IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 005699

FINDING INTO DEATH WITHOUT INQUEST

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

I, K. M. W. PARKINSON, Coroner having investigated the death of DION HEATHER without holding an inquest:

find that the identity of the deceased was DION HEATHER
born on 24 November 1971
and the death occurred on 5 December 2009
at South Melbourne, Victoria

from:

1a. ASPIRATION OF GASTRIC CONTENT

1b. COMBINED DRUG TOXICITY (METHADONE, BENZODIAZEPINES, OLANZAPINE AND ALPRAZOLAM)

Pursuant to Section 67(2) of the *Coroners Act 2008*, I make these findings with respect to the following circumstances:

1. Mr Heather was born on 24 November 1971 and he was 38 years old at the time of his death. Mr Heather resided in Elsternwick, Victoria and he would often visit his then girlfriend, Ms Tanya Harper at her residence in South Melbourne, during the course of their relationship.

2. A brief prepared by Victoria Police for the Coroner includes statements obtained from Mr Heather's friends, his clinician and from investigating officers. I have drawn on all of this material as to the factual matters in this finding.

3. Mr Heather had a history of substance abuse, including alcohol, illicit drugs and prescription medication. At the time of his death, he was being treated by his General Practitioner, Dr Yona Josefsberg and was receiving Diazepam tablets (5mg x 3), Olanzapine wafer (5mg x 2) and Alprazolam tablets (2mg x 3) on a daily basis along with his 90mg dose of methadone.[1] He last presented to Dr Josefsberg on 3 December 2009 with a chest infection and had been prescribed antibiotics.

4. Prior to commencing treatment with Dr Josefsberg, Mr Heather had been an inpatient at Caulfield Hospital. Caulfield Hospital referred Mr Heather to Dr Josefsberg, informing her that Mr Heather's medical conditions included him being an ex-IV Drug User, having chronic pain secondary to chronic osteomyelitis and suffering from anxiety and depression. Dr Josefsberg was directed to continue opiate replacement therapy for Mr Heather, which had been initiated at the South City Clinic, a specialist addiction clinic.

5. Mr Heather's methadone prescriptions were dispensed by a regular pharmacy, the Russell Frajman Pharmacy in St Kilda.

6. Methadone is a prescribed drug pursuant to Schedule 8 of the *Drugs, Poisons and Controlled Substances Act 2006*. The supply of methadone is regulated under the *Drugs, Poisons and Controlled Substances Act 1981* and *Regulations 2006*. Medical Practitioners and Pharmacists prescribing or dispensing pharmacotherapy (methadone and buprenorphine) require approval from the Drugs and Poisons Reference Group (DPRG) of the Department of Health (Cwlth). The prescribing and dispensing of methadone is regulated by that Act and there are professional practice guidelines issued by professional bodies and by the health or community services departments of both the State and Commonwealth.

7. Methadone is usually dispensed by the pharmacist to the patient at the pharmacy where it is ingested under the supervision of the pharmacist. This enables supervision of consumption as well as ensuring no adverse reaction or combination with other substances. A practice known as take away doses exists by which a stable patient may be allowed to take home doses a limited number of days per week, often weekends. This measure is largely for the convenience of the patient.

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[1] Statement of Russell Frajman dated 9 August 2011.

8. In the last couple of months before his death, Mr Heather was prescribed 90mg of methadone daily. He was authorised by his doctor for take away doses on a regular basis. Mr Heather was allowed to have five takeaway doses of methadone within a seven day period but never more than three consecutive doses without presenting for doses at the pharmacy.[2]

9. In the evening of Friday 4 December 2009, Mr Heather attended the unit of his neighbour, Ms Catherine La Ponder to see his girlfriend, Ms Tanya Harper, who was visiting Ms La Ponder at the time. After some time, Ms La Ponder requested that Mr Heather leave her apartment as she believed he was affected by some substance. Both Mr Heather and Ms Harper left and went to Mr Heather's apartment.

10. Ms Harper has stated that Mr Heather told her that he had incorrectly taken two doses of his takeaway methadone as he was confused with what day of the week it was.[3] Shortly after returning to Mr Heather's apartment, Mr Heather and Ms Harper fell asleep on the couch. Ms Harper woke during the night as she was uncomfortable and had indicated that she heard Mr Dion "moaning and groaning". She got off the couch and moved Mr Heather to the floor, with his assistance. She then returned to the couch to sleep.

11. In the morning of Saturday 5 December 2009, Ms Harper woke and noticed that Mr Heather was still asleep which she thought was unusual as he did not usually sleep for very long. She touched him and observed him to be cold and not breathing. Ms Harper immediately called for Ms La Ponder, a former nurse, to attend. Ms Harper and Ms La Ponder called emergency services and administered CPR which was then continued by the ambulance services when they arrived however Mr Heather was unable to be revived. It was reported that Mr Heather had been revived several times within the last two weeks following other incidents.[4]

12. An autopsy and report was undertaken by Dr Malcolm Dodd, Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Dodd reported that the cause of death was 1(a) Aspiration of Gastric Content and 1(b) Combined Drug Toxicity (Methadone, Benzodiazepines, Olanzapine and Alprazolam). Dr Dodd noted that the combined effects of Mr Heather's drugs led to central nervous system depression leading to aspiration of gastric

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[2] Statement of Dr Yona Josefsberg dated 16 August 2011, page 2.

[3] Statement of Tanya Harper dated 3 August 2011, page 2.

[4] Statement of Catherine La Ponder dated 2 August 2011, page 2.

content. There were no significant injuries detected in the examination that would have contributed or led to death.

13. Toxicological analysis identified methadone (0.7 mg/L), diazepam (0.4 mg/L) and its metabolite, nordiazepam (0.5 mg/L), olanzapine (0.6 mg/L), alprazolam (0.2 mg/L) and delta9-tetrahydrocannabinol (15 ng/mg) in blood.

14. I am satisfied having considered all of the evidence before me that no further investigation is required. I am satisfied that there were no suspicious circumstances surrounding Mr Heather's death.

15. I find that Mr Dion Heather died on 5 December 2009 and that the cause of his death was Aspiration of Gastric Content and Combined Drug Toxicity (Methadone, Benzodiazepines, Olanzapine And Alprazolam).

COMMENTS

Pursuant to section 67(3) of the *Coroners Act* 2008, I make the following comments connected with the death:

1. The program allowing for 'take-away' methadone a Schedule 8 drug, by a substance addicted person, for consumption in the home, is undertaken with little actual oversight or supervision.

2. I have commented about the availability of 'take-away' methadone in previous findings. The availability of a Schedule 8 drug designed and prescribed for treating illicit drug addiction, to be 'taken-away' by a registered addict to be used by them in the community, in circumstances where there is little or no supervision by authorities, is a danger to public health and safety and should be ceased.

RECOMMENDATIONS

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

1. That the Minister for Health take steps to prohibit the supply of 'take-away' doses of the Schedule 8 drug methadone by drug addicted persons and require that methadone therapy be

delivered and administered at a pharmacy premises under the supervision of a registered pharmacist.

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

The family of Mr Dion Heather;
The Investigating Member;
The Minister for Health (Victoria);
The Minister for Community Services of Victoria;
The Health Practitioner's Board Australia;
The National Pharmacy Board of Australia; and
Interested parties.

Signature:

K. M. W. PARKINSON
CORONER
Date: 1 October 2013