IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 002004

FINDING INTO DEATH WITHOUT INQUEST

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

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of WILLIAM JOHN BAILEY
without holding an inquest:
find that the identity of the deceased was WILLIAM JOHN BAILEY
born on 9 June 1990
and that the death occurred 9 May 2013
at 2/22 Vautier Street, Elwood Victoria 3184
from:

I (a) COMBINED DRUG TOXICITY (METHADONE AND BENZODIAZEPINES).

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

1. Mr Bailey was a 22-year-old man who was residing at a rooming house at the above address at the time of his death. His mother was Ms Jeanette Warren and his father, Clifford Bailey, died when Mr Bailey was a child. He had a younger sister, Brenda Bailey.
2. Mr Bailey had been released from prison on 24 March 2014. He stayed with Brenda for a short time before some accommodation was arranged for him in Morwell. However, Mr Bailey did not like living there so he moved to Melbourne.
3. Mr Bailey and Ms Rattya met when he moved into the Elwood accommodation where she was staying at the time. Ms Rattya described him as an alcoholic, drinking up to three casks of wine per day. On 6 May 2013, Mr Bailey was with Ms Rattya in her room and complained of chest pain, so she called an ambulance. Mr Bailey was taken to The Alfred Hospital where he was monitored and released about 6 hours later.

4. Ms Rattya was being prescribed methadone at the time of Mr Bailey's death, and stated that she had been on methadone for some 5 years. Her dosage was 115ml per day. She collected five takeaway doses on the afternoon of 8 May 2013 from the pharmacy and consumed one in the pharmacy, and returned home. She spent the evening in her room with Mr Bailey and stated that he asked to try some of her methadone, and that she declined.

5. According to Ms Rattya, they fell asleep at about 7.00pm. She awoke at around midnight and noticed that Mr Bailey was sweaty and drowsy. He told her he had consumed a bottle of methadone and was okay, and she fell asleep again. When she woke about an hour later on 9 May 2013, Mr Bailey was unresponsive and had no palpable pulse. Ms Rattya called 000 and performed CPR under instruction of the telephone operator until paramedics arrived and took over. Unfortunately, Mr Bailey could not be revived and was pronounced deceased.

6. An autopsy of Mr Bailey's body was performed by Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (VIFM) who reviewed the circumstances as reported by the police to the coroner and provided a detailed written report of his findings. Dr Bouwer attributed Mr Bailey's death to *combined drug toxicity (methadone and benzodiazepines).* He noted no significant natural disease, violence or injury that could have caused or contributed to death.

7. Dr Bouwer noted that toxicological analysis of post-mortem blood detected methadone at ~0.5mg/L and EDDP (a methadone metabolite) at ~0.02mg/L. Diazepam and alprazolam were also detected ~0.1 mg/L and ~0.03 mg/L respectively, as well as ethanol (alcohol) at 0.04g/100mL. Dr Bouwer advised that methadone may cause central nervous system and respiratory depression, especially when taken in conjunction with benzodiazepines.

8. Police also attended the home and located eight methadone bottles in Ms Rattya's room: three 120mg bottles were located on a dressing table and were all empty. One of these was prescribed to Simone Rattya and the other two were prescribed to a Cory Hardman; five 120mg bottles were found in a fridge in the room. All were prescribed to Simone Rattya. One bottle was ¾ full, one was empty, one was ¼ full and two were ½ full.

9. Ms Rattya advised police that the bottles prescribed to Mr Hardman, who was her previous partner, came to be in her room as he was homeless and some of his belongings might have mixed up with hers when she moved to Elwood.

COMMENTS

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

1. Ms Rattya had access to significant amounts of methadone in the form of "take-away" doses that she might not always have been taking as prescribed. As a result, she had an extra supply of methadone that could have been, and in this instance, was consumed by another/others.
2. The methadone dispensed as takeaway doses to Ms Rattya is relevant to Mr Bailey's death as it provided the opportunity for easy access to methadone that was not prescribed to him. Potential opportunities to prevent deaths arising from takeaway methadone have been articulated in a number of recent Victorian coroners' findings.[1]
3. Recent coronial findings have also identified Australian and international research, which shows that in the first weeks after release from prison, a person is at a markedly elevated risk of dying from drug overdose. A range of factors appear to contribute to this risk including a period of enforced abstinence, meaning that a dose tolerated by that person in the past or prior to incarceration, might have fatally toxic effects on release from prison.[2]
4. I have made comments in a recent coronial finding acknowledging that takeaway methadone dosing plays an important role in facilitating a person's reintegration into the community by assisting them to lead a normal life with minimal disruption from the demands of daily supervised dosing. However, the benefits of takeaway dosing must be balanced with the need to reduce deaths such as Mr Bailey's from acute methadone toxicity, whether opportunistic or otherwise.

[1] Tabitha Curnow (2004 4506), finding delivered by Coroner Audrey Jamieson on 15 November 2005; Melissa Irwin (2009 5712), finding delivered by Coroner Kim Parkinson on 16 December 2010; Michael Gledhill (2008 5241), finding delivered by Coroner Kim Parkinson on 17 February 2011; Damien Perceval (2009 2063), finding delivered by Coroner Kim Parkinson on 28 September 2012; Christina Mifsud (2012 2601), finding delivered by Coroner Kim Parkinson on 1 October 2013; Dion Heather (2009 5699), finding delivered by Coroner Kim Parkinson on 1 October 2013; Helen Stagoll (2010 1624), finding delivered by Coroner Jacinta Heffey on 29 October 2013; Benjamin Lindsay (2012 3580), finding delivered by Coroner Paresa Antoniadis Spanos on 26 February 2014; Kirk Ardern (2012 2254), finding delivered by Coroner Audrey Jamieson on 7 April 2014.

[2] This is discussed in detail in the case of Kirk Ardern (2012 2254).

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

The family of Mr Bailey

Dr Pradeep Philip, Secretary, Department of Health

Mr Matthew McCrone, Chief Officer, Drugs and Poisons Regulation, Department of Health

Mr Sam Biondo, Executive Officer, Victorian Alcohol and Drug Association (VAADA)

Detective Senior Constable Dimitros Tzeferemineos, St Kilda Crime Investigation Unit.

Signature:

PARESA ANTONIADIS SPANOS
CORONER
Date: **19 June 2014**

Cc: Manager, Coroners Prevention Unit