IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 3735

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**GREGORY MCNAMARA, CORONER**
Deceased:	**SO**
Date of birth:	9 February 1989
Date of death:	11 August 2016
Cause of death:	Mixed drug toxicity
Place of death:	Near Little Lithgow Street, Abbotsford, Victoria

BACKGROUND

1. SO was a 27-year-old man who had recently been discharged from a residential program at The Geelong Clinic at the time of his death.

2. SO was found deceased on 11 August 2016 near Little Lithgow Street in Abbotsford.

THE PURPOSE OF A CORONIAL INVESTIGATION

3. SO's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008.*

4. 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.

5. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family members, the forensic pathologist who examined SO, treating clinicians and investigating officers.

6. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established to the standard of proof of the balance of probabilities.[1]

PERSONAL HISTORY

7. SO had a long history of substance abuse including cannabis, alcohol, opiates and amphetamines. He was diagnosed as suffering from Polysubstance Abuse Disorder as well as Generalised Anxiety Disorder and Borderline Personality Disorder.

8. The diagnosis of Generalised Anxiety Disorder noted dysthymic and probable post-traumatic features, [redacted]

[1] This is 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.

[redacted]

11. Throughout his life SO had difficulty maintaining employment due to his addictions.

12. SO first saw a psychiatrist in 2005 but did not at that time engage in ongoing care. In 2008 SO was treated for anxiety using the antidepressant fluoxetine, but this had erratic effect.

13. Also in 2008 SO was admitted to the residential rehabilitation program at Tandana Place for six months. SO was also admitted to The Buttery residential rehabilitation program in northern New South Wales. He underwent detoxification a number of times at Windana Drug and Alcohol Recovery in Dandenong.

14. From 2011 onwards SO was treated for his opiate dependence with Opioid Replacement Therapy, first using methadone and then using suboxone. LG reports that it was after SO began suboxone treatment that he began abusing amphetamines.

15. Approximately four years before his death SO took an overdose of pills with the intention of ending his own life, but later told LG that he regretted this action.

16. Between September 2015 and February 2016 SO was admitted to a residential rehabilitation program at Foundation 61 near Geelong. LG reports that while SO was at Foundation 61 another resident provided SO with amphetamines.

Admissions to The Geelong Clinic

17. SO was first admitted to inpatient care at The Geelong Clinic in April 2015. He wished to cease taking suboxone for Opioid Replacement Therapy. However, as his suboxone

levels were decreased, his behaviour deteriorated and he eventually discharged himself from the Clinic against medical advice.

18. In May 2015 SO returned to The Geelong Clinic to enter the Addictive Behaviours Program directed by Dr Sharada Devarakonda which he completed without significant incident in June 2015.

19. SO was admitted to The Geelong Clinic for detoxification on a number of occasions, but rarely engaged with follow-up care.

20. On 26 May 2016 SO was discovered using substances while in the Addictive Behaviours Program and was assessed as being acutely suicidal; he was discharged and transferred to the Emergency Department at Geelong Hospital.

21. SO's last admission to The Geelong Clinic occurred on 24 June 2016 for detoxification. SO again wished to cease using suboxone before again seeking admission to The Buttery for rehabilitation.

22. During this admission SO was treated with the antipsychotic quetiapine, the anxiolytic diazepam and melatonin at 2mg per night to assist in sleep. He was also treated for his anxiety disorder with the antidepressant escitalopram.

23. On 20 July 2016 SO tested positive for the use of amphetamines on a urine drug screen. On 25 July 2016 nursing staff were concerned that SO may have used substances after meeting a visitor at reception and on 26 July 2016 staff discovered syringes and a white powder in SO's room.

24. At this time nursing staff also discovered a note in SO's room which appeared to be a suicide note. SO claimed that the note had been written two days prior but that he was no longer suicidal.

25. On the evening of 26 July 2016 SO was confronted in a family meeting and given the option of discharge or remaining until he was able to be admitted to The Buttery.

26. On 27 July 2016 SO tested positive for amphetamine use on another Urine Drug Screen.

27. On 4 August 2016, SO decided that he was feeling better and wished to discharge himself from The Geelong Clinic in one week's time. Consultant Psychiatrist Dr MA

of The Geelong Clinic notes that at the time of this decision, SO "*was feeling better. He had not been given a bed at The Buttery but was sleeping well, his mood had brightened, he was more engaged with others, and was intermittently positive with plans to work on a farm. However, he would occasionally express anxiety, sadness, negativity, nihilism and self-defeating statements as he had often done during previous admissions.*"

28. As part of Discharge Planning, SO was reviewed on the evening of 10 August 2016. It was noted that SO was "*at chronic risk of reverting to substance use behaviours*", but that he was less anxious and better in mood, with improved social interactions and engagement. He was noted to be "*keen for discharge*".

29. At 8.45am on the morning of 11 August 2016 SO was discharged from The Geelong Clinic in the company of LG and Clinic staff noted his plans to continue seeking admission to The Buttery. A follow-up appointment was made for 19 August 2016.

MATTERS IN RELATION TO WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased, pursuant to section 67(1)(a) of the Act

30. On 12 August 2016, LG visually identified SO's body as being that of her son SO, born 9 February 1989.

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

Medical cause of death, pursuant to section 67(1)(b) of the Act

32. On 15 August 2016, Dr Matthew Lynch, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon SO's body and provided a written report, dated 17 August 2016. In that report, Dr Lynch concluded that a reasonable cause of death was '*mixed drug toxicity*'.

33. Dr Lynch noted that there were "*scattered abrasions over the left and right sides of the forehead, bridge of nose and at the right angle of the mouth*" and commented that these abrasions were consistent with a collapse.

34. Toxicological analysis of the post mortem samples taken from SO identified the presence of 6-monoacetylmorphine (a metabolite of heroin), morphine, codeine, diazepam, nordiazepam (a metabolite of diazepam), citalopram and quetiapine.

Circumstances in which the death occurred, pursuant to section 67(1)(c) of the Act

35. After SO was discharged from The Geelong Clinic on 11 August 2016 he was taken home to Barwon Heads by LG and her husband DW and arrived there at around 10.00am. They planned to continue attempting to arrange for SO's admission to The Buttery.

36. LG at this point examined Mr SO's phone and found that he had contacted a friend about going to Richmond and using heroin. At this point with SO's agreement LG confiscated his phone and bank card.

37. LG then took SO to a pharmacy in Ocean Grove so that he could obtain his prescribed medications. While at this pharmacy SO is believed to have attended an adjacent branch of Commonwealth Bank where he was able to withdraw $690.00 in cash without requiring his card.

38. When he and LG returned to Barwon Heads, SO refused to continue home with LG. Both LG and DW attempted to convince SO to return home but he refused and boarded a bus at around 11.30am.

39. At approximately 5.25pm on 11 August 2016 PH was walking south on Little Lithgow Street in Abbotsford when he discovered SO lying in an alley unresponsive. PH contacted emergency services who arrived at 5.29pm.

40. Attempts at resuscitation were unsuccessful. At 5.38pm paramedics verified that SO was dead.

41. PH reported that another passer-by stated that he had found SO and attempted to wake him thirty minutes earlier but had been unsuccessful. This other passer-by could not be identified.

42. When SO was found there was a syringe in his hand and another sealed syringe was found in a paper bag nearby.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

43. Although SO had exhibited suicidal ideation in the past, there is no evidence that SO's death was the result of intentional self-harm. I am satisfied to the requisite standard of proof that SO's death was accidental.

44. I note that SO's overdose occurred in the suburb of Abbotsford which forms part of the City of Yarra. In her finding following an inquest into the death of Ms A, delivered on 20 February 2017, Coroner Jacqui Hawkins addressed the high rate of heroin-related deaths in the City of Yarra.

45. In that finding Her Honour made several recommendations to public officials on measures that should be taken to prevent such deaths in the future, including taking steps to establish a safe injecting facility trial in North Richmond.[2]

46. In a response to Coroner Hawkins' recommendation regarding such a trial, The Honourable Martin Foley MP, Minister for Mental Health, advised that he anticipated the recommendation would be considered in the Inquiry into Drug Law Reform being undertaken by the Law Reform, Road and Community Safety Committee of the Parliament of Victoria.

Distinctive features of fatal heroin overdose in the City of Yarra

47. I further note that SO travelled from Greater Geelong to the City of Yarra on the day of his death, and that he was found deceased in a non-residential location. In a finding without inquest into the death of David Leslie Chapman dated 8 May 2017, Coroner Audrey Jamieson addressed several distinctive features of fatal heroin overdose in the City of Yarra:

> *Compared to other Victorian LGAs examined, over the past five years a much greater proportion of fatal heroin overdoses in the City of Yarra involved people who travelled there from other areas; and a much greater proportion occurred in non-residential locations such as parks, carparks, public toilets, restaurant toilets, cars, and on streets.*[3]

48. SO's death is another example of the pattern of heroin-related deaths in the City of Yarra. In addition, his death exhibits characteristics which are unusually pronounced in the City of Yarra compared to other parts of Victoria with high rates of heroin-related deaths.

49. This death again demonstrates that the City of Yarra bears a disproportionate burden of drug-related harms for the entire State of Victoria, and emphasises the importance of taking measures to reduce the impact of drug use in this particular area.

50. Accordingly, I support the recommendations made by Coroner Hawkins in her finding following an inquest into the death of Ms A.

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[2] This finding has been published on the Coroners Court of Victoria website under Case Number 241816.
[3] This finding has been published on the Coroners Court of Victoria website under Case Number 272216.

FINDINGS AND CONCLUSION

51. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) the identity of the deceased was SO, born 9 February 1989;

    (b) the death occurred on 11 August 2016 at Abbotsford, Victoria, from mixed drug toxicity; and

    (c) the death occurred in the circumstances described above.

52. I convey my sincerest sympathy to SO's family.

53. Pursuant to section 73(1A) of the *Coroners Act 2008*, I order that this Finding be published on the internet.

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

    (a) Ms LG, senior next of kin.

    (b) Mr JO, senior next of kin.

    (c) The Honourable Martin Foley MP, Minister for Mental Health.

    (d) Ms Kym Peake, Secretary of the Department of Health and Human Services.

    (e) Mr Geoff Howard MP, Chair, Law Reform, Road and Community Safety Committee.

    (f) Senior Constable Byron Smith, Victoria Police, Coroner's Investigator.

Signature:

GREGORY MCNAMARA

CORONER

Date: 7/7/17