consumers with complex needs. It clarifies the roles and actions required of multiple treatment providers under various circumstances.

her behaviour and to provide a consistent management approach and support Ms Hanlon's safety while avoiding inadvertently rewarding certain negative behaviours.

71. A Behaviour Support Outline (**BSO**) and Community Safety Plan (**CSP**), both developed by Shayna Franklin, supported the SWs to manage Ms Hanlon's behaviours of concern.
72. The BSO detailed triggers and reinforcers for the behaviours of concern, suggested preferred ways of responding and scripts that could be employed by SWs.
73. The CSP described a range of behaviours commonly undertaken by Ms Hanlon that carried some degree of risk. The activities were categorised according to levels of risk such as going to the shops or out for a walk through to spending time at a friend's house, use of substances outside of the home, and running into oncoming traffic. For each level of risk activity, there was a suggested staff response. For example, if Ms Hanlon wanted to go shopping, to avoid triggering behaviours of concern, it was suggested SWs offer to accompany her but if this was not possible, they allow her to shop but let her know how and when they would be checking up on her. When Ms Hanlon made safe choices, she was rewarded with points on a star chart that was linked to her chosen rewards and identified goals.

The fatal incident

74. On 25 January 2021, at Ms Hanlon's request, her SWs drove her to her brother's home and then to a bank. On the drive back to the SDA, Ms Hanlon made a phone call to her mother and requested she returned some money that was owing to her. The SW who completed the Incident Report indicated the conversation "*did not go well*" and Ms Hanlon was upset. When they returned to the accommodation, Ms Hanlon did not wish to speak with staff, went to her bedroom and locked the door. About five minutes later, SWs unlocked the door and saw Ms Hanlon sitting on the side of the bed with a knife to her wrist, still refusing to converse with staff. Police were called and de-escalated the situation, but Ms Hanlon informed them she had ingested 50 'Phenergan' tablets. The SDA staff and police were unable to locate the medication packaging.
75. Ms Hanlon became increasingly drowsy and was transported to Casey Hospital via ambulance, where her condition deteriorated and she died on 10 February 2021.

Review of care

76. The CPU noted that Ms Hanlon had a long history of contact with mental health services and emergency departments with the primary issue being her behaviours of concern that, at times, put herself and others at risk and led to property damage. Managing Ms Hanlon's behaviour appeared to be further complicated by a lengthy stay in Monash Health psychiatric facilities, where the service model and use of restrictive practices came to act as additional triggers and reduced her ability to take responsibility for her actions. Throughout her contact with both Monash Health³² and the SDA, clinicians and staff were challenged to balance safety issues against Ms Hanlon's dignity of risk.
77. The right to dignity of risk is promoted by the NDIS Quality and Safeguards Commission who regulate SDA provider and worker compliance under the NDIS Act 2013. Accordingly, the NDIS Practice Standards and Quality Indicators require that: "*each participant is supported by the provider to make informed choices, exercise control*" with one of the indicators that must be demonstrated being:

*Each participant's right to the dignity of risk in decision-making is supported. When needed, each participant is supported to make informed choices about the benefits and risks of the options under consideration and maximise their independence relating to the supports provided.*³³

Was discharge to an SDA appropriate?

78. The treating team at Monash Health appropriately recognised that the service model and restrictive environment of their psychiatric facilities was not therapeutic for Ms Hanlon as it exacerbated the behavioural issues. At the Monash Health High Risk Review Panel meeting in December 2019, it was noted that Ms Hanlon's needs would best be met by residing in a long term, secure and stable environment where an appropriate behavioural plan incorporating risk tolerance could be implemented. The Monash Health medical record included multiple discussions indicating Ms Hanlon's best opportunity for rehabilitation would be through residing in the community with a consistently implemented behaviour management plan, stable environment and psychotherapy targeting the symptoms of borderline personality

³² Monash Health staff were guided by section 1(d) of the *Mental Health Act 2014*, which states that every individual has the right to make their own choices and take reasonable risks to achieve personal growth, self-esteem, and quality of life.

³³ National Disability Insurance Scheme, Practice Standards and Quality Indicators (version 4) (November 2021): <https://www.ndiscommission.gov.au/rules-and-standards/ndis-practice-standards>.

disorder. Spectrum had advised Monash Health that they would be able to support in the provision of psychotherapy.

79. In summary, the CPU considered the decision to discharge Ms Hanlon to an SDA supported by SWs and community services (including a Behavioural Support Specialist) was appropriate.
80. However, the CPU noted that Ms Hanlon experienced a lengthy wait for an appropriate discharge location. There was ample evidence in the medical record that the restrictive nature of public psychiatric facilities was not therapeutic for Ms Hanlon yet a referral to SECU was unsuccessful and it took 10 applications before an SDA would accept Ms Hanlon, apparently due to her propensity to engage in property damage.
81. The CPU noted that there continues to be a gap between demand and availability of SDA housing in Victoria leading to lengthy waitlists,³⁴ but for Ms Hanlon this was exacerbated by the apparent concerns about the potential for property damage.

Was the community-based care team that supported Ms Hanlon at the SDA appropriate to meet her needs, and were Ms Hanlon's behaviours of concern appropriately managed with adequate safety mechanisms in place?

82. There is no doubt that Ms Hanlon had complex needs and required the support of a comprehensive multidisciplinary team once discharged to the SDA.
83. The NDIS Support Coordinator and Monash Health clinicians worked together to put in place a team that included behavioural and mental health specialists who regularly saw Ms Hanlon and supported the SWs. Despite the team being drawn from various agencies and funding streams, the NDIS Support Coordinator ensured effective communication among team members, the House Manager, and Ms Hanlon's guardian through fortnightly meetings. The care team included the appropriate skill-base to support Ms Hanlon's needs and they appeared to work effectively together to support her goals of achieving further independence.
84. Regarding assistance from SWs, there were differing views expressed by the various occupational therapists who assessed Ms Hanlon with regard to whether she required support

³⁴ National Disability Insurance Scheme, Specialist Disability Accommodation demand data, <https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/specialist-disability-accommodation/sda-demand-data#demand>.

on a 24/7 basis. Ultimately, two SWs were rostered each shift to provide around-the-clock support.

85. The report by National Occupational Therapy to the NDIS recommended that staff be trained mental health SWs experienced in managing self-harming behaviours and able to read and implement a behaviour support plan. While it was not possible to determine the extent to which these training requirements were consistently applied at the SDA, one entry in the case notes suggests there was awareness of the need for compliance; that is, when putting in place plans to support Ms Hanlon to have sleepovers at her friend's house, an entry in the case notes indicated that the SW who would accompany Ms Hanlon would need to be appropriately trained (i.e., an experienced worker with Certificate IV in disability, medication endorsement, and familiar with Ms Hanlon).
86. Ms Hanlon's NDIS Plan included substantial funding for specialist behaviour intervention support, a behaviour management plan, and staff training to implement the plan and there was a BSO and CSP in place developed by a Behaviour Support Specialist. According to the NDIS, an Interim BSO is designed to:
- ... focus on safeguarding and risk mitigation whilst a functional behaviour assessment is undertaken and a Comprehensive Behaviour Support Plan is developed with the person with disability.*³⁵
87. Ms Hanlon's BSO and CSP used easy to understand language appropriate to be used by the SWs and provided strategies to help prevent Ms Hanlon's behaviours of concern from occurring and to reduce harm if they did occur.
88. It was difficult to ascertain the extent to which the SWs consistently applied the strategies set out in the BSO and CSP. However, it was apparent that Ms Hanlon and her support workers received substantial support from the behavioural specialist and there was no plan to use restrictive practices to manage Ms Hanlon's behaviour and no evidence of restrictive practices being used in the house records. There was evidence of a dedicated approach by staff to supporting Ms Hanlon's safety, with staff raising concerns with the care team about the frequency of self-harm attempts in her first few months of living at the SDA. They were assured by a clinician from Monash Health that:

³⁵ National Disability Insurance Scheme Quality and Safeguarding Commission, Interim Behaviour Support Plan Checklist: Requirements for Specialist Behaviour Support Providers, <https://www.ndiscommission.gov.au/rules-and-standards/behaviour-support-and-restrictive-practices/how-develop-behaviour-support-plans#paragraph-id-9384>.

... we need to hold in mind that prior to her current accommodation, Liz was essentially cared for in hospital settings for almost 2 years. The fact that she has had a small number of behavioural issues/presentations to ED since her discharge remains something of a minor miracle! The work that LHS [Life Health Services] staff and others are doing in supporting Liz is clearly working incredibly well... I don't think we should be overly reactive to Liz's current presentation. There are going to be escalations – this is the nature of Liz's presentation.

89. The CPU noted that the case notes indicate that SWs were often successful in redirecting Ms Hanlon when she was upset by something and, on at least one occasion, with Ms Hanlon's consent, checked her room for medication that she may have taken. Ms Hanlon had placed a lock on her bedroom door, but staff had a key to access her room if she locked herself in. There was no reference in the case notes to the House Manager or SWs seeking help from any neighbours to de-escalate Ms Hanlon's behaviour.
90. The CPU also noted there were multiple examples in the case notes of staff awareness of the importance of providing dignity of risk in relation to Ms Hanlon's decision-making and that they should not "*overstep in terms of managing her social life even if we feel it might not be the best choice*". There were several documented situations where Ms Hanlon was supported to make informed choices; for example, clear rules were developed around requests for sleepovers at Ms Hanlon's friend's house that avoided imposing control that was triggering but nevertheless supported her safety. Similar strategies were used in relation to Ms Hanlon requesting sleepovers with her boyfriend. The House Manager also involved Ms Hanlon's guardian in decision-making.
91. The House Manager and Support Coordinator also appropriately sought advice from the Behaviour Support Specialist about how to manage specific behavioural incidents should they occur again. For example, they discussed how to respond in situations where Ms Hanlon informed a friend she was going to self-harm resulting in the friend attending the SDA and the situation escalating to include behaviours of concern. In December 2020, following Ms Hanlon ingesting unknown tablets, the House Manager sought assistance from the Behaviour Support Specialist who advised seeking to prevent such behaviour by reminding Ms Hanlon of the house rules and impact of such behaviours on her mind and body, as well as reducing her ability to accrue points on the star chart, further delaying her desired rewards and goal of independence. However, if Ms Hanlon appeared to have consumed unknown tablets, the House Manager was advised to explain to Ms Hanlon that the staff cannot help her

if she does not provide information and the situation not only impacts her (in terms of failure to accrue points on the star chart) but is also distressing for staff. The CPU considered that the SWs were provided with both appropriate person-centred proactive strategies but also ways to respond when a behaviour of concern threatened Ms Hanlon's safety.

92. Ms Hanlon's mother raised concerns that her daughter was allowed to shop independently while living at the SDA and this may have been how she came to acquire the promethazine tablets used in the fatal overdose. The evidence indicates that Ms Hanlon enjoyed shopping trips though, as noted above, the desire to shop independently was a trigger for behaviours of concern and was thus included on the BSO and CSP. Appropriately, these documents guided the SWs to offer to accompany Ms Hanlon but if she declined, to provide her with clear expectations regarding how they would check in on her to support her safety. The case notes indicate that SWs did accompany Ms Hanlon on several shopping excursions.
93. Of note, when Ms Hanlon was in the ICU after the promethazine overdose, the Support Coordinator asked at a care team meeting (February 2021) if there was any way they could prevent such an incident in the future. The entry in the case notes was:

Lisa [Monash Health psychologist] advised we cannot prevent this from occurring ... there is nothing wrong with SW's allowing her to shop independently and give her some freedom. She advised if Liz is restricted with her freedom it can escalate her. She advised if LHS [Life Health Services SWs) checked all of her shopping it would escalate her. She advised that this incident may naturally give Liz a fright and may learn from this experience... She advised LHS has done the right thing providing her independence.

94. The NDIS Behaviour Support Specialist was documented as endorsing the psychologist's view. This episode reflected the reasonable efforts made by the staff and care team to ensure they met Ms Hanlon's right to dignity of risk, as stipulated by the NDIS Quality and Safeguards Commission, through supported decision-making while holding awareness of her safety needs.
95. In summary, the CPU advised that the SWs appeared to have a reasonable level of awareness and skill in managing behaviours of concern and were supported to address challenges associated with implementing the plan.

Was Ms Hanlon provided with appropriate treatment to address the underlying mental health diagnoses?

96. During Ms Hanlon's lengthy admission to Monash Health facilities, a clinician from Spectrum had clarified her diagnosis, shifting from schizophrenia to borderline personality disorder. This diagnostic clarity had important implications for treatment and Ms Hanlon was weaned off antipsychotics with the expectation of commencing psychotherapy for borderline personality disorder.

Were there issues in relation to Ms Hanlon's ability to access promethazine?

97. The available evidence does not indicate the source of the promethazine tablets which led to the fatal incident. The only evidence that the medication ingested by Ms Hanlon was promethazine appears to have come verbally from Ms Hanlon herself.

98. Ms Hanlon's August 2020 discharge plan from Monash Health indicated she was prescribed promethazine 25mg daily PRN (as needed) for allergies. However, when discharged from a planned voluntary admission to the Mental Health Unit at Casey Hospital on 19 January 2021,³⁶ promethazine was listed as a ceased medication. This suggests there may have been promethazine on site at the SDA.

99. In the month prior to taking the fatal overdose, it is possible that Ms Hanlon ingested quantities of promethazine. On 9 January 2021, Ms Hanlon told the SWs she had taken 50 "antihistamine." Staff monitored Ms Hanlon's condition but there were no medical sequelae on this occasion. On 11 January 2021, the SWs received a call from Ms Hanlon's friend advising that Ms Hanlon had taken 25 promethazine and when questioned, Ms Hanlon confirmed this. She complained of feeling drowsy and weak and was taken to Dandenong Hospital but left later that night without receiving a discharge plan.

100. The CPU noted that promethazine 25mg tablets are sold in packs of 50. Thus, if Ms Hanlon ingested 50 as part of the fatal incident (and possibly more during earlier incidents), she had access to at least a whole box of the medication. One possibility is that the medication was purchased at a pharmacy when Ms Hanlon was shopping on her own and brought back to the house; though it was unclear where it was stored or how she disposed of the packaging.

³⁶ When registrar Dr Grace Vitto entered Ms Hanlon's room on the ward not long after admission, she was found fiddling with curtains and had torn off a curtain cord and hid it in her pillowcase. Ms Hanlon refused to engage with the medical officer about the incident. She was invited to have a conversation with the medical officer or be discharged. Ms Hanlon requested discharge back to the SDA, with the admission ultimately lasting only three hours.

Alternatively, promethazine may have been stored on the premises as, at least at some point, it was prescribed to Ms Hanlon on a PRN basis.

CPU conclusion

101. In addition to a mild intellectual disability, Ms Hanlon had a long history of psychological and behavioural issues that escalated as she reached adulthood leading to interactions with the criminal justice system, self-harm, and multiple episodes of care with psychiatric facilities.
102. In the lead-up to moving to an SDA with 24/7 SW presence, she spent nine months in various Monash Health mental health inpatient facilities for diagnostic clarification and stabilisation of her behaviours of concern. The length of stay was prolonged due to difficulties in obtaining suitable discharge accommodation and this appears to have exacerbated her behavioural issues but is also in keeping with the diagnosis of borderline personality disorder in March 2020.
103. When placement in an SDA became available, Monash Health clinicians collaborated with Ms Hanlon's NDIS Support Coordinator to develop a comprehensive discharge plan and care team that was appropriate to meet her needs. The collaborative approach to Ms Hanlon's care at the SDA appeared to reflect a high standard of practice.
104. At face value, it seems inexplicable that despite the presence of two SWs on a 24/7 basis, that Ms Hanlon could access and ingest a large amount of medication. However, the evidence suggests that the SWs, supported by the Behavioural Support Specialist and broader care team, had adequate plans in place to minimise the frequency of Ms Hanlon's behaviours of concern and, when they did occur, to support her safety.
105. The CPU considered the BSO and CSP were reasonable and likely to have been easily understood by the SWs. It is not possible to know the extent to which the plans were consistently implemented by the various SWs who supported Ms Hanlon, but there was nothing in the case notes to indicate any concerns.
106. In relation to the concerns raised by Ms Hanlon's family about her independent shopping, the CSP included appropriate proactive and reactive strategies to manage this situation to minimise the chance of escalation and harm. Searching Ms Hanlon's shopping was a major trigger for escalation but doing so without her consent would not only have been considered a restrictive practice, but also contrary to advice provided by both the NDIS Behaviour Support Specialist and by Ms Hanlon's Monash Health psychologist.

107. The CPU noted that the proposed strategies also aligned with a key principle of the NDIS Commission, specifically the right of people with a disability to dignity of risk and to express their will and preference. The NDIS Participant Safeguarding Policy³⁷ states, “*Taking risks is an essential part of life. Dignity of risk means exploring new opportunities and extending a person’s choice,*”³⁸ and the NDIS Act 2013 seeks to “*ensure that a reasonable balance is achieved between safety and the right of people with disability to choose to participate in activities involving risk*”.³⁹
108. The CPU noted that it was never going to be possible to keep Ms Hanlon free from all risks – something that had not even been possible when she was in the restrictive environment of an acute psychiatric facility. The CPU advised that a review of the available materials did not identify any clear prevention opportunities.
109. I accept and agree with the CPU’s advice.

STANDARD OF PROOF

110. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, having regard to the ‘Briginshaw sliding scale’.⁴⁰ When finding facts, a coroner has to reach a comfortable or reasonable satisfaction having regard to all of the available evidence relevant to the questions in issue in the investigation.⁴¹ When considering whether that level of satisfaction has been achieved, regard must be had to the seriousness of the allegation; the inherent likelihood or unlikelihood of an occurrence of fact, and; the gravity of the consequences flowing from a particular finding.⁴²
111. This is particularly so with regard to adverse comments or findings about an individual in their professional capacity which should only be made when a coroner has reached a state of comfortable or reasonable satisfaction based on the evidence that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death.⁴³

³⁷ National Disability Insurance Scheme, Participant Safeguarding Policy (April 2023) <https://www.ndis.gov.au/policies-rules-and-legal/policy/participant-safeguarding-policy>.

³⁸ National Disability Insurance Scheme, Supported Decision Making Policy (April 2023) <https://www.ndis.gov.au/policies-rules-and-legal/policy/supported-decision-making-policy>.

³⁹ *National Disability Insurance Scheme Act 2013* (Cth), section 118(1)(a)(v).

⁴⁰ *Briginshaw v Briginshaw* (1938) 60 CLR 336.

⁴¹ *Anderson v Blashki* [1993] 2 VR 89 at 96; *Secretary to the Department of Health and Community Services v Gurvich* [1995] 2 VR 69 at 73.

⁴² *Briginshaw v Briginshaw*, op cit, at 362.

⁴³ *Ibid.*

112. It is axiomatic that the materiality of any departure from applicable standards must be assessed without the benefit of hindsight, only on the basis of what was known or should reasonably have been known at the time, and not from the privileged position of hindsight. Patterns or trajectories that may become apparent subsequently or may even be obvious once the tragic outcome is known, are to be eschewed in favour of a fair assessment made from the perspective of the individual at the material time

FINDINGS AND CONCLUSION

113. The applicable standard of proof for coronial findings is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.⁴⁴

114. Adverse findings or comments against individuals or institutions are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and in so doing caused or contributed to the death under investigation.

115. Having applied the applicable standard of proof to the available evidence, I find that:

- (a) the identity of the deceased was Elizabeth Jean Hanlon, born 23 June 1982;
- (b) the death occurred on 10 February 2021 at Casey Hospital, 62-70 Kangan Drive, Berwick, Victoria;
- (c) the cause of Ms Hanlon's death was pulmonary thromboembolism secondary to deep venous thrombosis due to promethazine overdose; and
- (d) immediately before death, Ms Hanlon was a "*person placed in custody or care*" as defined in section 4 of the Act; and
- (e) the death occurred in the circumstances described above.

⁴⁴ *Briginshaw v Briginshaw* (1938) 60 CLR 336 especially at 362-363. "*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences...*"

116. Further, the available evidence supports the following findings:

- (a) Ms Hanlon had a complex social and mental health history. Her behavioural issues meant that finding appropriate accommodation where services could provide appropriate care and support was difficult.
- (b) In 2020, Ms Hanlon moved to Life Health Services at 8 Rock Daisy Drive, Cranbourne, where she would receive 24/7 support from support workers. In the lead up to this move, there was extensive planning, including from a Behaviour Support Specialist who continued to be involved in Ms Hanlon's care post discharge. Despite identification of behavioural triggers and implementation of strategies to reduce and deescalate triggers, Ms Hanlon continued to exhibit behaviours of concern, including behaviours with risk.
- (c) In line with legislation and relevant guidelines, the services and clinicians involved in providing Ms Hanlon with support recognised her ability to make informed decisions and exercise dignity of risk. As Ms Hanlon was not subject to any restrictive order (such as a Compulsory Treatment Order made under mental health legislation), there were limited interventions available to ensure Ms Hanlon's complete safety.
- (d) On 25 January 2021, Ms Hanlon advised police that she had ingested 50 Phenergan (promethazine) tablets. The packaging of this medication has not been located, and available ante-mortem toxicology analysis did not detect promethazine. It therefore remains unclear whether Ms Hanlon did in fact ingest promethazine as she reported (or some other medication) and, if so, where she obtained this medication.
- (e) Ms Hanlon was able to shop independently, which was an identified risk and strategies were implemented around checking this and encouraging her to make appropriate choices. It is unclear whether Ms Hanlon purchased the medication she ingested on 25 January 2021 on such an outing.
- (f) In summary, the evidence suggests that Ms Hanlon received a significant NDIS package and a high level of care and support in particularly difficult and complex circumstances. Services and clinicians involved in her care recognised that whatever supports and plans were put in place, Ms Hanlon's risk would never be entirely mitigated and her behaviour would fluctuate.

117. I convey my sincere condolences to Ms Hanlon's family for their loss.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

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

Dale Hanlon, senior next of kin

Colin Hanlon, senior next of kin (copy to GMP Law)

Monash Health

National Disability Insurance Scheme Quality and Safeguards Commission

Sergeant Warrane Frost, Victoria Police, Coronial Investigator

Signature:



Deputy State Coroner Paresa Antoniadis Spanos

Date: 19 June 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.
