IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 002229

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Olivia Alexandra Evans

Delivered On:	3 September 2025
Delivered At:	Southbank, Victoria
Hearing Dates:	3 September 2025
Findings of:	Coroner Simon McGregor
Representation:	Gemma Cafarella, Counsel Instructed by Alice O'Connell, K&L Gates
Counsel Assisting the Coroner	Nicholas Ngai, Senior Coroner Solicitor
Keywords	Death in care; Suicide; Mental Health; Youth

I, Coroner Simon McGregor, having investigated the death of Olivia Alexandra Evans, and having held an inquest in relation to this death on 3 September 2025 in the Coroner's Court of Victoria at Melbourne, find that the identity of the deceased was Olivia Alexandra Evans, born on 19 August 2007, and the death occurred on 28 April 2023, at the Royal Children's Hospital, 50 Flemington Road, Parkville, Victoria, 3052, from:

1a: Paracetamol Toxicity in the setting of 2: Anorexia Nervosa

I find, under section 67(1)(c) of the *Coroners Act 2008* (**the Act**) that the death occurred in the following circumstances.

1. Liv (as she was known to her family) was 15 years old when she passed away at the Royal Children's Hospital on 28 April 2023. At the time of her death, Liv was receiving treatment at the Royal Children's Hospital.

2. Liv was the youngest daughter of Angela Evans and Robb Evans and had an older sister, Emily Evans. She lived in a co-parenting arrangement with her parents.[1]

3. Liv was reported by her parents to have 'never really had a good relationship with food.' She was noted to be a fussy eater from a young age and often reported feeling bloated after eating breads and other foods.[2]

4. In 2020, as Liv was entering her teenage years, she became 'obsessed' (as described by her father) with eating healthy foods, often substituting healthier ingredients, for example using honey rather than sugar, when baking, and in December of the same year, she informed her parents that she was vegetarian.[3] At around the same time, Liv's sister informed Liv's mother that Liv had made references to 'wanting' to die. Liv's parents arranged support for Liv through Headspace, and she was provided an appointment in February 2021.[4]

[1] *Coronial Brief, Statements of Angela Evans and Robb Evans*
[2] Ibid.
[3] Ibid.
[4] Ibid.

5. At the initial Headspace meeting Liv denied any plans to kill herself but confirmed wanting to die and a belief that things would be easier if she were not alive anymore.[5]

6. In early March 2021 Liv appeared unwell, lethargic, and was refusing to eat. She attended at her general practitioner (**GP**) and was found to be two kilograms under her normal weight. The GP advised Liv's parents to take her to a hospital.[6] Upon arriving at Monash Health's Emergency Department, Liv's observations were normal, and her parents were advised to take Liv home and attempt to get her to eat. Once home, Liv ate some food, but continued to generally restrict her eating.[7]

7. On 9 March 2021, Liv was admitted to the Aviary ward at Monash Children's Hospital and was diagnosed with Anorexia Nervosa.[8] Liv's parents informed hospital staff of Liv's vegetarianism and issues with gluten, however staff advised that vegetarianism was likely a symptom of Liv's eating disorder, and because coeliac had not been medically diagnosed, no accommodations would be made regarding the inclusion of gluten in her diet and meal plan.[9] Liv was noted to refuse solid meals, opting instead for a liquid bolus, on each occasion that a meal including meat was served. A diagnosis of coeliac disease was subsequently made on 15 August 2022 when Liv was an inpatient in a paediatric medical ward at Monash Health.[10]

8. Throughout 2021, Liv's condition continued to deteriorate. She had many inpatient hospital admissions, often being admitted for approximately 10 days, before being discharged to home for 5 days during which time she would refuse to eat, before being readmitted. In late 2021 'Code Greys' became frequently necessary for the facilitation of nasogastric feeding as Liv was refusing to attend voluntarily.[11]

9. Throughout 2022, Liv engaged in many self-harming behaviours and attempts to suicide while an inpatient, via various methods such as ingesting salt, attempting to suffocate

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[5] Ibid.
[6] Ibid.
[7] Ibid.
[8] Ibid; *Coronial Brief*, Statement of Dr Michael Gordon.
[9] *Coronial Brief*, Statement of Dr Michael Gordon.
[10] Ibid.
[11] Ibid.

herself and paracetamol overdose. Liv also engaged in many episodes of significant self-harm, such as scratching, head banging and ripping out nasogastric feeding tubes, resulting in the use of restraint and other restrictive interventions.[12]

10. In total, Liv had 38 inpatient medical admissions over a period of approximately two years.[13] After her first admission, these were typically brief in nature (generally 10 days or less), frequency (with most re-admissions within a week of discharge), and did not feature solid food consumption.[14]

11. In November 2022, Liv was trialled on ketamine as a treatment of her major depressive symptoms.[15]

12. In January 2023, Liv was formally diagnosed with autism spectrum disorder (**ASD**).[16]

13. In February 2023, Liv was advised that she would be admitted again to Monash Children's Hospital the following day. During the evening Liv ran away from her mother's home. She was located by police in Melbourne's central business district and taken to Monash Children's Hospital.[17]

14. While Liv and her family were provided with supported meals during her early inpatient stays, no meal support other than through Family-Based Treatment for Anorexia Nervosa was provided as an outpatient. No in-home meal support was provided.

Incident

15. In the period before her death, Liv was placed on both an Inpatient Treatment Order **(ITO**) and a Community Treatment Order (**CTO**) under the *Mental Health Act 2014*, which was the predecessor to the current *Mental Health and Wellbeing Act 2022*.

[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid.

16. On 28 March 2023, the Mental Health Tribunal made an ITO regarding Liv, lasting 12 weeks until 19 June 2023.[18]

17. On 6 April 2023, Liv's ITO was varied to a CTO by Monash Health psychiatrist, Dr Junko Yamaoka. The ITO was varied to allow Liv to return home after a period of inpatient treatment.[19]

18. On 26 April 2023, Liv was observed to be disoriented and unsteady on her feet. She soon began vomiting and an ambulance was called.[20]

19. The ambulance transported Liv to Monash Children's Hospital, where it was determined that she had taken a significant overdose of paracetamol.[21] Dr Yamaoka varied the CTO to an ITO because during her attendance at Monash, Liv required life-saving treatment following the overdose in circumstances where she was resistant to treatment and mechanical restraints were required. From this point onwards, she was a person "in care" for the purposes of the Act, such that this inquest is mandatory.[22]

20. Liv was later transferred to the Royal Children's Hospital as a compulsory patient which was authorised by Dr Yamaoka.[23]

21. On 27 April 2023, a care team meeting was held to discuss Liv's viability for a liver transplant, with the outcome being agreement that Liv was not a viable candidate for the transplant.[24]

22. On 28 April 2023 in the late evening, Liv's life support was turned off, and she passed away at 10:38pm.

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[18] *Coronial Brief*, Statement of Dr Michael Gordon
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] See [60] below.
[23] Ibid.
[24] Ibid.

INVESTIGATIONS

23. Liv's death was reported to the coroner, as it falls within the definition of a reportable death under the Act. Reportable deaths include deaths that are unexpected, unnatural, violent or result from accident or injury.[25] The death of a person in care or custody is a mandatory report to the coroner, even if the death appears to have been from natural causes.

24. Section 52(2) of the Act provides that a coroner must hold an inquest into a death if the death or cause of death occurred in Victoria, and a coroner suspects the death was a result of homicide or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown. In this case, Liv was subject to an Inpatient Treatment Order at the time of her death, so her passing was determined to be 'in care' and, as such, is subject to today's mandatory inquest.[26]

25. The role of the coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. The purpose of a coronial investigation is to establish the facts, not to determine criminal or civil liability.

26. A coroner may also make comments or recommendations relating to public health about any matter connected with the death under investigation, and with the assistance of the interested parties here, I intend to do so in this case.

27. Victoria Police assigned Senior Constable Jack Bennett to be the Coronial Investigator for this matter. He conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence on 22 November 2023.

28. This finding draws on the totality of the coronial investigation into Liv's death 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.

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[25] Section 4(1) of the Act.
[26] Section 52(2)(b) of the Act.

29. In considering the issues associated with this finding, I have been mindful of Liv's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006*, in particular sections 8, 9 and 10.

Identity of the deceased

30. On 29 April 2023, Olivia Evans, born 19 August 2007, was visually identified by her father, Robb Evans and identity is not in dispute.

Medical cause of death

31. On 1 May 2023, Forensic Pathologist Doctor Judith Fronczek of the Victorian Institute of Forensic Medicine conducted a postmortem external examination of Liv's body.

32. On the basis that external examination and a post-mortem CT scan, Dr Fronczek provided an opinion that the medical cause of death was 1(a) Paracetamol toxicity secondary to 2: Anorexia Nervosa.[27]

33. I accept Dr Fronczek's opinion.

Concerns of care

34. In communications with the Court,[28] Liv's parents expressed understandable concerns about the following:

    a. They had a perception that the treatment Liv received focussed primarily on physical stabilisation, without due attention to treatment of her mental health needs, particularly while being treated within the 'Aviary' ward;

    b. Liv's mother indicated a belief that Liv responded positively to experimental ketamine treatment, indicating though that effectiveness appeared to wane after a couple of weeks. Liv's mother referred to a need for more research into use of

[27] Medical Inspection Report of Forensic Pathologist Judith Fronczek
[28] *Coronial Brief,* Statements of Robb Evans and Angela Evans; written submissions received on 9 May 2025 and 8 May 2025.

ketamine as treatment for adolescents and young people with eating disorders and treatment resistant depression;

c. Liv's parents indicated that they felt unsupported regarding the need for them to supervise Liv's eating at home, following discharge from hospital. In her statement, Liv's mother suggested a need for funding of in-house feeding programs; and

d. Liv's father expressed a belief that treatment approaches for young people with eating disorders need to change, and that current treatment approaches appear to be a 'one size fits all' approach, and that the 'system' does not allow for alternate approaches.

35. In response to these concerns, I directed that further information be obtained from Monash Health. In response, I received a comprehensive and considered statement from Dr Michael Gordon, Child Psychiatrist, Monash Health, dated 11 September 2024.

36. I also directed the independent practitioners in the Mental Health Team of the Coroners Prevention Unit (**CPU**)[29] to review Liv's case, including the available evidence, the family's concerns and statements from Monash Health.

EXPERT OPINION

37. With the CPU's assistance, I commissioned an expert report from an independent specialist psychiatrist, Professor Sloane Madden and then shared the report with the interested parties.

38. Professor Madden's report dated 5 March 2025 was comprehensive and I have considered it in full, but for the purposes of this finding, I have noted only these key passages under the following sub-headings, to which I had directed him:

[29] The CPU is a team made up of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

Whether Monash Health's treatment of Olivia's mental health needs were reasonable and appropriate, giving consideration to the need to balance both her medical needs and stabilisation and treatment of her mental health

39. While significant mental health supports and resources were provided to both Liv and her family, the separate nature of the medical and psychiatric teams had the potential to lead to a disjointed approach to care, particularly in the inpatient setting where the adolescent medical team was primarily responsible for the provision of care.[30]

40. While such a model is not unusual, other child and adolescent eating disorder services are jointly medically and psychiatrically run with mental health and medical clinicians as part of the one service. This alternative model has the potential advantage of simultaneously considering the medical and psychological impacts of care in all treatment decisions.

41. Similarly, the delayed consideration of admission to the Stepping Stones Unit and the lack of capacity for the Stepping Stones Unit to manage or be supported to manage food refusal and nasogastric refeeding had the perhaps unintended consequence of prioritising medical care over intensive psychological support.[31]

42. The aspect of Liv's care that suggests there was a prioritising of medical management over psychological support was the failure, identified in the pattern of recurrent brief medical admissions for medical instability without ensuring Liv had a capacity to eat sustainably outside of hospital, which resulted in a further pattern of escalating coercive interventions, increasing distress, treatment refusal and self-harm.[32] While coercive interventions are at times necessary to ensure safe care of eating disorder patients, the frequency and nature of Liv's interventions argued strongly for a change in treatment direction and emphasis. Such interventions are by their nature traumatic not only for the patient and their family, but also for treating clinicians, and can impact negatively on treatment outcomes and the provision of care. Consideration of Liv's mental health needs and the capacity for admission to a

[30] *Professor Sloane Madden expert report dated 5 March 2025,* 7.
[31] Ibid, 8.
[32] Ibid, 9.

setting capable of providing such care should, in Professor Madden's opinion, have occurred much earlier in Liv's treatment pathway.[33]

43. The treatment of comorbid psychiatric conditions, including anxiety, depression and autism spectrum disorder, is vitally important for enhancing treatment outcomes for eating disorders. The delay in the formal diagnosis of autism spectrum disorder in Liv's case had an impact on her treatment and management. In terms of the psychotropic medications provided to Liv, olanzapine was certainly helpful for the management of refeeding distress, but there is no mention of antidepressants other than a ketamine treatment in November 2022 for the management of depression and anxiety. While this may have happened, the separate nature of the medical and psychiatric teams may also have negatively impacted the provision of such interventions.

44. In Liv's case, seeking out second opinions would also have been both necessary and reasonable. Professor Madden acknowledged the Centre for Excellence in Eating Disorders' high level of expertise and supported the recommendations provided by Dr Christine Rizkallah. However, Professor Madden also highlighted that experience in managing complex eating disorder presentations such as Liv's is limited. In this case, consideration could have been given to seeking the opinion of a child and adolescent psychiatrist from another specialist eating disorder service in Victoria or Australia to provide advice on successful interventions for similar young people.[34]

The use of ketamine in the treatment of young people presenting with both eating disorders and treatment resistant depression

45. There is limited evidence to guide the use of ketamine in adolescents with treatment-resistant depression. While ketamine has been suggested as a potential treatment agent for anorexia nervosa, there is little research to guide its use.[35]

[33] Ibid.
[34] Ibid.
[35] Ibid.

46. In Liv's case, the chronic and severe nature of her depression, her refusal to take oral antidepressants and her apparent response to ketamine used for intravenous sedation would support the decision for a trial of ketamine. The current literature supports such a trial.

The appropriateness and reasonableness of in home supports available for families, both during Liv's treatment and currently

47. Professor Madden notes that in Liv's case, providing supported meals involving both the parents and young person prior to discharge would have been helpful. There is a lack of evidence that Liv's parents jointly attended in the "family meal" sessions. The family meal is key in treatment for anorexia nervosa in children as parents provide a meal to their child with the therapist present to allow the therapist to coach families to deal with food refusal and distress. This is meant to provide the parents with skills to manage food refusal outside therapy sessions.[36]

48. The failure to ensure that Liv ate all her meals in the hospital setting before discharge was a key failure in her care. Discharging patients when they are not eating strongly predicts that they will continue to refuse food outside of the hospital and negatively impacts parents' confidence in their capacity to support their children to eat.[37] Monash Health's new policy requiring young people to have eaten at least six consecutive meals is a positive step forward but does not ensure young people will eat with their families upon discharge.

49. Professor Madden noted the difference in standard care in the Sydney Children's Hospital Network's Eating Disorder Service, and other additional treatment interventions used in NSW, that could have been beneficial in Liv's case.[38]

[36] Ibid, 11.
[37] Ibid.
[38] Ibid, 12.

General commentary about how treatment pathways for young people with eating disorders could be improved within Victoria and whether the approach to treatment of eating disorders at Monash Health is in line with contemporary best practice

50. Professor Madden supports consideration of eating disorder teams containing medical, psychiatric and psychological staff, so as to minimise the risk of prioritising either medical or psychiatric management of eating disorders over the other. He also supports greater flexibility in the provision of inpatient care to allow longer admissions with higher levels of psychiatric support for young people with anorexia nervosa who fail to respond to first-line interventions.[39]

51. Professor Madden noted that it is important to provide 'step-up' and 'step-down' facilities for the treatment of adolescent eating disorders to prevent inpatient hospital admissions and to facilitate successful transitions from hospital, including intensive adolescent eating disorder day programs, family admission programs, consideration of home-based treatment for eating disorders and multi-family therapy programs. Professor Madden notes that some of these programs are now being provided, or will soon be provided, as part of the recently announced *Victorian Government Eating Disorder Strategy 2024-2031.*[40]

52. The nature and frequency of restrictive interventions used in this case did not represent best practice. Strategies to minimise such interventions will improve care. The changes to the Monash Health Eating Disorder Program since Liv's treatments may provide a framework for similar changes that could be implemented statewide.[41]

53. Professor Madden reviewed the changes made to the provision of adolescent eating disorder treatment in Dr Michael Gordon's statement, including mental health program-led changes and the changes arising from the Lived Experience Forum. He supports these and acknowledges that these changes will lead to better care. He also supports the moves to

[39] Ibid, 13
[40] Available online at: https://www.health.vic.gov.au/practice-and-service-quality/victorian-eating-disorders-strategy
[41] *Professor Sloane Madden expert report dated 5 March 2025,* 13.

reduce the risk of restrictive practices in eating disorders and the need to ensure eating in patients prior to discharge from hospital.[42]

54. Professor Madden noted that there needs to be capacity and flexibility to manage patients with anorexia nervosa in settings that allow for more intensive psychological interventions including inpatient mental health units and intensive eating disorder day programs. The provision of such care would be in line with current best practice.

55. Professor Madden commented that Monash Health's contemporaneous processes to support eating when young people are discharged into their parents' care were lacking. Professor Madden provided details of care available to support young people with eating disorders in NSW as well as internationally and would see these as current best practices. Additional treatment interventions that have been successfully used in NSW include:[43]

    a. Family admissions for up to two weeks where a young person and their family are admitted to hospital or a nearby apartment and provided with intensive daily support by a multidisciplinary team of eating disorder clinicians to address eating, exercise and distress around eating.

    b. Multi-Family therapy where up to 8 families are seen together in an outpatient setting over one week to improve parents' capacity to refeed their child with anorexia nervosa.

    c. Intensive Eating Disorder Day Programs where children are seen five days a week to address difficulties in recovering from their eating disorder. This program provides individual psychological therapy, group psychological therapy, educational interventions, family therapy, dietician support, medical review and psychiatric review. Young people consume three meals a day in the program and the remainder of their meals at home. Where young people cannot complete meals at home, parents are supported by program staff to complete missed meals when

[42] Ibid, 13.
[43] Ibid, 12.

they attend the service. Ongoing failure to complete meals can be managed by hospital admission for more intensive support.

56. From an international perspective, Professor Madden commented that the provision of home-based treatment for adolescent anorexia nervosa is being researched in Germany.[44] This model involves clinicians visiting families at home and providing treatment interventions and support in the family home. In Germany, this is considered both a step-down treatment from the hospital and a stand-alone treatment to prevent hospitalisation. Early treatment results suggest positive outcomes and higher degrees of family satisfaction.

MONASH HEALTH'S RESPONSE

57. Monash Health was invited to respond to Professor Madden's report, and in doing so they also provided the Court with a statement from Dr Jacinta Coleman dated 14 July 2025.

58. In summary, those key responses were:[45]

    a. Whilst Monash accept that they operate separate medical and psychiatric units, the adolescent medical unit, Aviary, already provided integrated and collaborative medical and psychiatric services to Liv.

    b. Dr Coleman disagrees that the psychiatric and medical teams were 'separate' or that the care was disjointed. However, she acknowledges that Monash Children's Hospital does not have a specialist eating disorders unit or designated mental health clinician to oversee the management of patients with eating disorders. Dr Coleman agrees that it would be beneficial to have such oversight. Previous funding applications directed towards this capacity have to date not been met with success.

    c. Active consideration was given to Stepping Stones during earlier admissions (from April 2022) but it was felt that the Aviary ward was preferrable due to Liv's familiarity with staff and routines. Dr Coleman notes several occasions where clinicians considered Stepping Stones between May 2022 and June 2022. On 15

[44] Ibid.
[45] Statement of Dr Jacinta Coleman dated 14 July 2025, 12-13.

July 2022, Liv was admitted to Stepping Stones but only stayed for a brief period due to a decline in her medical condition.

d. Monash acknowledges that there was some delay in getting a formal autism diagnosis due to Liv's malnutrition and waitlists for Autism Spectrum Disorder (**ASD**) services from May 2021. Dr Coleman confirmed that there were barriers to a formal assessment including Liv's ongoing malnutrition as well as a waiting list for assessment. The diagnosis of ASD cannot be made definitively when a person is underweight, as several of the symptoms of ASD can be temporarily mimicked in the cognitive effects of their low body mass index and the effects of starvation on the brain. Monash also contend that while formal diagnosis took some time, a preliminary diagnosis was made in a timely manner and treatment through an ASD lens was provided to Liv from that time onwards.

e. Monash Health confirmed that COVID-19 had a substantial impact on the treatment options available to Liv, specifically in relation to inpatient admission times and that their clinicians believed at the time that brief admissions for medical stabilisation followed by outpatient care was appropriate. Dr Coleman confirmed that early in Liv's treatment pathway with Monash, they did not have the capacity or appropriately trained staff to provide meal support with parents. During the pandemic, efforts were made to expand support via the adult based Wellness and Recovery Centre. This was offered to Liv's family but due to Liv's parents work commitments and the ongoing nature of Liv's illness and frequent admissions it was difficult. During COVID there were many times Liv could not have her sister or parents present for meals. Dr Coleman states that Monash Health offered the Wellness and Recovery Day Program during COVID and this required young people to join from their homes and have meals and group discussions with the support of the clinicians. This program was offered to Liv in May and August 2021, and whilst Liv attended the program for a few days in August 2021, she was not ready to participate in recovery.

59. I note the following improvements and recommendations have already been implemented by Monash Health since Liv's passing:[46]

a. Paediatric clinicians now aim to ensure an assessment is completed within 24 hours of admission for all eating disorder patients including providing a provisional diagnosis. Feedback is aimed to be provided to families by the Paediatric clinician, and where possible, by the community clinician to ensure consistency of communication.

b. Mental health meal support clinicians now provide education to parents and carers around meals during the first one or two days of their first admission. Parents are encouraged to be present for the majority of the meals for the duration of the admission to facilitate a smoother transition home and will be offered more family meal support sessions as needed. Parents are provided with multiple opportunities for additional family meal sessions on the ward in the case of subsequent inpatient admissions. A weekly parent education group is also offered on the ward.

c. Families are now linked in with Eating Disorders Victoria's carer support services, including 1:1 coaching and weekly group sessions at discharge to provide additional carer led 'scaffolding' for families in addition to their community mental health service.

d. Complex patients with suspected co-morbidities including ASD, additional mental health issues such as depression, OCD, or personality traits and who have been readmitted will be reassessed by Paediatric clinicians for further clarification. This is done in conjunction with the Community mental health teams who can subsequently arrange further formal assessments in the community.

e. Monash Health aim to provide all our young people with individualised care plans and those that are coming in with repeated admissions (>3 admissions) have an intensified care plan developed in conjunction with the community mental health team, medical team, nursing, allied health and maternal child health school to

[46] Ibid.

provide consistency of care. These plans aim to reduce the number of readmissions, reduce the impact of trauma, encourage the young person to reconnect to their school community and peers, and prevent the development of behaviours which may require restrictive intervention.

f. Groups of identified young people who are having increasing admissions also have regular multidisciplinary care team meetings (fortnight-monthly) with medical and mental health services (inpatient and outpatient). Monash Health believe this will better integrate their care with intensifying community supports wherever possible, such as by increasing family sessions at the outpatient clinic and with earlier referral to the Wellness and Recovery Intensive Day Program, so as to avoid hospital admissions.

g. Monash Health has recently held a multidisciplinary workshop with 50 attendees from all professions across the hospital. From this workshop, they created working parties to further develop the ideas that were raised. The PEACE model, (Pathway for Eating disorders and Autism developed from Clinical Experience) recommends a neuro-affirming approach to care for patients with neurodiversity and eating disorders. It was developed at the Maudsley Hospital, UK in 2017 for adults and has been further trialled in at least 3 hospitals there, with a significant decrease in both trauma and readmissions. The framework supports a more flexible approach to the management of these patients and caters to their heightened sensory aversions such as loud noises, bright lights and food preferences.

h. Monash Health's community teams managing patients with eating disorders now has an experienced new manager skilled in family-based treatment and individual therapy. Community clinicians are invited to attend family discussions on the inpatient unit so that the parents feel that a bridge has been built between inpatient and outpatient care has been built.

i. Monash Health supports the Victorian Government's *Victorian Eating Disorders Strategy 2024 – 2031* which aims to create a care system that is centred on the

needs of people with eating disorders, their families, carers and supporters. Some key aspects include:

i. Hospitals are encouraged to adopt a mental health–led model for eating disorder admissions, ensuring psychiatric and medical needs are addressed concurrently.

ii. Area Mental Health and Wellbeing Services will provide short-term inpatient care for adolescents with moderate to high needs.

iii. Expansion of highly specialised statewide services, including residential eating disorder treatment centres and women's mental health inpatient units.

iv. Emphasis on coordinated care involving medical, psychological, nutritional, and peer support professionals.

60. The quality of the written material provided to me by Monash Health meant that it was not necessary to hear oral evidence, and I thank the interested parties for that assistance. I could also see that subsequent action had been taken by Monash Health to address issues about support for families with a child who has an eating disorder and at home supports, and this was influential in my determination that Monash Health had provided an adequate response in addressing the family's concerns as well as the prevention opportunities articulated by Professor Madden.

COMMENTS

I make the following comment(s) connected with the death under section 67(3) of the Act:

1. A review of Liv's admissions reveals a spiralling pattern of increasing food refusal, increasing conflict around nasogastric tube insertion, escalating distress, increasingly frequent and severe self-harm, recurrent involuntary observation, sedation, restraint and recurrent suicidal ideation.

2. Liv's distress around readmission often required involuntary restraint and sedation to deliver her to hospital, and in February 2023, it resulted in Liv running away from home. Liv was reported to have attempted suicide when an outpatient on up to 13 occasions, including the ingestion of paracetamol with lethal intent in August 2022 and April 2023.[47]

3. Liv's case demonstrates that people with eating disorders often experience higher rates of co-morbid mental health problems than the general population, and many people find it difficult to access the treatment, care and support they need through orthodox medical pathways.

4. The mental health reforms currently taking shape across Victoria offer an opportunity to embed a mental health–led response to address many of the existing challenges experienced by people with or at risk of developing an eating disorder. I endorse these reforms. Liv's case supports the need to adopt a mental health–led response which will allow health services to deliver holistic care that can address the complex factors underpinning a person's illness.

5. The *Victorian Eating Disorders Strategy 2024-2031* notes that eating disorders can have profound impacts on families, carers, and supporters. There is evidence that around 78 per cent of carers face work losses or must give up their studies to provide care for their loved ones.[48] The impact of caregiving reaches many aspects of their lives, affecting sleep, relationships, and social life.[49] As a result, carers often place caring for their loved one above their own needs and wellbeing.

6. Adequate funding and resourcing of public mental health and wellbeing services to prioritise engagement with families, carers and supporters as core members of the care team and deliver in-home supports to prevent recurrent treatment through in-patient facilities, especially for vulnerable children and young people with significant life expectancy, can reasonably be expected to save the community money in the long term, given the obvious chronicity of this patient cohort.

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[47] *Coronial Brief,* Statement of Dr Michael Gordon
[48] Butterfly Foundation 2022, Raising the alarm: carers need care too, Butterfly Foundation, Glen Iris.
[49] Ibid.

7. Having considered all the evidence, I am satisfied that Liv intentionally took her life in circumstances suggesting that she was experiencing significant distress from her treatment.

8. I commend Monash Health for embracing this tragic opportunity to reflect on these events and implement the significant improvements in their own practises that they have identified.

9. I further commend Liv's parents for their continued support, care and love for Liv throughout periods of time that were profoundly challenging and exhausting.

RECOMMENDATIONS

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

1. Whilst I commend the Victorian Government for developing the *Victorian Eating Disorders Strategy 2024-2031*, I recommend that they commit funding to ensure the development of at-home meal support programs designed specifically for families with children or young people suffering from eating disorders. Such programs should adopt a mental health led response to deliver holistic treatment and strengthen the support to parents or carers.

I convey my sincere condolences to Liv'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:

Angela Evans, Senior Next of Kin

Robb Evans, Senior Next of Kin

Senior Constable Jack Bennett, Coronial Investigator

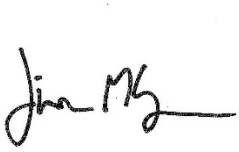
Peter Ryan, Monash Health

Alice O'Connell, K&L Gates

Meena Singh, Acting Principal Commissioner for Children and Young People

Jenny Atta, Secretary to the Victorian Department of Health

Signature:



Coroner Simon McGregor

Date: 3 September 2025

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an 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.