IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 001336

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	Edward Grant Harris
Date of birth:	19 December 2004
Date of death:	11 March 2023
Cause of death:	1a: Heroin toxicity
Place of death:	13 Datura Avenue, Cranbourne North, Victoria, 3977
Keywords:	Autism Spectrum Disorder, ADHD, Child Protection, out-of-home residential care, supported accommodation, drug toxicity

INTRODUCTION

1. On 11 March 2023, Edward Grant Harris[1] was 18 years old when he was found deceased in his bedroom. At the time of his death, Edward lived in supported accommodation at 13 Datura Avenue, Cranbourne North, Victoria.

2. Edward was born in Malvern, the second of two children to parents Louise and Paul. As a young child, Edward was happy, social and active. At around the age of five, he began to have behavioural difficulties, as he struggled with impulse control, angry outbursts, kicking, punching and screaming at others when frustrated. Yet, he was also highly social and loved company, particularly enjoying spending time with his grandparents, Anne and Dennis.[2]

3. In 2010, Edward's parents divorced and commenced a shared custody arrangement, with Edward living with his mother for the majority of the time.[3]

4. From 2012, Edward was enrolled in an independent specialist school that catered for children with specific social, emotional and behavioural needs, though he struggled to attend as he did not view himself as needing specialist help and did not enjoy being at school.[4] In this period, he developed an obsession with technology and his challenging behaviours escalated.[5]

5. In 2013, Edward began seeing Dr Lionel Lubitz, a consultant paediatrician with specialisation in autism, ADHD and anxiety disorders. Edward was diagnosed with high functioning autism and associated ADHD and major behavioural difficulties, and was prescribed Vyvanse and risperidone.[6] Edward's father observed an improvement in his anxiety symptoms, but Edward continued to struggle with socialising, and he started to lash out more frequently by kicking and punching his parents or walls.[7] He was later also diagnosed with oppositional defiance disorder.[8]

6. In 2017, Edward transitioned to high school, where he continued to experience severe anxiety and clashed with teachers. Over the next few years, Edward developed a high-level addiction to gaming and technology, and regularly punched and pushed his mother in disputes over

[1] A pseudonym. Pseudonyms have been used throughout to refer to the deceased and members of his family.
[2] Statements of Louise Harris and Paul Harris, Coronial Brief; Appendix 11 – Email statement from Anne and Dennis Ramsey, Coronial Brief.
[3] Statements of Louise Harris and Paul Harris, Coronial Brief.
[4] Statement of Paul Harris, Coronial Brief.
[5] Statements of Louise Harris and Paul Harris, Coronial Brief.
[6] Statements of Dr Lionel Lubitz and Paul Harris, Coronial Brief.
[7] Statements of Louise Harris and Paul Harris, Coronial Brief.
[8] Statement of Dr Michael Gordon, Coronial Brief.

access to his devices, also on occasion damaging property in the home. In 2018, Edward moved to a specialist school with a focus on sports, and in this period he started using illicit drugs, including marijuana, MDMA, cocaine and methamphetamine.[9]

7. In 2019, Edward moved from his mother's house to live with his father, as he had become too strong for his mother to manage him safely, but his aggressive behaviours and drug use continued to escalate.[10] In May 2020, police were called to an incident at Paul's house in which Edward punched Paul to the face and attempted to assault Paul's partner.[11] Child Protection identified protective concerns for Edward in relation to the breakdown in family relationships due to threats and physical violence by Edward towards Paul and his partner. Edward was arrested by police following the assault, which also constituted a breach of a limited Intervention Order in place against Edward. Following this incident, Edward was placed overnight in residential care, as Child Protection were unable to identify any family members that were equipped to care for him.[12]

8. On 29 May 2020, Edward was placed on an Interim Accommodation Order to out-of-home care.[13] From May 2020, Edward lived in a number of residential care homes, and his high-risk behaviours and illicit drug use continued. Edward's parents observed that he became more involved with his peer group and began to engage in criminal activities with other residents, including stealing, carjacking and assaults. He largely stopped attending school and taking the medications prescribed by Dr Lubitz. While in residential care, Edward started 'chroming',[14] overdosed on Xanax and alcohol, and self-harmed by cutting his arms, requiring hospitalisation on a number of occasions.[15] He spent three periods in a secure welfare unit in response to escalating risks of serious harm in the community, threats of harm towards his parents and carers, being missing from care, poly-substance and alcohol misuse, and unwillingness to engage with therapeutic services.[16]

[9] Statements of Louise Harris and Paul Harris, Coronial Brief.
[10] Statements of Louise Harris and Paul Harris, Coronial Brief.
[11] Statement of Paul Harris, Coronial Brief.
[12] Statement of Kirstin Hargreaves, Coronial Brief.
[13] Ibid.
[14] Inhaling volatile substances/solvents, e.g. fumes from chrome-based paints, as recreational drugs.
[15] Statements of Louise Harris and Paul Harris, Coronial Brief.
[16] Statement of Kirstin Hargreaves, Coronial Brief.

9. From 31 May 2021, Uniting (Victoria and Tasmania) (**Uniting**), a Community Service Organisation, assumed contracted case management responsibility for Edward.[17]

10. In this period Edward's parents observed that he had limited capacity for impulse control and emotional regulation, and when he was angry or upset, he would lash out at his parents and support workers and otherwise act in ways that he later regretted.[18] Edward struggled with low mood and on numerous occasions expressed to his parents that he wanted to kill himself.[19] In October 2021, it was agreed with Dr Lubitz that Edward would stop his prescribed medications until he was in a position to take them safely, as intermittent use could be counterproductive.[20]

11. During a Secure Care Service (**SCS**)[21] admission in mid-2021, Edward was assessed by clinical psychologist Robert Leardi, who provided an assessment report dated 20 August 2021. Mr Leardi made recommendations on how to work successfully with Edward and assessed him as meeting diagnostic criteria for Conduct Disorder and Autism Spectrum Disorder with features of pathological demand avoidance. Edward's intellectual functioning was also assessed by clinical neuropsychologist Dr Alan Tucker as within the mid-Borderline (Very Low) range. In his report dated 19 March 2021, Dr Tucker concluded that Edward's ASD was the major factor impacting Edward's daily functioning and that he would best be supported from an ASD-informed therapy framework.[22]

12. On 15 November 2021, a case plan meeting was chaired by Child Protection, and an application for a Care by Secretary Order (**CBSO**)[23] was made by Child Protection to the Children's Court, as Child Protection assessed that Edward was unable to return to parental

[17] Statement of Kirstin Hargreaves, Coronial Brief. A case contract is a formal arrangement in the form of a written agreement between Child Protection and another agency for the provision of case management for a child subject to a protection order. When cases are contracted, Child Protection retains ultimate case planning responsibility, but the contracted agency delivers the case management activities on a day-to-day basis.

[18] Statements of Louise Harris, Paul Harris and Ivan Duzel, Coronial Brief.

[19] Statements of Louise Harris and Paul Harris, Coronial Brief.

[20] Statement of Dr Lionel Lubitz, Coronial Brief.

[21] Statement of Kirstin Hargreaves, Coronial Brief: SCS is the current term used to refer to a secure welfare service, which is 'a community service that has lock-up facilities' that is established under the *Children, Youth and Families Act 2005*. A young person may be placed (via an interim accommodation order) in a secure welfare service by the Children's Court. Child Protection may also place a young person in secure care where the Secretary has parental responsibility and is satisfied there is substantial and immediate risk of harm and a placement in a secure setting provides the only suitable option for ensuring their protection.

[22] Statement of Kirstin Hargreaves, Coronial Brief.

[23] Statement of Kirstin Hargreaves, Coronial Brief: A Care by Secretary Order (CBSO) gives parental responsibility for a child's care to the Secretary to the Department of Families, Fairness and Housing or delegate to the exclusion of all other persons. This order is made for a period of two years. A CBSO is considered appropriate when a child has been in an out-of-home care for a period of 24 months, or earlier where it has been determined that a child will not be able to safely return to the care of the parent and the appropriate permanency objective is adoption, or permanent care, long-term out-of-home care.

care. Neither parent felt able to provide full-time care to Edward, due to continuing conflict and concerns regarding his high-risk behaviours. Edward also voiced his preference to remain in care and be supported to access independent living or supported living. The Children's Court granted the CBSO on 16 December 2021 until 18 December 2022 (the eve of Edward's 18th birthday).[24] For the duration of the order, Edward continued to have regular and positive contact with both parents. Edward's father recalled that the family was advised that a CBSO was the best way to ensure ongoing accommodation and support for Edward.[25]

13. In January 2022, Child Protection records indicate there was an escalation in Edward's threats to kill his parents, that he was in possession of a box cutter, and showing increased levels of agitation. The Uniting quarterly report dated 15 February 2022 records concerns about Edward's decreased engagement with staff, isolation, and lack of motivation, which he linked to his fear of being homeless and unsupported following his 18th birthday,[26] a fear he also expressed to his parents.[27]

14. Child Protection and Uniting arranged a Targeted Care Package (**TCP**)[28] for Edward, which commenced on 26 April 2022 and was funded to 30 June 2023, approximately six months after his 18th birthday. Uniting remained engaged with Edward throughout this TCP until the time of his death. The goals of the TCP were to support Edward to exit residential care and transition him into an independent living option.[29]

15. On 26 April 2022, Edward moved into a 'Lead Tenant' property as a step-down approach to prepare him for independent living.[30]

16. From 2 to 8 June 2022, Edward was placed back in SCS due to concerns for his immediate safety and wellbeing. Edward had overdosed from polysubstance use on 28 May 2022, and was found unconscious. There were also staff safety concerns due to other young people being at the property using substances, as well as Edward's increased aggression and threats and

[24] Statement of Kirstin Hargreaves, Coronial Brief.
[25] Statement of Paul Harris, Coronial Brief.
[26] Statement of Kirstin Hargreaves, Coronial Brief.
[27] Statements of Louise Harris and Paul Harris, Coronial Brief.
[28] A Targeted Care Package (TCP) is a funded package for children and families to attend to the child's needs and intended to minimise entry into residential care. TCPs are funded by the Department of Families, Fairness and Housing for Child Protection clients.
[29] Statement of Simona Agostina, Coronial Brief.
[30] Statement of Simona Agostina, Coronial Brief: Lead Tenant is semi-independent support and accommodation for young people aged 15-18 years who are unable to live with their family. A volunteer lead tenant lives in a residential unit with a small group of young people and provides them with support and guidance in developing their independent living skills.

continued substance use over the next few days. During this SCS admission, mental health, drug and alcohol, and health assessments were arranged, and professionals and family visited Edward to try to re-engage with him.[31]

17. As a result of this incident, the National Disability Insurance Scheme (**NDIS**) supported Specialist Disability Accommodation (**SDA**) as an accommodation option for Edward. In late August 2022, an SDA property and provider were identified, and planning was commenced for Edward to move there.[32]

18. On 17 October 2022, Edward moved into an SDA property through Best of Home Care, a registered NDIS provider, with 24-hour support. This accommodation broke down on 4 November 2022 following a physical altercation between Edward and his care staff.[33]

19. Edward then moved to 13 Datura Avenue, Cranbourne North, a residence where he was supported by Healscope, a registered NDIS provider. He was the sole resident, with one disability support worker rostered on at all times. Healscope's role included providing 24-hour care, food preparation, transport, organising and transporting Edward to appointments, cleaning, emotional and social support, and grocery shopping.[34]

20. On 28 November 2022, Child Protection submitted an application to the Victorian Civil and Administrative Tribunal (**VCAT**) for financial and guardianship administration after Edward's 18th birthday. Edward had expressed that he would not remain at his supported residence after turning 18 and there were concerns about his ability to manage his finances. Child Protection assessed that both these matters would leave Edward at significant risk of harm. The VCAT hearing was held on 15 December 2022. The application for guardianship was dismissed after Edward indicated that he wanted to remain in his supported residence. The application for financial administration was adjourned until 15 March 2023 to enable the care team to further assess Edward's capacity to manage his finances.[35]

21. As Edward's 18th birthday approached, Child Protection and Uniting undertook closure planning. Edward appeared to be settling into the Datura Avenue residence well. He had disengaged from school several months prior and was not expressing any plans for employment or training. Edward had stated that he did not want to engage with NDIS after

[31] Statement of Kirstin Hargreaves, Coronial Brief.
[32] Statement of Kirstin Hargreaves, Coronial Brief.
[33] Statement of Kirstin Hargreaves, Coronial Brief.
[34] Statement of Joppan John (1 September 2023), Coronial Brief.
[35] Statement of Kirstin Hargreaves, Coronial Brief.

turning 18 and was not engaging with any NDIS services outside of the supported residence. He continued to decline alcohol and other drug services. Child Protection records indicate Edward otherwise had a good relationship with his TCP workers from Uniting.[36]

22. On 18 December 2022, the CBSO expired, and Edward's Child Protection file was moved into closure phase.[37] From this date, Child Protection was not actively involved with Edward and it was anticipated they would cease administrative involvement following the VCAT hearing on 15 March 2023. The Department of Families, Fairness and Housing continued to fund the Targeted Care Package managed by Uniting, who were working to support Edward's transition to independent living.[38]

23. After moving to Datura Avenue, Edward's parents and NDIS support worker observed an improvement in his mood and capacity to manage his emotions and behaviour.[39] He reported to his NDIS support worker that he was no longer using methylamphetamine, but was observed to be using 'nangs',[40] which he ordered online.[41] He was engaging positively with fitness training and, on 6 March 2023, he attended a celebration for Louise's 50th birthday and engaged well with family. Edward's parents continued to have regular contact with him at the residence, including visits several days a week and daily phone or FaceTime contact.[42]

24. Edward's parents remember him as a brave and spirited person, who lived life with intensity and wild abandon. They spoke of his empathy for those less fortunate, his humour, bravery and enormous capacity for love.[43]

[36] Statement of Kirstin Hargreaves, Coronial Brief.
[37] Statement of Kirstin Hargreaves, Coronial Brief: Case closure is the last phase of Child Protection statutory involvement with a child and his/her family and is an active phase involving casework action and tasks as well as administrative tasks.
[38] Statement of Kirstin Hargreaves, Coronial Brief.
[39] Statements of Louise Harris, Paul Harris and Ivan Duzel (25 September 2023), Coronial Brief.
[40] Small cannisters of nitrous oxide bulbs, inhaled as a recreational drug.
[41] Statements of Ivan Duzel (25 and 27 September 2023), Coronial Brief.
[42] Statement of Louise Harris, Coronial Brief; Appendix 11 – Email statement from Anne and Dennis Ramsey, Coronial Brief.
[43] Statements of Louise Harris and Paul Harris, Coronial Brief.

THE CORONIAL INVESTIGATION

25. Edward'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.

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

27. 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.

28. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Edward's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

29. This finding draws on the totality of the coronial investigation into the death of Edward Grant Harris 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.[44]

30. In considering the issues associated with this finding, I have been mindful of Edward'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.

[44] 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.

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

Circumstances in which the death occurred

31. On Friday 10 March 2023, disability support worker AK[45] commenced his shift at the Datura Avenue residence at 7:00 am. During the day, Edward asked to be taken to Woolworths. The support worker drove Edward to the Cranbourne North Woolworths, where he stayed in the car while Edward spent approximately 10 minutes out of the car. AK did not observe Edward go inside the store, and noted that when he returned, he was hiding something in a white plastic bag behind his back. AK did not ask what it was and otherwise noticed nothing unusual in Edward's behaviour. When they returned home, Edward went back into his bedroom.[46]

32. Disability Support Worker VS began his shift at the residence at 6:00 pm. At handover, VS was told that Edward was 'in his room and okay'. At approximately 7:00 pm, VS knocked on Edward's bedroom door to ask him what he wanted for dinner, but received no response and assumed he was sleeping.[47] It is apparent from the statements of VS and other support workers employed at this residence that there was a general understanding that Edward spent most of his time in his bedroom and did not like to be disturbed, either by staff knocking on his door or going into his bedroom. Staff appear to have expected that Edward would come out of his bedroom when he needed something.[48]

33. At approximately 7:30 pm, Paul spoke with Edward via Facetime. Edward seemed happy. After the call, Edward and Paul texted to arrange to have breakfast the following morning.[49]

34. VS knocked on Edward's door again at around 12:00 am, 3:00 am, and 4:00 am, but received no response. He recalled hearing the fan was on in his room at these times. He did not consider it unusual to have no response from Edward, as he assumed he was still sleeping. VS awoke at 5:30 am and left the residence at 6:00 am on completion of his shift. VS confirmed that Edward had no visitors overnight, and was confident that Edward did not leave the residence at any time overnight.[50]

35. At approximately 7:10 am, disability support worker FJ arrived at the residence to commence the day shift and immediately went to the office to check the progress notes. FJ knocked on

[45] Pseudonyms have been used to refer to individual disability support workers.
[46] Statement of AK, Coronial Brief.
[47] Statements of VS (12 March and 16 November 2023), Coronial Brief.
[48] Statements of FJ (4 September 2023) and Joppan John (1 September 2023), Coronial Brief.
[49] Statement of Paul Harris, Coronial Brief.
[50] Statement of VS (16 November 2023), Coronial Brief.

Edward's bedroom door at 9:00 am and 9:30 am, but there was no response. FJ thought this was unusual, as he could usually hear Edward talking on the phone or playing video games by this time. At 10:15 am, FJ entered Edward's bedroom and found him lying face-down on the bed. When he touched his leg to wake him, he found him cold to the touch. He was unable to find a pulse. FJ called his manager, who advised him to call 000, which he did.[51]

36. A short time later, Ambulance Victoria paramedics arrived and found Edward in the bedroom, clearly deceased. Edward was formally pronounced deceased at 10:34 am.[52]

37. Police attended and examined the scene. In surveying Edward's bedroom, they located two small snap-lock bags on the bed, one containing white powder and the other empty, as well as 81 nitrous oxide cannisters.[53] Preliminary testing of the white powder indicated that it was heroin.[54]

38. Subsequent analysis of Edward's mobile phone revealed messages between an unknown Instagram user and Edward on 7 March 2023 asking Edward if he still wants 'the drip or some buds for cheap', offering to do '10 a gram'. Numerous messages were located on Edward's phone which indicated purchases of nitrous oxide, as well as numerous messages from Australia post about parcel deliveries. Between 10:30 am and 2:02 pm on 10 March 2023, Edward's internet browser history showed searches for 'how long does heroin last', 'is sleeping on heroin dangerous', 'how long does heroin snorted take to kick in', 'heroin safety for first time user', and 'does heroin make you vomit', and 'heroin breathing problem death'.[55]

Identity of the deceased

39. On 16 March 2023, Edward Grant Harris, born 19 December 2004, was visually identified by his father, Paul Harris.

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

[51] Statement of FJ (11 March 2023), Coronial Brief.
[52] Statement of Ryan Griffin, Coronial Brief.
[53] Exhibit 3 – Scene photographs, Coronial Brief.
[54] Exhibit 11 – TruNarc Scan Report, 20 March 2024, Coronial Brief.
[55] Exhibit 10 - Cellebrite mobile phone download, Coronial Brief.

Medical cause of death

41. Specialist Forensic Pathologist Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 15 March 2023 and provided a written report of her findings dated 16 August 2023.

42. The autopsy revealed no evidence of significant injury or violence, and no evidence of significant natural disease.

43. Dr Francis found some focal myocardial fibrosis and small vessel disease in the myocardium. While some of these changes may be related to stimulant use, there is no clear evidence that Edward used stimulant drugs such as methamphetamine or cocaine. As some of these changes may also be related to hereditary conditions, Dr Francis recommended that relatives attend their General Practitioner for a risk assessment.

44. Toxicological analysis of post-mortem blood samples identified the presence of morphine (~0.2 mg/L) and a small amount of codeine (~0.03 mg/L). 6-Monoacetylmorphine[56] was detected in the urine (>1.0 mg/L), indicating recent ingestion of heroin.[57] Alcohol, volatile compounds and novel psychoactive substances were not detected in the blood.

45. Dr Francis explained that heroin acts as a depressant of the central nervous system as it reduces the rate and depth of breathing and eventually it can cause cessation of the breathing reflex. In deaths due to heroin use, death can be immediate. The exact mechanism of death is unknown in these cases, but may be a result of a heroin overdose (as a result of the pharmacologic properties of the drug). The mechanism of this is usually central nervous system depression causing decreased respiration. Death can also be a complication of unconsciousness caused by a non-fatal overdose in which the unconscious person may suffer airway obstruction either due to posture or airway obstruction due to vomit. It is not possible to definitively exclude positional issues as a potential contributing factor to the mechanism of death.

46. Dr Francis noted that it is not possible to detect nitrous oxide in post-mortem toxicology. Recreational nitrous oxide use may cause hypoxia and/or cardiac arrhythmias. It is not known whether Edward was using nitrous oxide around the time of his death, however, given the

[56] An unequivocal marker of heroin use
[57] In urine, 6-Monoacetylmorphine has a window of detection of up to 12 hours after heroin use.

presence of gas cannisters in his bedroom at the time of his passing, the possibility that nitrous oxide use may have had some contribution to his death cannot not be excluded.

47. Postmortem biochemistry showed electrolytes within normal post-mortem limits. Tryptase[58] levels were found not to be elevated, indicating that Edward had not recently experienced anaphylaxis.

48. On the basis of her findings, Dr Francis provided an opinion that the medical cause of death was 1(a) heroin toxicity.

49. I accept Dr Francis's opinion.

FAMILY CONCERNS

50. In his statement dated 15 September 2023, Edward's father, Paul, expressed concerns about the Child Protection system, particularly relating to residential care, and Edward's exposure to a negative peer group during his teenage years.[59]

51. In her statement dated 24 October 2023, Edward's mother, Louise, expressed feeling failed by the education system and support services and expressed the following concerns:

    a) That children with complex disabilities should not be placed in group residential homes;

    b) That current therapeutic interventions to support children and families experienced complex behaviours of concern are inadequate;

    c) That Child Protection practitioners should be better educated about the complexities of children living with disabilities, and that Care by Secretary Orders ought not be made in respect of children with disabilities;

    d) That disability support housing should be reviewed; and

[58] An enzyme released by mast cells in the setting of anaphylaxis which peaks approximately one hour after the onset of anaphylaxis.
[59] Statement of Paul Harris, Coronial Brief.

e) That Autism Spectrum Disorder subtypes should be included in the DSM-5 to improve recognition and availability of appropriate therapeutic supports.[60]

52. In response to the Coronial Brief of Evidence, Louise also made comprehensive written submissions expressing grave concerns about Edward's experiences in out-of-home care, stating:

> *'Our families direct lived experience mirrors [research that shows] "… the government isn't meeting its targets on prioritising restoring children into the care of their families within two years when safe to do so". The trauma which Edward experienced due to his relinquishment, combined with the flawed therapeutic interventions delivered to him whilst in state care, ultimately rendered any possibility of reunification impossible. By the time Edward was placed on a CBSO, the complexities of his mental health concerns, which now included PTSD, were so acute that he was regularly being involuntarily admitted into hospital and secure welfare, given his persistent attempts to end his own life. To have lived this experience, with Edward, was a parent's worst nightmare.*[61] [citations omitted]

53. Louise advocates strongly for increased recognition of Pathological Demand Avoidance, which is not currently recognised as a standalone mental health condition in Australia. To support her submission, Louise developed a survey and gathered responses from 79 parents and carers of children with PDA, with her findings indicating that many carers for children and young persons with PDA presentations feel unsupported by therapeutic professionals and the education system. On the basis of her findings, Louise has formulated a suite of detailed recommendations calling for increased education and funding in the mental health, education and disability support systems to provide better treatment and support to children with the PDA profile and their families.[62]

54. Whilst I appreciate the time taken to detail these concerns and recommendations, the role of the coroner is limited. I am only empowered to examine matters that are proximate and causative, or contributory, to a death. Coroners do not investigate aspects of care that have not contributed to a person's death. The limitations on this jurisdiction sometimes lead to the result that concerns raised by families are not able to be investigated because they are not sufficiently connected with the cause and circumstances of their loved one's death.

[60] Statement of Louise Harris, Coronial Brief.
[61] Coronial Brief Response of Louise Harris dated 2 June 2024.
[62] Coronial Brief Response of Louise Harris dated 2 June 2024.

55. Here, the recommendations formulated by Louise on the basis of her research largely fall outside the scope of this coronial investigation, but I commend her tenacious advocacy on behalf of her son in extremely difficult circumstances.

CPU REVIEW

56. As a result of receiving the family's concerns, I directed the independent practitioners in the Mental Health and Disability Investigation Team of the Coroners Prevention Unit (**CPU**)[63] to review Edward's case.

57. The CPU clinicians confirmed that Pathological Demand Avoidance (**PDA**) is not listed in the two diagnostic manuals most commonly used in psychiatry and psychology to diagnose mental health and developmental conditions, the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the World Health Organization's International Classification of Diseases (ICD-11). The CPU noted that many of the features described in PDA are present in a subset of people with Autism Spectrum Disorder (**ASD**), but there are no specific evidence-based recommended treatments or management strategies for PDA. As such, it is not widely accepted in the Australian psychiatry/psychology/paediatric sectors as a diagnosis that requires specific treatment.

58. On review of Edward's relevant reports and assessments, the CPU observed that at the time of his ASD diagnosis, it was described as 'high functioning' or 'Aspergers'. The terminology surrounding ASD has since changed, and these terms are no longer used; rather, ASD is classified into categories of functional impairment requiring different levels of support (Levels 1-3). They considered that this aspect of his early diagnosis may have led Edward's parents to understandably feel that many of his challenges could not solely be accounted for by ASD. However, based on subsequent comprehensive psychology reports during his adolescence,[64] the CPU were of the view that Edward's ASD likely had a far greater functional impact than may have been initially understood, compounded by his borderline intellectual capabilities.

[63] 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.

[64] Records of Uniting (Victoria & Tasmania) Ltd.

59. As Edward grew from a young child into an adolescent, the challenges from his neurodiversity may have become more apparent as the gap between him and his peers widened. This may have been underappreciated given the initial impression of his ASD at a young age. As a consequence of this, he may not have received the scaffolding and support he required, resulting in a cascade of behavioural challenges that he faced in his teenage years. This was further compounded by changes in the family unit, his co-occurring diagnoses of ADHD and borderline intellectual function, and the significant trauma often faced by young people in out of home care.

60. With regard to his death from heroin, the CPU considered that this does not appear to have been due to him residing in residential care, as Edward was already sourcing illicit substances while living with a parent.

61. Ultimately, the CPU clinicians concluded that Edward's death appears to have been a tragic outcome of all the culminating factors discussed above, and there was no clear point in time when his death may have been prevented. This was despite him having a loving, dedicated and resourceful family who clearly sought all the resources and support that were available to them.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Edward Grant Harris, born 19 December 2004;

    b) the death occurred on 11 March 2023 at 13 Datura Avenue, Cranbourne North, Victoria, 3977, from 1(a) heroin toxicity.

    c) the death occurred in the circumstances described above.

63. Having considered all of the circumstances, I am satisfied that his death was the unintended consequence of the deliberate ingestion of heroin.

I convey my sincere condolences to Edward's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this deidentified 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:

Louise Harris, Senior Next of Kin

Paul Harris, Senior Next of Kin

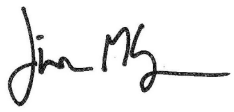
Uniting (Victoria & Tasmania) Ltd (c/- Dora Cosentino, MinterEllison)

Danielle Kelley, NDIS Quality & Safeguards Commission

Office of Professional Practice, Department of Families, Fairness and Housing

Detective Leading Senior Constable Senka Markovic, Coronial Investigator

Signature:



Coroner Simon McGregor

Date: 28 January 2025

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