IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2022 007423

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Catherine Fitzgerald
Deceased:	LG
Date of birth:	2006
Date of death:	28 December 2022
Cause of death:	1(a) Complications of acute alcohol intoxication
Place of death:	The Royal Children's Hospital Melbourne, 50 Flemington Road, Parkville, Victoria, 3052
Keywords:	Acute alcohol intoxication, underage drinking

INTRODUCTION

1. On 28 December 2022, LG was 16 years old when he died at the Royal Children's Hospital (**RCH**). At the time of his death, LG lived at Echuca, Victoria, with his parents and older sister.

2. From the age of about 15, LG started to ask his parents to have sips of alcohol, which his parents permitted. It appears that there was other alcohol consumption from this time and that LG had been slightly intoxicated on occasions.

3. Once LG turned 16, his parents permitted him to have a drink under supervision on special occasions, such as birthdays, barbeques, and other family gatherings. On his 16th birthday, he had friends over and was permitted to have a maximum of four drinks under parental supervision. It appears that LG also practiced drinking alcohol quickly by 'snorkelling' or 'vortexing' bottles of water. Both techniques permit the alcohol to come out of the bottle within seconds, thereby allowing the drinker to consume the alcohol and become intoxicated quickly.

THE CORONIAL INVESTIGATION

4. LG's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of LG's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of LG including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Circumstances in which the death occurred

9. On the morning of 25 December 2022, LG and his family prepared to go to the home of his maternal aunt, BV, for Christmas lunch. Christmas lunch was attended by LG, his parents, his sister and her partner, Ms V, her husband JV, their two children, son-in-law and grandchildren, and LG's maternal grandparents, KG and JG. Long-time friend of Ms V, KB, and her two children were also in attendance. With the exception of LG, Ms V's infant grandchildren and the teenage daughter of Ms B, all attendees at the Christmas lunch were over the age of 18. Each of the adult attendees brought their own alcohol to the lunch, and Ms V's house had a 'bar' set up at the back of the house which contained assorted spirits.

10. That morning, LG's parents, Mr CG and Ms BG, organised an esky to take their drinks to Ms V's house. Ms G previously provided LG a ten-pack of 'vodka cruisers', telling him that the drinks were for his use over the school summer holiday period, and she offered for LG to take those drinks in their esky to the Christmas lunch. Instead, LG took his own esky, with the ten vodka cruisers and a "*handful of UDL cans as well*", which were provided to him a few weeks earlier by his older sister, SG.

11. Ms G saw LG putting all these drinks in an esky to take with him to the lunch and stated that she told her son not to take so many drinks, however LG insisted that he was going to bring them all with him. Ms G stated that she also warned him to pace himself with his drinking, however she did not want to cause a fuss or an argument on Christmas morning, and therefore did not push the issue further with LG.

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

12. LG and his family arrived at Ms V's home between 11.30am and 12.00pm. Ms G reported that she started consuming alcohol as soon as she arrived at her sister's house, and it appears that most of the other adults were also consuming alcohol from that time. She recalled seeing LG "*with a couple of drinks*" but did not perceive any issues with his drinking.

13. In contrast, SG noted that from about 12.30pm to 1.00pm, LG was already "*a bit dazed and maybe already had a vomit*". She did not see him drinking alcohol prior to lunch but assumed that he had consumed alcohol due to his demeanour. She opined that "*He looked tipsy, but maybe more than that. He was on his way to being drunk*". Ms V's daughter, AV, observed LG "*skull a few cruisers*" and thought he consumed about seven vodka cruisers prior to lunch. AV also observed Ms G admonish LG for consuming too much alcohol and thought that he did not drink any alcohol with lunch.

14. Various attendees including Ms V and her son, JG, observed that LG had a big plate of food in front of him but did not appear to eat much at lunchtime. This was unusual, as LG was a "*big eater and would sometimes go back for 'thirds'*". After lunch, Mr G and his partner heard someone vomiting in the backyard, near the chicken coop and witnessed LG come out from behind the hedge. LG informed his cousin that "*he had just had a 'Tactical Vomit*'", a technique used by drinkers to vomit "*early and set [themselves] up for a few drinks later*".

15. Sometime that afternoon, the entire group attended the house of a family friend to use their pool. LG was observed in the pool, playing with his younger relatives. Most attendees did not observe LG consume any alcohol whilst in the pool or at the family friend's house. Mr G observed that LG left the pool with Ms B's son, ZL after about forty-five minutes, and returned to the Ms V's house. The rest of the party remained at the pool for a few hours, before also leaving and returning to Ms V's house.

16. Upon returning to Ms V's house, the older attendees mostly congregated inside the house, whilst LG and the younger attendees moved between the bungalow at the rear of the house and the backyard. At various times throughout the evening, LG was accompanied by his sister and her partner BR, cousins AV and Mr G, Mr G's partner JD, and Ms B's children SS and Mr L. He continued to consume alcohol throughout the evening and whilst LG's parents, aunt and uncle, and Ms B were all present, they were not providing any supervision of LG's alcohol consumption during that time.

17. There are varying reports about the level of LG's alcohol consumption that evening from the people who were with him and who state that they observed him drinking. It is also apparent that many of the other attendees were themselves intoxicated, and thus the accuracy and reliability of their recollection of events may have been impacted. However, even taking these factors into account, LG clearly consumed a significant quantity of alcohol. Various attendees reported seeing LG "*shotgunning*" alcohol and sneaking alcohol from other people's eskies. Ms G told LG "*to slow down*" after "*shotgunning*" a can of double strength Jim Beam and cola.

18. LG, Mr R, Mr G, and Mr L were actively encouraging one another to drink, and consumed shots of spirits from the bar at the rear of Ms V's house. LG was observed at various times running off to the garden to vomit. Some of these incidents were reportedly "*tactical vomits*", however as the evening progressed, it appeared that this was simply the result of his intoxication, rather than any decision-making process.

19. At about 11.00pm, AV drove LG's parents home, as they were allegedly both intoxicated. Mr V had gone to bed earlier that evening, with Ms V and Ms B remaining along with the younger attendees. SG reported that after 11.00pm, "*the boys started going for it*", which I interpret as meaning consuming larger amounts of alcohol. This included LG. She observed them "*shot-gunning*" more alcohol, mixing drinks from the bar and that LG was "*drunk and [staggering]"* by that point.

20. Between 12.00am and 1.00am on 26 December 2022, LG walked onto the grass in the backyard and "*just dropped*" to his hands and knees and vomited again. SG and a few others checked on LG, noted that he was unable to stand up and fell over each time he tried. LG was laughing, asking for more alcohol, and wanted to do another "*shotgun*"; however, he did not have anymore alcohol after this time. SG, Ms B, Mr R and Mr L tried to help LG move to an outdoor couch, however LG's "*legs refused to work*". SG tried to get her brother to drink some water, however he refused. She was concerned about her brother as he was unable to stand up, however Ms B reassured her that "*it was all good and that [LG] will be alright*".

21. LG was then placed on the outdoor couch. SG and Mr R rolled him onto his side as they thought that he may vomit during the night. He fell asleep quickly and did not appear to wake up throughout the night, although was noted to be snoring loudly by many of the attendees who were still awake and socialising.

22. At about 1.30am, SG, her partner, and SS left the party. SG considered taking LG with her but realised that she would be unable to get him into a taxi or an Uber, and even if she did, she thought that he would likely vomit on the drive home.

23. At about 6.30am, Ms B awoke and she and her son, Mr L, decided to go home. On their way out of Ms V's house, Ms B passed by LG and observed he was still asleep on his side, snoring loudly. She noted that he had not moved and there was no vomit present on or near him. Ms V awoke at a similar time and observed LG still asleep on the couch. At about 7.30am, Mr V woke up, made a coffee, and started cleaning up. Whilst cleaning, Mr V periodically observed LG on the couch and thought he was hungover and needed to sleep.

24. At about 8.30am, Mr V observed that LG looked grey and had vomit or foam coming from his mouth. He immediately alerted his wife and told her to call for an ambulance. LG was non-responsive at this time and Mr V performed cardiopulmonary resuscitation (**CPR**) under the 000 call-taker's instructions, until paramedics arrived and took over.

25. Paramedics arrived at the premises at and commenced treatment. They achieved a return of spontaneous circulation after 22 minutes of CPR. LG was then transferred by ambulance and airlifted by helicopter to the RCH and arrived at about 11.15am. Blood samples taken at about 12.57pm and 3.30pm revealed a blood alcohol concentration of about 0.16 g/100mL and 0.19 g/100mL, respectively.

26. A CT scan confirmed that LG had severe cerebral swelling and a nuclear medicine scan performed on 28 December 2022 confirmed brain death. His family generously agreed to donate his organs and he passed away on 28 December 2022.

Identity of the deceased

27. On 28 December 2022 LG, born 2006, was visually identified by his father, CG.

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

Medical cause of death

29. Forensic Pathologist Dr Linda Iles, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 30 December 2022 and provided a written report of her findings dated 27 February 2023.

30. The post-mortem examination revealed status post-cardiac arrest changes in the liver, brain, and pituitary gland. Neuropathological examination demonstrated autolytic changes in keeping with a period of brain death prior to circulatory cessation. Prominent congestive changes, foci of subarachnoid haemorrhage and foci of parenchymal haemorrhage were related to changes associated with brain death on a background of hypoxic ischaemic and congestive changes. There was no evidence of central nervous system infection.

31. Toxicological analysis of ante-mortem samples taken at 12.57pm on 26 December 2022 identified the presence of ethanol[2] (0.16 g/100mL), fentanyl[3] and midazolam.[4] The fentanyl and midazolam would have been administered by paramedics or clinicians at the RCH as part of medical treatment.

32. Dr Iles explained that the constellation of the toxicological findings, autopsy findings and clinical findings were in keeping with cardiorespiratory arrest secondary to central nervous system depression of cardiorespiratory function by alcohol intoxication, with possible superimposition of aspiration pneumonia.

33. Dr Iles provided an opinion that the medical cause of death was "*1(a) Complications of acute alcohol intoxication*".

34. I accept Dr Iles' opinion.

FURTHER INVESTIGATIONS

35. Following receipt of the coronial brief and the medical examiner's report, I consulted with Dr Iles to obtain further information about the mechanism of LG's death. Dr Iles explained that the average person can metabolise between 0.01 and 0.015 g/100mL of alcohol per hour. Using the blood alcohol content of 0.19 g/100mL at 3.30pm and factoring a metabolism of

[2] Ethanol (ethyl alcohol, alcohol) is a social drug and product of yeast fermentation of sugars.
[3] Fentanyl is a synthetic opioid with 50-100 times the analgesic potency of morphine, rapid onset (2-3 min) and short duration of action (0.5-1hr). It is used in surgical anaesthesia, chronic pain and breakthrough cancer pain.
[4] Midazolam is an imidazobenzodiazepine derivative used as a preoperative medication, antiepileptic, sedative-hypnotic, and anaesthetic induction agent.

0.01 g/100mL per hour, LG's blood alcohol content at midnight was about 0.34 g/100mL. Using the rate of 0.015 g/100mL, his blood alcohol content would have been in excess of 0.4 g/100mL. Even the lower estimate of 0.34 g/100mL is a very significant blood alcohol concentration, particularly in a young person who is alcohol naïve.

36. Dr Iles explained that central nervous system (**CNS**) depressants such as alcohol, opioids, or benzodiazepines, work to slow the body's heart rate and breathing. In severe cases of CNS depression, a person can become unconscious with an extremely low heart rate and respiratory rate. It is very common for people experiencing severe CNS depression to snore loudly, which accords with various witnesses' observations between 6.30am and 7.30am on 26 December 2022. The snoring observed in this instance was likely a symptom of LG's deteriorating condition and was not evidence of him sleeping normally.

37. Acute alcohol intoxication is a medical emergency due to the risk of respiratory depression whilst the person is unconscious or unresponsive. A person in this condition is unable to actively protect their airways and is also at risk of aspiration if they vomit whilst unconscious. Medical intervention in this situation is generally simple and involves maintaining an open airway and sufficient oxygenation. Depending upon the person's condition, intubation may also be required.

38. When LG fell asleep or became unconscious at about midnight, he required medical intervention in the form of airway support. Although he was initially placed on his side, he was not monitored, and therefore if he rolled onto his side or front, or vomited, he would be unable to actively protect his airway. It is likely that if an ambulance was called for LG at midnight or proximate to that time, he would have received medical intervention in the form of airway and oxygen support which would have prevented his deterioration and subsequent death. However, it is not clear at what point in time the opportunity for successful medical intervention ceased prior to the observation that he was non-responsive.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was LG, born 2006;

    b) the death occurred on 28 December 2022 at The Royal Children's Hospital Melbourne, 50 Flemington Road, Parkville, Victoria, 3052, from complications of acute alcohol intoxication; and

c) the death occurred in the circumstances described above.

40. I note that LG was permitted some alcohol use by his parents from the age of 15, with their supervision. However, on this day it was known to his parents that he intended to consume a large amount of alcohol which he took with him to the party, including 10 vodka cruisers and a 'handful' of UDL cans. The alcohol was all supplied to LG by his family. This is a significant amount of alcohol for an adult, let alone a minor. Allowing a minor to consume thus amount of alcohol poses significant risks to their health and well-being and it should not have occurred. It bears remembering that he was only sixteen years of age, and the sale and supply of alcohol to minors is illegal.

41. In addition to the alcohol he took with him, there was more alcohol freely available to LG to take and consume (seemingly without any supervision) at the home which belonged to Mr and Ms V. It was clear to adult attendees on the day that LG was consuming alcohol from the early morning into the late evening, yet there is no indication that LG's drinking or intoxication was regarded by any of the adults present as either abnormal or concerning. The evidence supports a conclusion that there was a permissive attitude to LG's use of alcohol whilst in the presence of his family and extended family, which was in existence prior to this day.

42. No one made any adequate attempt to intervene or prevent LG's continued alcohol consumption on this day, even when it was apparent that he was intoxicated. Whilst there is some evidence that he resisted supervision of his drinking and was asked at times to moderate his consumption, the issue was not pursued in any meaningful way, and he was effectively left to drink unsupervised. The general impression arising from the witness statements is a lack of concern by the adults present about alcohol consumption and intoxication in a minor of his age. This is further evidenced by the fact he was left at the premises when intoxicated without parental supervision, and in circumstances where many of the adults were themselves intoxicated. The assessment made by adults present was that he would be fine when left drunk and unsupervised on a couch to "*sleep it off*", and the assessment made the next morning was that he was simply "*hungover*".

43. There was wholly inadequate supervision of LG's consumption of alcohol and level of intoxication by both his parents and adult family members. This effectively permitted LG to consume a dangerous amount of alcohol throughout the day and into the evening. I also note

that many of the adults present were themselves intoxicated and were simply unable to provide any appropriate supervision or monitoring of LG's alcohol consumption or his wellbeing.

44. It is unlikely that this situation would have occurred if it was appreciated by the adults present that LG's consumption of alcohol posed a danger to him. I infer that one of the factors which contributed to what occurred was a total lack of insight into the dangers posed by this level of alcohol consumption and intoxication. It seems that the relevant adults were also unaware of the legal responsibility to provide adequate supervision of LG's alcohol consumption, having made alcohol available to him.

45. In that context, it is unsurprising that no medical assistance was sought, and no proper monitoring provided, even when it was recognised that LG was very intoxicated and was moved to the outdoor couch. I note that by that time, he had been observed consuming large amounts of alcohol throughout the evening, vomiting on several occasions and that he was inebriated to the point where he could no longer walk. Whilst I am satisfied LG's death would have been prevented with appropriate medical treatment, there was never any real prospect that medical attention would be sought for him due to an absence of understanding that his alcohol consumption and intoxication was inappropriate, or that it posed any danger to him.

COMMENTS

46. As noted at the outset, an important function of the coronial jurisdiction is to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety. I have therefore ordered publication of this finding in the hope that it may serve as a timely reminder about the dangers posed to minors by alcohol consumption, and the legal responsibility imposed on adults who supply alcohol to minors. As that is the sole purpose of publication in this case, and it is a purpose which can be achieved without naming the deceased or any of his family members, their names have been redacted.

47. The consumption of alcohol by minors poses a clear danger to their health and well-being. The sale of alcohol to minors is not permitted and the supply of alcohol by adults to minors is also severely restricted for that reason, in acknowledgment that minors do not have the same decision-making capacity as adults. This case serves as a tragic reminder why the consumption of alcohol by minors is only permitted in very restricted circumstances with appropriate adult supervision, and of the great harm that can occur when that supervision is inadequate, and when there is no understanding of the risks posed by alcohol consumption.

48. LG was obviously very loved by all his family, and the death of someone so young and in these circumstances must be highly distressing. I offer my sincere condolences to LG's family for their loss.

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

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

LG's parents, Senior Next of Kin

Liana Buchanan, Commissioner for Children and Young People

DonateLife

Royal Children's Hospital

Senior Constable Michael Thompson, Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date : 12 December 2024

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.