



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2018 3158

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 60(2)*

*Section 67 of the Coroners Act 2008*

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	MKT
Date of birth:	11 July 1979
Date of death:	Between 1 and 2 July 2018
Cause of death:	Toxicity to heroin
Place of death:	Room 31, 726 Sydney Road, Coburg, Victoria, 3058

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of MKT without holding an inquest:

find that the identity of the deceased was MKT

born on 11 July 1979

and that the death occurred between 1 and 2 July 2018

at Room 31, 726 Sydney Road, Coburg, Victoria, 3058

**from:**

1 (a) TOXICITY TO HEROIN

Pursuant to section 67(1) of the *Coroners Act 2008*, I make findings with respect to the following circumstances:

**Background**

1. Mr MKT was 38 years of age at the time of his death. He was raised in Northcote and was part of a large family, having six sisters and four brothers.
2. Mr MKT had a long history of drug use. According to his sister, Ms MKT, he started using drugs at 14 years of age and developed an addiction to heroin, which dominated his life. As Ms MKT expressed it in her statement: *'There wasn't a moment when we saw him sober.'*<sup>1</sup>
3. Mr MKT spent much of his adult life in goal. Between 2002 and 2018, he was incarcerated on ten separate occasions for periods ranging from 3 months to 24 months. Most recently, Mr MKT was released from custody on 22 June 2018.
4. During his most recent incarceration, Mr MKT showed drug seeking behaviours. He regularly sought medical attention and reported several medical issues including chronic pain, for which he requested increasing doses of medication. On release from custody, his prescribed medications included morphine sulfate and paracetamol.
5. In April 2018, Mr MKT was referred to the Transit Outreach Housing Pathways Program for post release accommodation and community integration support. His case worker, Marina Mento, arranged for Mr MKT to have short term accommodation

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<sup>1</sup> Statement of Ms MKT dated 10 December 2018, Coronial Brief.

- at the Coburg Motor Inn on his release. Mr MKT told Ms Mento that he had used heroin for 10 years but had not used while in prison and planned to abstain when released. She offered him referral to drug and alcohol services but he declined.
6. On release from custody on 22 June 2018, Mr MKT went to the Coburg Family Medical Centre and requested scrips for morphine, alprazolam (Xanax) and pregabalin (Lyrica). He was prescribed pregabalin and diazepam (Valium) but was refused morphine and alprazolam and was also referred to a drug and alcohol clinic.
  7. Later that day, Mr MKT went to Cedars Medical Clinic and reported chronic right leg pain. General practitioner Dr Haissam Naim prescribed morphine sulphate (MS Contin), zopiclone (Imovane) and diazepam (Valium), although the diazepam was later withheld when Mr MKT tried to fill two prescriptions for the drug. Mr MKT saw Dr Naim almost daily thereafter until 27 June 2018, and reported ongoing pain and sleeping difficulties. Dr Naim referred Mr MKT to physiotherapy, a pain management clinic and a private pain management physician.
  8. A few days after his release, Mr MKT visited his parents. His sister stated that he brought his parents a cake and apologised to them for his past behaviours. His parents invited him to visit for dinner every night. In a conversation with Ms Mento on 26 June 2018, Mr MKT said that he missed his family and felt like he had let them down.
  9. Otherwise, Ms Mento described Mr MKT as upbeat and future focussed during their conversation on 26 June 2018. He said he had not used drugs since his release from goal and was proud of himself. However, two days later he told Ms Mento that he was feeling depressed. While he did not report suicidal thoughts, he agreed to visit his general practitioner.
  10. On 29 June 2018, Mr MKT was arrested for shoplifting. Police found capped needles in his possession and noted that he was using crutches and was unable weight bear on his right ankle. Mr MKT was bailed to appear at Melbourne Magistrates Court on 24 August 2018.
  11. On 1 July 2018, Mr MKT left a voice message for Ms Mento expressing gratitude for her support.

### **Circumstances immediately proximate to death**

12. At about 10:00am on 2 July 2018, a cleaner at the Coburg Motor Inn found Mr MKT deceased in his room. Emergency Services were called and Ambulance Victoria paramedics arrived shortly afterwards and confirmed that Mr MKT was deceased.
13. Senior Constable Thomas Gall of Moreland CIU also attended the scene and commenced a coronial investigation, later compiling the brief of evidence on which this finding is largely based. During a search of Mr MKT's room, police observed drug paraphernalia including a used syringe (found near Mr MKT's body on the floor), a small balloon containing an unknown substance that looked like heroin (on the bedside table) and prescription medications including pregabalin tablets, paxam tablets, and empty boxes of diazepam, morphine sulphate and zopiclone.
14. They found nothing to suggest that Mr MKT died in suspicious circumstances or that anyone else was involved in his death.

### **Medical cause of death**

15. On 3 July 2018, senior forensic pathologist, Dr Michael Burke of the Victorian Institute of Forensic Medicine, reviewed the circumstances of the death as reported by police to the coroner, post-mortem computer assisted tomography scans of the whole body (PMCT) and performed an inspection on the body of Mr MKT in the mortuary.
16. Dr Burke advised that PMCT showed changes of decomposition and no facial or skull fracture and that there were no remarkable findings on external examination.
17. Routine toxicological testing of post-mortem blood and urine samples detected the heroin-specific compound 6-monoacetylmorphine, codeine, morphine, dextromethorphan, diazepam and its metabolite, oxazepam and its metabolite, ethanol, clonazepam and its metabolite, and zopiclone.
18. The toxicologist advised that these results were consistent with recent use of heroin in a person also consuming diazepam and clonazepam and that the combination of drugs detected may cause death in the absence of other contributing factors.
19. Noting the results, Dr Burke advised that it would be reasonable to attribute Mr Mr MKT death to *toxicity to heroin*, without the need for autopsy.



## Findings

20. I find that Mr MKT death was caused by heroin toxicity in circumstances of an accidental of inadvertent overdose.
21. Sadly, the phenomenon of recently released prisoners dying of drug overdose is well-known to Victorian coroners. It is generally accepted that this reflects the deceased's use of drugs, which are more freely available, at a time of reduced tolerance.

## Comments pursuant to section 67(3) of the *Coroners Act 2008*

22. Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the Mr MKT's death.
23. It is not uncommon for Victorian Coroners to see the death of recently released prisoners from drug overdose.
24. Australian and international research shows that in the first weeks after release from prison, a person is at markedly elevated risk of dying from a drug overdose.<sup>2</sup> Factors that contribute to this elevated risk include, for regular opioid users, a period of enforced abstinence in prison that causes the user's opioid tolerance to decrease, so that a formerly tolerated dose can have fatally toxic effects upon release from prison. There may also be changes in the purity of available drugs between when the user is received into prison and released from prison which may contribute to fatal outcomes in post-release drug use.
25. The Coroner's Prevention Unit<sup>3</sup> has researched the rates of overdose deaths following release from prison that occurred between 1 January 2000 and 30 September 2013.

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<sup>2</sup> See for example Graham A, "Post-prison Mortality: Unnatural Death Among People Released from Victorian Prisons Between January 1990 and December 1999", *Australian and New Zealand Journal of Criminology*, vol 36, no 1, April 2003, pp.94-108; Farrell M, Marsden J, "Acute risk of drug-related death among newly released prisoners in England and Wales", *Addiction*, vol 103, no 2, February 2008, pp.251-255; Merrall ELC, Karimina A, Binswanger IA, et al, "Meta-analysis of drug-related deaths soon after release from prison", *Addiction*, vol 105, no 9 September 2010, pp.1545-1554; Zlodre J, Fazel S, "All-Cause and External Mortality in Released Prisoners: Systematic Review and Meta-Analysis", *American Journal of Public Health*, vol 102, no 12, December 2012, pp.e67-e75; Turban JW, "Can Parole Officers' Attitudes Regarding Opioid Replacement Therapy be Changed?", *Addictive Disorders and their Treatment*, vol 11, no 3, September 2012, pp.165-170.

<sup>3</sup> The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the Coroner. The CPU assists coroners to formulate prevention recommendations and comments and monitors and evaluates their effectiveness once published.

The CPU identified 151 overdose deaths during this period. Heroin was a contributing drug in approximately 75% of all fatal overdoses among people who had been recently released from prison.

26. I note for completeness that there have been a range of inquests since 2000 dealing with the overdose deaths of people on parole and recommendations have been made in relation to management and monitoring of parolees who had ongoing drug dependency problems. However, as Mr MKT was not on parole when he was released, he would not have benefitted from those recommendations or any actions taken in response to the recommendations.

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

Mrs MKT, Senior Next of Kin

Donna Filippich, St Vincent's Health

Senior Constable Thomas Gall (#40342) c/o O.I.C. Moreland C.I.U.

Signature:



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PARESA ANTONIADIS SPANOS

Coroner

Date: 12 June 2019

