IN THE CORONERS COURT
OF VICTORIA
AT WANGARATTA

Court Reference: 1803/2010

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: JOSHUA MELOURY-KAUP

Delivered On:	18 July 2012
Delivered At:	Coroners Court of Victoria Faithfull Street, Wangaratta
Hearing Dates:	16 March 2012
Findings of:	Coroner Susan Armour
Representation:	Sergeant Mario Eliades, Victoria Police, Wangaratta to assist the Coroner Mr P Skehan of Counsel instructed by Trish Devlin Lawyers on behalf of Ms Jan Meloury

I, SUSAN JANE ARMOUR, Coroner having investigated the death of

JOSHUA MELOURY-KAUP

AND having held an inquest in relation to this death on 16 March 2012

at Wangaratta

find that the identity of the deceased was JOSHUA ZANE MELOURY-KAUP

born on 31 July 1994

and the death occurred on 14 May 2010

at 135 Rowan Street, Wangaratta, Victoria, 3677

from:

1(a) MIXED DRUG TOXICITY (MORPHINE, 7-AMINOCLONAZEPAM, FLUOXETINE, SERTRALINE)

in the following circumstances[1]:

BACKGROUND

1. Joshua Meloury-Kaup was a 15 year old boy who, at the time of his death, was staying with his maternal grandparents at 135 Rowan Street, Wangaratta in Victoria, having been placed in the care of his grandmother under an interim accommodation order made by the Wangaratta Children's Court on 10 May 2010. Joshua, known to his family as Josh, had previously resided with his mother, Jan Meloury, at her home in Wangaratta.

2. Ms Jan Meloury, by letter from her solicitor dated 20 September 2011, indicated that she intended to seek leave to appear as an interested party at any inquest. Leave was subsequently granted on 16 March 2012. A number of matters were raised on behalf of Ms Meloury who

[1] The circumstances of Joshua Meloury-Kaup's death were the subject of an investigation by Senior Constable Colin Boyle (34657) of Victoria Police who prepared an Inquest Brief for the Coroner. I have drawn from this investigation in making my factual findings, together with the vive voce evidence of Dr Terry Stubberfield and Dr Roger Foot who gave evidence at the inquest, the statements and documents tendered in evidence together with the transcript of those proceeding.. This finding does not purport to refer to all aspects of the evidence obtained during the course of that investigation.

contended that Josh may have self-medicated using medication prescribed for his grandmother as a result of sleep deprivation and/or sleep disturbance arising from the cessation of Lovan ("fluoxetine") and prior to the commencement of a different drug, Chlorpromazine[2].

PURPOSE OF A CORONIAL INVESTIGATION

3. The primary purpose of a coronial investigation is to ascertain, if possible, the identity of the deceased person, the cause of death, the circumstances in which the death occurred and the particulars needed to register the death, namely:

a. the deceased's full name;

b. date of birth or age at his or her last birthday;

c. cause of death;

d. date and place of death;

e. the gender of the deceased; and

f. whether or not the deceased was Aboriginal or Torres Strait Islander origin, if known.

4. The *cause of death* is the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death whilst the *circumstances in which the death occurred* refers to the context or background and surrounding circumstances. These circumstances must be sufficiently proximate and causally relevant to the death and not merely circumstances which might form part of a narrative or chronology culminating in the death.

---

[2] The matters raised by Ms Meloury could be categorized as:

a. Concern in relation to actions of the Department of Human Services during and after Josh's time in secure welfare, including the Department's decision to seek an order placing him in the care of the maternal grandmother and not in other supervised care on release from secure welfare (Item 1,2 & 3);
b. The nature of the drug Lovan and its side effects and the decision to alter the dosage of Lovan and the timing of that change, and the subsequent decision to cease Lovan and substitute Chlorpromazine, including the impact that such a change would have on Josh's sleep disturbance, and any communications between her son's treating psychiatrist and his paediatrician in relation to those changes (Item 4,5,6,7,8,9,11 & 12); and
c. The communication by medical practitioners to the parent or maternal grandmother of any potential side effects arising from the cessation of Lovan (Item 10).

THE INQUEST

5. Josh's identity, the date and place of his death and the medical cause of his death, namely "Mixed Drug Toxicity (Morphine, 7-Aminoclonazepam, Fluoxetine, Sertraline)" were not contentious. The focus of the inquest was to clarify the nature of Josh's medications, the purpose for which Lovan was originally prescribed and the likely impact, if any, of Josh ceasing Lovan on 13 May 2012. At the inquest I heard evidence from Dr Terry Stubberfield, his paediatrician, and Dr Roger Foot, a child and adolescent psychiatrist, both of whom had seen Josh shortly prior to his death and were able to comment, inter alia, on the reasons for prescribing Lovan for Josh, the subsequent reduction of the dose and the later decision to cease that medication.

6. Dr Stubberfield gave evidence that Josh had been diagnosed with ADHD at the age of four and was later diagnosed with Generalized Anxiety Disorder, presenting with challenging behaviours over the years. He had experienced difficulties in sleeping since 2002 and was originally prescribed Catapres to address that issue. Dosages were increased over the years but eventually became ineffective and Neulactil was then tried in early 2009 but it did not assist Josh to sleep and caused some dizziness. On 22 January 2010, Dr Stubberfield prescribed Lovan 20mg, an anti-depressant, for the purpose of assisting Josh with sleep rather than depression and, when the dose was not found to be effective, he increased the dosage to 40mg on 15 February 2010.

7. Josh was again referred to the North East Child and Adolescent Mental Health Service ("NECAMHS") in February 2010 after reports that his behaviour at home and at school had deteriorated. Josh was seen by Dr Foot, an adolescent and child psychiatrist who was consulting to NECAMHS, on 30 March 2010 and again on 13 April 2010 after reports suggested that Joshua had become increasingly volatile and impulsive over the preceding two weeks. On 13 April 2010 Dr Foot emailed Dr Stubberfield, Josh's paediatrician who prescribed his medication, and suggested that the increased dose of Lovan from 20mg per day to 40mg per day may have precipitated an elevation in mood and contributed to increased risk taking and impulsive behaviours. He recommended reducing the dose of Lovan to 20mg in the hope that Josh may

continue to benefit with sleep but may experience some moderation of his recent behavioural excesses[3].

8. On 15 April 2010 a Protection Application by Safe Custody was filed in the Children's Court of Victoria at Wangaratta by the Department of Human Services ("DHS") and Josh was placed on an Interim Accommodation Order in the care of his mother, Ms Jan Meloury for two weeks. However, on 18 April 2010 Victoria Police were called to the residence in respect of an incident involving Josh and, as a result of that incident, he was placed in DHS Secure Welfare in Melbourne where he remained for three weeks. He was on both Ritalin and Lovan 20mg whilst in Secure Welfare[4] and on 28 April 2010 Dr Stubberfield wrote a prescription for Lovan 20mg for Josh although did not see him whilst he was in Secure Welfare. On Monday, 10 May 2010 Josh was released from Secure Welfare when the Children's Court of Victoria at Wangaratta placed Josh with his maternal grandmother, Mrs Rebecca Meloury, on an Interim Accommodation Order.

9. On Tuesday, 11 May 2011 Dr Foot saw Joshua again and found him considerably more settled in his general behaviour. However, Josh was having great difficulty sleeping since his dose of Lovan had been reduced from 40mg to 20mg and Dr Foot undertook to contact Dr Stubberfield to discuss possible strategies for sleep disturbance. By email to Dr Stubberfield dated 11 May 2010 Dr Foot suggested the use of Largatil 10mg for Josh with a progressive increase in dose to strike a balance between a hypnotic dose and daytime sedation[5]. When Dr Stubberfield saw Josh the following day on Wednesday, 12 May 2010 he appeared happy and engaged reasonably well but both Josh and his mother reported that Josh was having ongoing difficulties with getting off to sleep. On the recommendation of Dr Foot, Dr Stubberfield advised Josh to continue with Ritalin (10mg 2-3 times a day) but to cease taking 20mg Lovan at night with the intention that Josh commence a new medication, chlorpromazine ("Largactil") at 10mg at night the following week to address the sleep issues.

---

[3] Exhibit 2

[4] Statement of Jannette Christine Battley, Manager Secure Welfare, DHS, made October 2011 at paragraph 8.

[5] Exhibit 4

10. Josh's grandmother, Mrs Rebecca Meloury, reported that Josh didn't sleep at all on the Wednesday night after stopping Lovan. His grandfather, Laurence Meloury, described Josh as appearing "happy as Larry" on Thursday, 13 May 2010 although he had a cold and only ate half his dinner. That night his grandmother made him stay up until 11pm to ensure that he slept through the night. Josh went to sleep on a mattress in the foyer, next to the ducted heating, and to her knowledge he didn't stir before she went to bed around 2.00am. Josh's grandfather woke around 7.15am on Friday, 14 May 2010 and, on his return from the bathroom, noticed that his grandson was snoring loudly. At approximately 8.45am Josh's grandmother went to wake Josh and found him lying on his back, his colour normal but with thick drool coming from his mouth. She attempted CPR until the paramedics arrived and although further attempts were made at resuscitation, Josh was pronounced dead around 9.40am.

11. Police attended and found no signs of trauma, injury or needle marks or any other indicators of suspicious death. The mattress and bedding were examined and a small amount of vomit was observed on the pillow. Josh's medication was examined as were other medications in the household but nothing was found to be missing at that time. Preliminary toxicology, however, revealed the presence of Aminoclonazepam ("Rivotril"), Fluoxetine ("Lovan"), Morphine and Sertraline ("Sertra") in Josh's blood. Mrs Rebecca Meloury was prescribed MS Contin ("morphine sulphate"), Rivatril and Sertra and a further examination of her medications, kept in an unlocked cupboard in the kitchen, revealed that some medication were, in fact, missing. One of the two boxes of MS Contin (10mg x 60), belonging to Mrs Rebecca Meloury was obviously open and the other was apparently sealed. Mrs Meloury had believed the second, apparently sealed box of MS Contin to be unopened but it was found to contain only four of the six sleeves of ten tablets, with 20 tablets missing.

12. Victoria Police who investigated the circumstances surrounding Josh's death did not identify any suspicious circumstances. The investigating officer concluded that Josh had taken some of his grandmother's medications, ignorant to their strength, possibly to assist him to sleep.

13. An autopsy was performed by Dr Duncan MacGregor, Forensic Pathologist with the Victorian Institute of Forensic Medicine ("VIFM") who also reviewed the circumstances of Josh's death, spoke with Dr Terry Stubberfield and provided a written report of his findings. Dr MacGregor noted that Dr Stubberfield's had seen Josh several days prior to his death and did not consider he was at risk of self-harm or suicide. Toxicological analysis of post-mortem blood samples was negative for alcohol but positive for 7-aminoclonazepam ("Rivotril") (~ 0.4 mg/L), fluoxetine ("Lovan") (~ 0.1 mg/L), morphine, free 0.4mg/L; sertraline ("Sertraline") (~ 1.5 mg/L). The report of the forensic toxicologist, Mr Alex Kotsis of VIFM, noted the level of fluoxetine ("Lovan") was within in the therapeutic range.

14. Dr MacGregor commented that toxicology results indicated several compounds in peripheral blood (7-aminoclonazepam ~ 0.4 mg/L; fluoxetine ~ 0.1 mg/L; morphine, free 0.4mg/L; sertraline ~ 1.5 mg/L) and that the effect of these drugs, at those levels, was likely to have been significant central nervous system depression. He identified the medical cause of death to be mixed drug toxicity (morphine, 7-aminoclonazepam, fluoxetine, sertraline) with a likely terminal mechanism of respiratory depression.

15. Dr Foot, who had last seen Josh on Wednesday, 11 May 2010, gave evidence at the inquest that he had no reason to suspect self-harm when he last saw Josh. Dr Stubberfield gave evidence that, given the long half life of Lovan, it was unlikely that there would be any withdrawal effects as a result of cessation of the medication. Lovan had been prescribed to assist Josh with sleep and, given it had not been effective in doing so after the dose had been reduced from 40mg to 20mg, Dr Stubberfield did not consider that cessation of Lovan would result in any adverse response. He did not observe any such adverse response when the dose was decreased and, given the likelihood that the original increased dose had exacerbated Josh's daytime behaviour and the reduced dose was ineffective in addressing Josh's sleep issues, it seemed sensible to try an alternative medication.[6]

---

[6]Transcript at 37-40.

16. I find that Joshua MELOURY-KAUP died from mixed drug toxicity (morphine, 7-aminoclonazepam, fluoxetine, sertraline) but that his death was an unintended consequence of his intentional act of taking Rivotril, Sertra and MS Contin in combination while Lovan was still present in his system.

Signature:

SUSAN JANE ARMOUR
CORONER

Date: 18 July 2012