IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 4969

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	CAITLIN ENGLISH, CORONER
Deceased:	Nathan Dimech
Date of birth:	29 June 1996
Date of death:	1 November 2013
Cause of death:	1(a) Global cerebral ischaemic injury and aspiration pneumonia post cardiac arrest 1(b) Methadone toxicity
Place of death:	Royal Melbourne Hospital 300 Grattan Street, Parkville, Victoria

1. Nathan Dimech was born on 29 June 1996. He was seventeen years old when he died from complications following a cardiac arrest due to methadone toxicity. Nathan was supported on a disability pension and lived with his father in Broadmeadows, Victoria at the time of his death. He is survived by his family.

The coronial investigation

2. Nathan Dimech's death was unnatural and unexpected and fell within the definition of a reportable death in the *Coroners Act 2008* (the Act).

3. The role of a coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the medical cause of death and the surrounding circumstances of the death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The role of the coroner is to establish the facts, not to determine criminal or civil liability.[1]

4. Under the Act, coroners have another important function and that is, where possible, to contribute to the reduction in number of preventable deaths and the promotion of public health and safety by way of making comment or recommendations about any matter connected to the death under investigation.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Nathan Dimech's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses including family and emergency personnel, and submitted a coronial brief of evidence. I have also taken into account statements from Nathan's treating clinicians, statements from dispensing pharmacists and pharmacy records and Department of Health and Human Services (DHHS)[2] policy documents relating to the dispensing and storage of opioid replacement therapy in Victoria. The circumstances of Nathan's death was also reviewed by the Commissioner for Children and Young People.

Background

Family life

6. Nathan Dimech was born into a home in which DHHS had longstanding concerns for both parents in relation to mental health, intellectual disability and significant poly-substance abuse issues. Nathan was the subject of fourteen Child Protection reports between 2003 and 2013.

7. Nathan's mother, Dianne Dimech gave birth to Nathan at the age of sixteen years. Ms Dimech parented appropriately, and '*impressed as trying to do the best for her children in difficult*

[1] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

[2] The Department of Health and Human Services will be referred to in this document as DHHS, although at the time of Nathan Dimech's death it was known as DHS.

circumstances.'[3] Nathan had a fifteen year old sister and a two year old half-sibling at the time of his death.

8. Nathan's father, Paul Scicluna, had an intellectual disability [4] and a lengthy history of substance abuse.[5]

9. Nathan grew up in Banksia Gardens, Meadow Heights where he lived with both parents until they separated in 2008. Mr Scicluna moved to nearby Broadmeadows and Nathan continued to live with his mother in Meadow Heights, whilst frequently spending time with his father and subsequently moving back and forth between his two parents.

10. Nathan's maternal grandfather, Anthony Dimech was a strong influence on Nathan's life. Mr Dimech lived in a bungalow at the back of the Meadow Heights property and was often responsible for caring for Nathan and his two siblings.

11. During 2013, Mr Scicluna did not have secure housing. He lived in crisis accommodation until he was allocated supported accommodation in July 2013.

Health history

12. Nathan was identified with learning and behavioural difficulties at the age of five. He was diagnosed with a mild intellectual disability. He was described as having poor impulse control, associated with intermittent violent behaviour and was diagnosed with attention deficit disorder at the age of seven.

13. He was treated by Paediatrician, Dr Sian Hughes. Although Nathan was intermittently prescribed stimulant medication, anti-anxiety medication and anti-psychotic medication, these had limited success and environmental factors tended to override any beneficial medication. All medication was ceased as it appeared to have no impact on his behaviours or mood.[6]

Education

14. Nathan attended Roxburgh Park primary school. He presented with challenging behaviour, including physical and verbal aggression, social isolation and learning difficulties.

15. Nathan then attended Hume Valley School from the age of ten, where he was intensively supported with a variety of supplementary programs and initiatives. Initially Nathan thrived, but over time his behaviour deteriorated and his conduct involved threatening and physically violent confrontation with his classmates and his teachers. His school attendance was poor, and he ceased attending school altogether in April 2012 aged fifteen years and nine months.

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[3] Statement Dr Sian Hughes Coronial Brief p 41

[4] Statement Dr Sian Hughes Coronial Brief p 40

[5] Mr Scicluna described himself as a '*long time heroin user*' Coronial Brief p 11

[6] Statement Dr Sian Hughes, Coronial brief p40

16. After his schooling ceased, an unsuccessful attempt was made by Hume Valley School to enrol Nathan in a Technical and Further Education program.

Employment

17. Nathan had been employed at Kentucky Fried Chicken but ceased as his attendance became unreliable after he moved to Broadmeadows to live with his father. Nathan's substance abuse was becoming an impediment to his ability to hold down a job.[7] He was on a disability pension at the time of his death.

Substance abuse

18. According to his mother, Nathan began using drugs approximately a year and a half before his death. Ms Dimech stated she was aware Nathan was accessing the drugs from his father. She stated she took Nathan to his general practitioner where he tested positive for 'ice' and heroin. She stated she also told the Broadmeadows Police about his drug use [8] and sought assistance from DHHS.[9]

Sexual abuse

19. Sexual abuse presented as a recurring risk for Nathan in six out of thirteen reports to DHHS. According to Dr Hughes, Nathan was deeply affected by these experiences[10] and his family were very supportive and the Gatehouse at the Royal Children's Hospital was involved.

Events in 2013

20. On 18 January 2013, Nathan' grandfather, Anthony Dimech died. Nathan's relationship with his grandfather was very close and his death deeply affected Nathan and his family. According to Dr Hughes and his mother, Nathan suffered from depression in the months following his grandfather's death.[11]

21. On 24 January 2013, Nathan was involved in a dispute with his mother in which police attended. Police records noted Ms Dimech had disapproved of Nathan's continued drug use.

22. On 18 May 2013, Nathan moved in permanently to live with his father in Broadmeadows. Mr Scicluna was using amphetamines and heroin. According to Nathan's sister, Rebecca, the two would smoke 'ice' at home using a 'crack' pipe and that Mr Scicluna would encourage both Nathan and Rebecca to use both heroin and 'ice'. Mr Scicluna also reportedly withdrew money from Nathan's bank account with Nathan's ATM card to purchase 'ice' and heroin and that Mr Scicluna always sourced the drugs Nathan used. Rebecca later told her mother she felt that Nathan was intimidated by his father.[12] She last spoke to Nathan on the Tuesday before his death.

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[7] Statement of Dianne Dimech in relation to Nathan's absence from work and viewing CCTV footage at KFC of Nathan and his father, Coronial brief p23
[8] Statement Dianne Dimech, Coronial brief p23
[9] *Ibid* p28
[10] Statement of Dr Sian Hughes, Coronial brief p41
[11] *ibid*
[12] Statement of Dianne Dimech dated 9 May 2014.

Circumstances in which the death occurred

23. On 28 October 2013, Ms Dimech stated her cousin, Sam Nasser told her that Nathan and his father were arguing and that Nathan may return home. Mr Nasser recounted the argument as being about Mr Scicluna wanting to use Nathan's income to 'pay someone'.[13]

24. On 29 October 2013, Mr Scicluna stated he spoke to Nathan at around 9.00 am. He reportedly told his father he felt unwell. Mr Scicluna left the house to ride to a 9.30 am appointment in Broadmeadows and then to Greenvale Pharmacy to pick up his methadone prescription. He stated he returned home at around 12.20 pm and noted the blinds were still down. There was no response to his knocking and he managed to access the house through a window.[14]

25. Mr Scicluna stated he found Nathan unresponsive on the floor at the top of the staircase.

26. Mr Scicluna ran outside to raise the alarm and a neighbour called emergency services. Mr Scicluna then proceeded to give Nathan 'mouth to mouth' resuscitation, whereupon Nathan vomited.

27. Paramedics attended and continued resuscitation attempts. When asked by paramedics whether Nathan had taken any drugs, Mr Scicluna reported he believed some of his methadone was missing from the fridge. Mr Scicluna later stated he suspected that Nathan had taken his methadone.[15] When asked by paramedic Lynne Hall why he thought that, she reports he stated, "*...said he didn't know, stating something like, maybe he thought it would help him, because it helps me.*"[16]

28. Nathan was transferred to the Royal Melbourne Hospital and was admitted to the intensive care unit. Doctors determined he had suffered 'global cerebral ischaemic injury' and had a very poor prognosis.

29. On 30 October 2013, Hume Crime Investigation Unit officers executed a search warrant at Nathan's home at 9 Gum Close, Broadmeadows. They found a 700 ml bottle of methadone, a 40 ml bottle of methadone, and a 20 ml bottle of methadone belonging to Paul Scicluna and four syringes.[17]

30. On 1 November 2013, after consultation with family and medical staff, a decision was made to cease active treatment. Nathan passed away at 7.45 pm.

Medical cause of death

31. Dr Linda Iles, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted a post mortem examination on 8 November 2013. She formulated the cause of death as 'global cerebral ischaemic injury and aspiration pneumonia post cardiac arrest and methadone toxicity'. I accept Dr Iles' opinion as to the medical cause of death.

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[13] *ibid*
[14] Statement Paul Scicluna, Coronial brief p
[15] *ibid*
[16] Statement of Lynne Hall, Coronial brief appendix 2.
[17] Statement Detective Senior Constable John Tsianakas, Coronial brief p46

32. Dr Iles noted toxicological studies performed on blood taken on admission to the Royal Melbourne Hospital demonstrated the presence of methadone at a concentration of ~ 0.1mg/l. Dr Iles commented methadone is a potent central nervous system depressant and is capable of producing fatal centrally mediated depression of cardiorespiratory function in those who are not tolerant to its effects.

33. Toxicological studies performed on blood sampled at the Royal Melbourne Hospital also identified the presence of diazepam at ~ 0.4mg/l, which may have been given to Nathan in hospital, and other drugs consistent with his medical treatment – valproic acid at ~ 3mg/l and lignocaine was detected.

Findings

34. On 29 October 2013, Nathan Dimech accessed his father's opioid replacement therapy, namely methadone, from the family refrigerator and consumed a fatal dose.

35. I find that Nathan Dimech died on 1 November 2013 at the Royal Melbourne Hospital in Parkville, Victoria, from global cerebral ischaemic injury, aspiration pneumonia post cardiac arrest and methadone toxicity.

Take away Methadone

36. The question arises whether Mr Scicluna was stockpiling his methadone. Three unfinished bottles of methadone were located in his refrigerator on the day of Nathan' death, with a new bottle purchased the same day by Mr Scicluna.

37. Mr Scicluna was prescribed Opioid Replacement Therapy by Dr Harry Kwiatek in Epping in July 2008 and Dr George Harris in Greenvale in August 2008.

38. Dr Harris was aware that Nathan was living with Ms Scicluna from 8 September 2013. Somewhat contradictorily in his statement he also stated he knew Mr Scicluna did not have young children living with him but that it was not possible to know if his older children were visiting or living with him. He further stated that Mr Scicluna had been on the methadone program for the past nine years without incident.

39. Dr Harris reported that Mr Scicluna was having difficulty attending the chemist for his methadone due to transport issues therefore missing doses and requiring new scripts. He reported that Mr Scicluna was going through a difficult period and daily dosing of methadone would not have been practical. Because of his difficulty attending he was provided with 5 take away doses of methadone a week. Dr Harris advised:

- He provided an eight week script to Mr Scicluna on 23 September 2013;
- He provided an eight week script to him on 8 October 2013; and
- He provided a four week script on 28 October 2103.

40. Mr Scicluna was dispensed methadone from Pharmacy World North Fawkner from 2008 to 2009, Sable Pharmacy Broadmeadows from 2009 to 2010 and the Greater Discount Chemist from 1 November 2010 onwards.

41. Pharmacist Aaron Tran from Greater Discount Pharmacy has provided information to the Coroner[18] in relation to his pharmacy's take away methadone dispensing regime. Mr Tran reported his pharmacy computer records revealed Mr Scicluna had two supervised doses of methadone and five takeaway doses in the week Nathan died. Mr Tran indicated this was consistent with the script prescribed from the doctor which allowed Mr Scicluna to attend the pharmacy for methadone to receive his dose with five takeaway doses per week.

42. In response to inquiries as to the pharmacy's compliance with the protocols and procedures surrounding the dispensing of take away methadone, Mr Tran further reported that each patient, when commencing an opioid replacement program, undergoes a twenty minute general consultation, which includes the rules, responsibility and reason for the program.

43. A client is also required to sign an agreement stating they understand the rules and their responsibility. He further states that take away doses are only given to stable clients who turn up regularly and have a prescription from a doctor allowing for take away doses. Patients are reminded to keep their doses out of reach of children and other persons as it may cause unwanted side effects or may be fatal. Written warnings are also attached to the label of the take away doses in accordance with regulations.

44. Methadone takeaway doses are filled to two hundred millilitres (200ml) to dilute the dose per regulations to prevent accidental over-dose by others and also have a child resistant closure mechanism.

45. Mr Tran further stated all pharmacists within the pharmacy have been educated about the dangers involved with pharmacotherapy treatment and have signed documentation in relation to the dispensing rules surrounding opioid replacement therapy and their responsibilities to their clients and the community. He states they ensure customers are aware of how to take their medication and how to store them properly.

Coroners Prevention Unit

46. In September 2014, at my direction, the Coroners Prevention Unit[19] (CPU) reviewed the issues surrounding the safe storage of takeaway methadone.

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[18] Emails from Aaron Tran to the Coroners Court of Victoria dated 6 October 2015 and 29 March 2016.

[19] The Coroners Prevention Unit (CPU) is a specialist service created to strengthen their prevention role and provide them with assistance on issues pertaining to public health and safety.

47. The key policy guiding the provision of Opioid Replacement Therapy (ORT) in Victoria is the DHHS policy, Maintenance Pharmacotherapy for Opioid Dependence, revised in 2013. The policy includes several warnings regarding the need for safe storage of takeaway methadone.

48. The requirement for a patient's eligibility for takeaway dosing is noted as:

The patient's circumstances and details of the presence of children or other drug users in the household should be sought, and advice about safe, secure storage should be provided to reduce the possibility of use by others or poisoning of children or other adults.

49. A contraindication to take away dosing is:

Reasonable concerns about diversion of doses for illicit or unsanctioned use. This requires an assessment of the stability of the patient's home environment (for example, whether they are living with another substance abuser), their means of securing the takeaway doses away from children and other potential misusers, and their past performance with take away doses.

50. The following advice is given to pharmacists, to assist them in educating ORT clients about the importance of safe takeaway dose storage:

Patients should be advised to store their takeaway doses in a secure place out of the reach of children and other drug users. Takeaway doses do not need to be refrigerated. Advise patients that placing take away doses in the fridge creates a risk of a dose being taken by children or other household members.

It is essential to inquire about the presence of children or other drug users in the house and to seek agreement about arrangements for safe and secure storage to help prevent unintentional poisoning of children or deliberate misuse by another person. In some circumstances a lockable box might be considered appropriate for safe storage.

51. Mr Scicluna indicated he was aware of the dangers of methadone and had warned his son about it on more than one occasion.[20] Mr Scicluna was unlikely to have imparted the information about his new living arrangements (with Nathan) to the dispensing pharmacist, and he had been a regular methadone client for the past three years, without further information there was no reason for the pharmacist to alter the regime or dispensing arrangements. The evidence suggests that Nathan had been living on and off with each parent for a considerable period of time since their separation in 2008.

52. Mr Scicluna's general practitioner would likely have had a better idea of who was living with Mr Scicluna and in the context of prescribing the methadone could have notified the pharmacy of a change to his living arrangements and the potential for third party access.

53. Dr Harris was aware Nathan was living with Mr Scicluna from 8 September 2013 but did not alter his prescribing of methadone.

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[20] Statement Paul Scicluna, Coronial brief p13

54. The Policy requires that the treating ORT provider should consult with other people involved in treatment, including the dispensing pharmacist to assess whether the client meets these criteria and therefore is suitable for takeaway dosing.

55. DHHS funds training available free of charge to medical practitioners intending to become prescribers and to currently approved prescribers wishing to attend a clinical update or refresher training.[21]

56. DHHS strongly recommends all pharmacists administering doses are required to be familiar with the policy, clinical guidelines and procedures, and provide certification of compliance on site, readily available.

57. DHHS also funds training available free of charge to pharmacists involved in providing pharmacotherapy services, and to pharmacists wishing to attend a clinical update or refresher training.

Previous coronial recommendation

58. Brenton Grosser died on 21 February 2013 from drug toxicity (methadone) after he consumed three 100ml takeaway bottles of methadone that had been prescribed to his house mate.

59. In response to a recommendation made to the DHHS in my finding into the death of Brenton Grosser[22] DHHS advised the Advisory Group for Drugs of Dependence was reconvened between June 2014 and February 2015 to review the *Victorian Policy for Maintenance Pharmacotherapy for Opioid Dependence.*

60. In a letter dated 21 September 2015, DHHS further advised the Advisory Group had completed a thorough review of the current policy and revised a number of key aspects in reference to recent evidence concerning the effectiveness and safety of maintenance pharmacotherapy for opioid dependence. The revised policy would be published in the coming months. I note as at August 2016 the revised policy has not yet been provided by DHHS.

Comments

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

1. Nathan Dimech was a vulnerable seventeen year old young person with an intellectual disability who was under stress due to family difficulties, drug use and the death of his grandfather in early 2013.

2. Attempts by Ms Dimech to stem Nathan's access to and use of illicit substances were unsuccessful and she sought assistance from Nathan's doctor, Victoria Police and DHHS.

3. The Policy for Pharmacists section of the Victorian Policy for Maintenance of Pharmacotherapy for Opioid Dependence highlights the risk to children of not safely storing unsupervised methadone doses;

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[21] DHHS, Policy for maintenance pharmacotherapy for opioid dependence, 3 policy for prescribers, approval to prescribe p13.

[22] *Brenton James Grosser COR 2013 786, 4.*

pharmacists are encouraged to explain these risks, inquire about the presence of children in the patient's house, and seek the patient's agreement about arrangements for safe methadone storage. The Policy further emphasises that the pharmacists should only dispense methadone to a patient if it is safe to do so. The implication of this is, the pharmacists should be regularly discussing the requirement for safe storage, the presence of children in the home, and other issues relevant to the safety of unsupervised dosing.

4. In the case of Nathan Dimech, there is evidence that the pharmacist had an initial detailed consultation with Mr Scicluna which covered such issues as safe storage and the presence of children in the home, but it is unclear whether a follow up conversation had occurred preceding Nathan Dimech's death. In light of these circumstances, Drugs and Poisons Regulation could consider whether the Policy for Pharmacists could be revised to emphasise more explicitly the need for regular discussions about issues relating to unsupervised dosing safety; for example a monthly brief discussion and then a quarterly or twice yearly review supported by a checklist of topics to discuss.

5. Although Mr Scicluna stated he warned Nathan not to take his methadone, Nathan was easily able to access the large doses of take away methadone he had in his refrigerator.

6. As Nathan was able to access the methadone stored in the refrigerator a central issue for prevention is the safe storage of methadone.

7. Nathan's death after taking methadone dispensed to a family member is unfortunately not an isolated occurrence.

8. The Coroners Court of Victoria identified 68 overdose deaths between 2007 and 2013 involving the diversion of methadone that had been dispensed to another person for unsupervised consumption in opioid replacement therapy. Among these, in 14 deaths the methadone was gifted to the deceased by an acquaintance or partner; in 32 deaths the deceased took the methadone without permission from a partner, acquaintance or family member, usually because it was not stored in a secure locked location; and in six deaths the methadone was sold or traded to the deceased (the reasons for diversion in the remaining 14 deaths could not be established from the available material).

9. The high number of deaths involving unsafe methadone storage contrary to the DHHS Policy for Maintenance Pharmacotherapy for Opioid Dependence, was the focus of a series of coronial findings delivered by Coroner Kim Parkinson between 2011 and 2013 (see cases 5241 of 2008, 5712 of 2009 and 2601 of 2012).

10. Coroner Parkinson recommended that the responsible regulatory authority establish a clear mechanism to supervise the safety arrangements for storage of unsupervised methadone doses, and prohibit unsupervised methadone dosing unless the responsible regulatory authority is satisfied there are safe storage arrangements in place where the methadone client resides.

11. In response, DHHS Secretary Dr Pradeep Philip rejected both recommendations. He stated that giving the Department a legislative power to enter people's homes and inspect how they store medications would be unlikely to be supported by the public, would be very expensive to implement, and would likely act as a serious disincentive to engagement in opioid replacement therapy.

12. Between 2010 and 2013, there were five overdose deaths of teenage children who accessed other people's methadone dispensed for unsupervised dosing in opioid replacement therapy. An additional overdose death of a child during this period was likely to have involved unsupervised methadone dose diversion, but the methadone source could not be positively confirmed.

Recommendation

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

That the Department of Health and Human Services review the safe methadone storage section of its Policy for Maintenance Pharmacotherapy for Opioid Dependence, and consider whether any further action can be taken to encourage safe storage of methadone. In particular, DHHS could consider whether distributing *lockable boxes* to methadone clients might be effective, as an appropriate response to the death of Nathan Dimech and in the context of six deaths between 2010 and 2013 of young people under the age of eighteen years.

I direct that a copy of this finding be provided to the following:
Ms Dianne Dimech
Mr Paul Scicluna
Detective Senior Constable John Tsianakas, Coroner's Investigator, Victoria Police

I direct that a copy of this finding be provided to the following for action:
Dr Pradeep Phillip, Secretary, Department of Health and Human Services

Signature:

CAITLIN ENGLISH
CORONER
Date: 31 August 2016