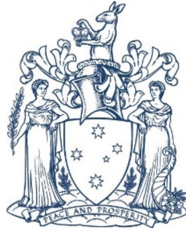

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2988

**FINDING INTO DEATH WITHOUT INQUEST**

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

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|---|---|
| Findings of: | Caitlin English, Coroner |
| Deceased: | MDJ[1] |
| Date of birth: | 17 July 1982 |
| Date of death: | 24 June 2017 |
| Cause of death: | I(a) Hypoxic/ischaemic encephalopathy<br>I(b) Heroin toxicity |
| Place of death: | Sunshine Hospital, St Albans, Victoria |

[1] This Finding has been de-identified to replace the names of the deceased and their family members with pseudonyms of randomly generated three-letter sequences to protect their identity and to redact identifying information.

## INTRODUCTION

1. MDJ was a 34-year-old man who lived in Highett at the time of his death.

2. MDJ was brought to Sunshine Hospital on 24 June 2017 after becoming unresponsive following heroin use. He did not recover and died later that day.

## THE PURPOSE OF A CORONIAL INVESTIGATION

3. MDJ's death was reported to the Coroner as it appeared to be unnatural and so 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, the forensic pathologist who examined MDJ, a treating clinician 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 on the balance of probabilities.[2]

## IDENTITY

7. On 24 June 2017, MDJ's mother visually identified her son MDJ, born 17 July 1982.

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

## CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

9. MDJ had a history of heroin abuse but had been in a residential rehabilitation program at Destiny Transformations in Hoppers Crossing from April 2017 to 13 June 2017. According to his partner PJY, MDJ was '*kicked out … because he was having some issues with one of*

[2] 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.

*the other patients*' and the operators of the program arranged for him to attend another facility in Tasmania.[3]

10. After MDJ left the facility PJY noticed that he was using heroin. On the morning of 24 June 2017 he informed PJY that he was taking a taxi to St Albans to '*get on*'. PJY accompanied MDJ to St Albans.[4]

11. MDJ went to 301 Main Road East, St Albans, and purchased heroin. He and PJY then went to the nearby Errington Reserve. She saw him prepare heroin for injection but does not recall seeing the act of injection itself.[5]

12. After some time she '*saw [MDJ] was lying on his back. He wasn't responding then I was trying to talk to him or wake him up. I could feel his heart beat but it was very, very faint*'. Both PJY and a passerby contacted emergency services.[6]

13. The Metropolitan Fire Brigade and Ambulance Victoria arrived and attempted to resuscitate MDJ. At 9.38am MDJ was transported to Sunshine Hospital.[7]

14. On arrival to the Intensive Care Unit at Sunshine Hospital MDJ's Glasgow Coma Score was 3 and he had signs of multiorgan failure. According to Dr Rashid Bashir, MDJ '*had no spontaneous breathing effort, had rising urea and creatinine, deranged liver function tests and had signs of brain death. ... It was clear within few hours that he is brain dead and will not recover*'.[8]

15. After consultations with MDJ's family, he was extubated and died at 6.17pm on 24 June 2017.

## CAUSE OF DEATH

16. On 27 June 2017, Dr Malcolm Dodd, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection of MDJ's body and provided a written report, dated 7 July 2017. In that report, Dr Dodd concluded that a reasonable cause of death was '*I(a) Hypoxic/ischaemic encephalopathy; I(b) Heroin toxicity*'.

[3] Statement of PJY dated 22 August 2017, Coronial Brief.
[4] Ibid.
[5] Statement of PJY dated 22 August 2017, Coronial Brief; Statement of D/S/C Aftyn Rockes dated 13 November 2017, Coronial Brief.
[6] Statement of PJY dated 22 August 2017, Coronial Brief.
[7] Statement of Guy Robert Hampshire dated 1 July 2017, Coronial Brief.
[8] Statement of Dr Rashid Bashir (undated), Coronial Brief.

17. Toxicological analysis of ante mortem samples identified the presence of free morphine and free codeine, consistent with the use of heroin.

18. I accept Dr Dodd's opinion as to cause of death.

**Intent**

19. There is no evidence that MDJ intended to end his life. I find that his death was the accidental consequence of the effects of heroin use.

**FURTHER INVESTIGATION AND POLICE ACTION**

20. On 23 June 2017 another man, Jason Hill, had also died after injecting heroin at the Errington Reserve. D/S/C Rockes was also the Coroner's Investigator for Mr Hill's death.

21. D/S/C Rockes identified that both MDJ and Mr Hill have purchased heroin at 301 Main Road East. He obtained a search warrant pursuant to the *Drugs, Poisons and Controlled Substances Act 1981*and executed it on 25 June 2017.[9]

22. According to D/S/C Rockes, '*inside the premise, police located fourteen (14) persons, most of who stated they were there to buy heroin. During the search, an amount of what is believed to be heroin was located.*' More search warrants were later executed on the same premises.[10]

23. D/S/C Rockes has informed the Court that, since 24 June 2017, there have been no further fatal heroin overdoses linked to 301 Main Road East, St Albans.

24. I made enquiries through the Police Coronial Support Unit as to whether the Errington Reserve was an area known for drug use. They advised that there had been ten reports in the previous year relating to Errington Reserve and referring to drugs.

25. D/S/C Rockes has given the opinion that MDJ's and Mr Hill's use of the Errington Reserve as a location for drug use was a matter of convenience as it was nearby the house where both purchased heroin.

**COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT**

26. On 6 August 2018 Coroner Audrey Jamieson delivered her finding without inquest into the death of Samuel Jack Morrison, who died in Hoppers Crossing, part of the City of Yarra, from

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[9] Statement of D/S/C Aftyn Rockes dated 13 November 2017, Coronial Brief.
[10] Ibid.

combined drug toxicity including heroin.[11] This finding noted characteristics particular to heroin-related deaths in the City of Yarra and included a summary of data from the Coroners Prevention Unit (CPU) on overdose deaths in Victoria.

27. Coroner Jamieson made the following comment in relation to Mr Morrison's death:

'*The data suggests that the continuing rise in fatalities associated with heroin use is manifesting in a number of areas around Metropolitan Melbourne, and that locally-specific responses to these emerging harms – such as the MSIC [Medically Supervised Injecting Centre] in North Richmond – may require broader strategic coordination so that lessons learned from interventions in one area are shared and applied in a timely manner to other areas where they could have a positive impact on the lives of people who inject drugs*.'

28. Further to this, Coroner Jamieson made the following recommendation:

'*With a view to promoting public health and safety and preventing like deaths, **I recommend** that the Secretary of the Department of Health and Human Services considers the circumstances of Mr Morrison's death in the context of continuing increases in heroin related harms and in relation to the latest data which supports the need for continued development of risk reducing strategies for people who inject drugs.*'

**Heroin-related deaths in the City of Brimbank**

29. The City of Brimbank is the Local Government Area (LGA) containing the suburb of St Albans, where both MDJ's and Mr Hill's deaths occurred. To provide contextual information for these deaths, I requested that the CPU provide information on heroin-related deaths in the City of Brimbank.

30. The CPU advised me of the following:

- The City of Brimbank was the third-most frequent location of Victorian heroin-involved overdose deaths during the period 2012-2017, and was the site of the highest number of these deaths in 2017.

- The City of Brimbank was also the second-most frequently identified LGA as a source of heroin in Victorian heroin-involved overdose deaths.

[11] Published on the Coroners Court of Victoria website under case number 273016.

- Most heroin-involved overdose deaths in the City of Brimbank were of people who usually resided in the LGA and most occurred in residential locations.

- Within the City of Brimbank, the suburb of St Albans was a location where there was a higher concentration of heroin-involved overdose deaths.

31. Heroin-related overdose deaths in the City of Brimbank have a different profile from deaths in the City of Yarra, where a significant majority of overdose deaths involve people who travelled from other areas to consume heroin and where an unusually high proportion of overdose deaths occur in non-residential areas.

32. I note that MDJ's and Mr Hill's deaths do not fully match the City of Brimbank profile as they occurred in a public park in close proximity to where the heroin was sourced. Nonetheless, the differences between deaths in these two LGAs emphasise the importance of a local place-based response to the development of risk reducing strategies for people who inject drugs.

33. I attach the CPU's memorandum on heroin-involved overdose deaths in Brimbank as an appendix to this finding.

**Place-based death prevention – suicide and overdose**

34. In July 2016, the Victorian Government published the *Victorian Suicide Prevention Framework 2016-25.*[12] Among the principles guiding all initiatives in the Framework is that suicide is preventable when we '*empower communities to achieve their goals through place-based approaches*'.[13]

35. One initiative in the Framework is a place-based approach to suicide prevention. This is through the implementation of coordinated place-based suicide prevention trials, both to find out what works in suicide prevention in Victoria and to apply this more broadly with a concrete aim of reducing suicide by 50% in the next ten years.

36. I commend this initiative and the work of the Victorian Department of Health and Human Services (DHHS) and Primary Health Networks throughout Victoria to co-commission place-based trials.

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[12] Victorian Department of Health and Human Services, *Victorian Suicide Prevention Framework 2016-25* (July 2016).
[13] Ibid p 7.

37. I also note that, in Victoria, the annual frequency of overdose deaths has grown steadily over the past decade and reached 523 deaths in 2017, not far below the frequency of deaths by suicide (approximately 680).

38. For this reason, and because of the different characteristics of overdose deaths in different LGAs, I consider that a comparable approach of locally-specific responses, with a similar target for overdose death reduction, might be appropriate for overdose deaths and might substantially reduce the number of heroin-related deaths in Victoria as well as reducing the broader harm caused by heroin use.

**FINDINGS**

39. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that MDJ, born 17 July 1982, died on 24 June 2017 at St Albans, Victoria, from I(a) Hypoxic/ischaemic encephalopathy; I(b) Heroin toxicity in the circumstances described above.

**RECOMMENDATIONS**

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations:

1. With a view to promoting public health and safety and preventing like deaths, **I recommend** that the Secretary of the Department of Health and Human Services note that two deaths, MDJ's and Mr Hill's, occurred within a day of each other in the suburb of St Albans. St Albans is within the City of Brimbank and has a higher concentration of heroin-related deaths than the City of Brimbank as a whole, which itself was, in 2017, the LGA with the highest number of heroin-related deaths in Victoria.

2. With a view to promoting public health and safety and preventing like deaths, **I recommend** that the Secretary of the Department of Health and Human Services consider applying a place-based approach to drug overdose prevention along the lines of their place-based approach to suicide prevention, setting a similarly ambitious target for overdose death reduction.

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

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

Senior next of kin.

Secretary of the Department of Health and Human Services.

Detective Senior Constable Aftyn Rockes, Victoria Police, Coroner's Investigator.

Signature:

**CAITLIN ENGLISH**

**CORONER**

Date: 9 November 2018