IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 786

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, CAITLIN ENGLISH, Coroner having investigated the death of Brenton James Grosser

without holding an inquest:
find that the identity of the deceased was Brenton James Grosser
born on 6 August 1963
and the death occurred on 21 February 2013
at 13 Kevin Street, Pascoe Vale, Victoria
from:

1 (a) DRUG TOXICITY (METHADONE)

Pursuant to section 67(1) of the **Coroners Act 2008**, there is a public interest to be served in making findings with respect to **the following circumstances**:

1. Brenton Grosser was 49 years of age at the time of his death. For a short time he resided at a rooming house, 13 Kevin Street, Pascoe Vale, Victoria. Mr Grosser was studying to be a chef at the School of Hospitality and Training in Melbourne. He had divorced in 1992 and had three daughters. Mr Grosser had experienced periods of homelessness in recent times prior to his death.
2. A police investigation was conducted into the circumstances of his death.
3. A brief prepared by Victoria Police for the coroner includes statements obtained from Mr Grosser's housemates, treating health practitioners and investigating police officers. I have drawn on all of this material as to the factual matters in this finding.

Health History

4. Mr Grosser had a history of right epididymo-orchitris[1], alcohol addiction and acute pancreatitis.

Events Proximate to Death

5. On 20 February 2013, Mr Grosser commenced drinking alcohol during the afternoon with another housemate, Alf Crooke. Mr Crooke estimated that Mr Grosser consumed 2 litres of wine and six beers.

6. Mr Grosser went to bed at approximately midnight on Mr Crookes' bed. Mr Crooke went to bed at approximately 1am and saw Mr Grosser seemingly asleep. He thought Mr Grosser had passed out following the amount of alcohol he had consumed. He wrapped a blanked around his feet as he thought he looked cold.

7. Mr Crooke awoke at approximately 8.30am on 21 February 2013 and attempted to wake Mr Grosser. After noticing his arm to be rigid and that he was unresponsive, Mr Crooke attempted CPR but could not obtain a response. He left the house and went down the street to call an ambulance from a phone box.

8. Paramedics and fire brigade attended promptly and located Mr Grosser deceased.

9. Police attended the scene. They were advised by Mr Crooke that he had three full 100mg bottles of methadone that had been prescribed to him in his room the evening prior and that they were now empty.

10. Mr Crooke was prescribed Methadone (four 100ml takeaways) which he collected from Brunswick Pharmacy, Sydney Road on a weekly basis. He stated that he took approximately 100ml a day (20mg concentrate) and that that he had left three of these bottles in his room the night prior to Mr Grosser's death in his suitcase. The following day Mr Crooke noted that all three bottles were empty and assumed that Mr Grosser had taken them.[2] Photographs on the coronial brief indicate three bottles labelled '100ml methadone take away dose' on the side table in Mr Crooke's bedroom.

11. Attending police officer Detective Senior Constable Tanya Baker stated that;

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[1] Epididymo-orchitis is inflammation of the epididymis, and occasionally the testis.

[2] Statement of Alf Crooke, 21 February 2013, 2.

"It is my opinion that [Mr] Grosser consumed three bottles of methadone belonging to Alf Crooke and this is what caused his death. It is unclear if [Mr] Grosser drank these bottles with the intention of committing suicide, or if his death was accidental. I do not believe that [Mr] Crooke assisted [Mr] Grosser or was involved in his death in any way."[3]

Post Mortem Examination

12. A post mortem autopsy and report was completed by Forensic Pathologist Dr Kate Strachan at the Victorian Institute of Forensic Medicine on 27 February 2013. Dr Strachan formulated the cause of death. I accept her opinion. Dr Strachan noted that;

"Histological examination of the myocardium showed occasional myocyte hypertrophy and a minimal increase in interstitial fibrosis. Mild intimal thickening was identified in the main coronary artery branches but no critical stenoses were seen. Sections of the liver showed mild portal chronic inflammation but no active hepatitis or fibrosis was seen.

Toxicological studies performed on blood sampled after death showed methadone at 0.3 mg/L and Eddp (methadone metabolite) at 0.02 mg/L. Methadone and Eddp were also detected in urine. Ethanol was present in blood at 0.08 g/100mL, and in vitreous at 0.07 g/100mL...

Methadone is a synthetic narcotic analgeic used for the treatment of opioid dependency or treatment of severe pain. It has a depressive effect on the central nervous system and can result in repiratory depression and sedation. Non-habitual methadone users are more at risk of methadone toxicity due to a lack of opiate tolerance. There is an additive CNS depressive effect with concurrent use of methadone and alcohol, enhancing the respiratory depressive and sedative effects."

13. Blood methadone concentrations have been shown to range from 0.06 – 3.0mg/L in fatal methadone overdoses.

Finding

I find that Brenton Grosser died from drug toxicity to methadone. It appears he consumed three 100ml takeaway methadone bottles which were prescribed to his housemate. There is no evidence to indicate that he took the dose intentionally to end his life.

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[3] Statement of Detective Senior Constable Tanya Baker, 10 October 2013, 3.

Recommendation

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation connected with the death:

I support the comments and recommendations made by Coroner Jamieson in her finding following inquest into the death of *Shannon James Lees (Peat) COR 2012 485*. Coroner Jamieson noted that;

"It is evident that far too many Victorians have recently died by overdosing on diverted methadone that was dispensed as a takeaway dose to an opioid replacement therapy client. The frequency of deaths - at least 58 confirmed deaths between 2010 and 2013, and probably far more than this - is evidence that current regulation of access to takeaway methadone in Victoria does not adequately manage the risk of dose diversion. The longer-term trend in overall Victorian methadone overdose deaths, which were relatively stable at between 22 and 34 per year in 2000-2006, then increased steadily after access to takeaway dosing was expanded, reaching 70-74 deaths per year in 2011-2013, also evidences this concern."[4]

I support the recommendations made by Coroner Jamieson in her finding and recommend that;

1. That the Victorian Department of Health request the Advisory Group for Drugs of Dependence review the circumstances of Brenton Grosser's death, when considering whether the current takeaway dosing advice in the Victorian Policy for Maintenance Pharmacotherapy for Opioid Dependence adequately balances client benefits with risks to public health and safety.

2. That the Victorian Department of Health request the Advisory Group for Drugs of Dependence to consider the probable impact on pharmacotherapy clients and the broader public, of revising the *Policy for Maintenance Pharmacotherapy for Opioid Dependence* so that an opioid replacement therapy client is eligible to receive at most two takeaway methadone doses per week and no consecutive takeaway doses. Given the current significant harms associated with methadone takeaway dose diversion, the Advisory Group for Drugs of Dependence should ideally report publicly on its conclusions, so the Victorian public is informed as to the rationale for the Advisory Group and Department of Health's stance on access to takeaway methadone.

I direct that a copy of this finding be provided to the following for their information only:
Ms Christine Grosser

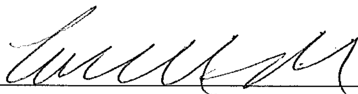
[4] *Shannon James Lees (Peat) COR 2012 485*, 20 of 24.

Detective Senior Constable Callan Heaney

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

Dr Pradeep Phillip, Secretary, Department of Health

Signature:



CAITLIN ENGLISH
CORONER
Date: 20 July 2015