IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 003629

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Simon McGregor
Deceased:	EZT[1]
Date of birth:	1981
Date of death:	7 July 2020
Cause of death:	1(a) Toxicity to gamma hydroxybutyrate
Place of death:	Hastings, Victoria
Keywords:	Overdose, GHB, Justice Assurance and Review Office, JARO, Community Correctional Services, CCS, Corrections Victoria, RAPIDS, ReConnect, Victorian Department of Justice and Safety, naloxone, Naloxone on Release

[1] This Finding has been de-identified by order of Coroner Simon McGregor to replace the names of the deceased and their family members with psuedonyms of randomly generated three letter sequences to protect their identity and to redact identifying information'

INTRODUCTION

1. On 7 July 2020, EZT was 38 years old when he overdosed whilst staying at his partner's house in Hastings.

2. EZT was raised by his parents in the Wyndham Vale area and was one of four children. He met his partner IPD approximately 18 years ago. They had four children during their intermittent but long-term relationship.[2]

3. EZT had trouble with police from a young age, recording his first drug and family violence incidents in 1997 when he was 17 years of age. A pattern of drug use and criminal offending persisted from this time onwards, culminating in three periods of imprisonment.[3] His final release from prison on 11 May 2020.[4]

THE CORONIAL INVESTIGATION

4. EZT's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. Such deaths require a mandatory inquest if the deceased was in custody but section 6C(1) of the *Corrections Act 1986* gives a list of persons who are specifically not to be regarded as being in the Secretary's legal custody, and subsection (b) is '*a person who is serving a combined custody and treatment order and who is in the community under that order*'. Given that an inquest is not mandatory, I have exercised my discretion to close this matter at the investigation phase, because the material my investigator has gathered has been sufficient to enable me to complete my statutory tasks.

6. 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.

[2] Statement of GDG, Coronial Brief.
[3] LEAP Criminal Record, Coronial Brief.
[4] Ibid.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of EZT's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of EZT including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[5]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

10. On the 7th of July 2020, EZT stayed overnight with IPD. He went out in the morning and obtained a bottle of what she believed to be the drug known colloquially as GHB.[6] He consumed the 60mL bottle sometime between approximately 10 and 11.30am that day. By 11.45am, he appeared drug affected as he fell off the toilet seat onto the bathroom floor. IPD kept an eye on him as he slept unconsciously, and at 1.50pm she noticed he had stopped breathing.[7]

11. IPD, unsure about what to do, rang a friend who told her to ring an ambulance immediately whilst she headed over to help.[8] Ambulance Victoria paramedics attended the scene at 2.01pm but EZT was unresponsive, not breathing and had no pulse.

[5] 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.
[6] Gamma hydroxybutyrate.
[7] Statement of IPD, Coronial Brief.
[8] Statement of FTW, Coronial Brief.

12. Resuscitation was attempted but was ultimately unsuccessful, with EZT being verified as deceased at 2.26pm.[9]

Identity of the deceased

13. On 7 July 2020, EZT, born 1981, was visually identified by his partner, IPD.

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

Medical cause of death

15. Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an autopsy on 14 July 2020 and provided a written report of his findings dated 26 August 2020.

16. Toxicological analysis of post-mortem samples identified the presence of gamma hydroxybutyrate in a concentration of ~ 510 mg/L. Gamma hydroxybutyrate is a central nervous system depressant, which may lead to respiratory arrest and subsequent death.

17. The remainder of the post-mortem examination revealed nothing inconsistent with the clinical history above.

18. Dr Burke provided an opinion that the medical cause of death was 1 (a) Toxicity to gamma hydroxybutyrate.

19. I accept Dr Burke's opinion.

REVIEW OF CARE

20. Given EZT's recent release from custody, I further reviewed the circumstances of his custodial supervision upon release from jail, with the assistance of the Justice Assurance and Review Office (**JARO**).[10]

21. The JARO report[11] confirmed for me that at the time of his death, EZT was serving the Community Correction Order component of a Community Correction Order and Imprisonment, under the supervision of Frankston Community Correctional Services (**CCS**).

[9] Ambulance Victoria Electronic Patient Care Record, Coronial Brief.
[10] Section 7 of the Act obliges me to expedite investigations and avoid unnecessary duplication.
[11] Report of the Justice Assurance and Review Office dated 17 November 2020, Coronial Brief.

Compliance with the CCO and management by Frankston CCS

22. EZT entered the custody of Corrections Victoria on 12 July 2019 and was eventually transferred to Port Phillip Prison where he remained until his release on 11 May 2020. After multiple unsuccessful contact attempts, EZT completed an induction session with ReConnect[12] on 27 May and was required to engage in twice-weekly appointments going forward.[13]

23. After attending a session with his case manager on 3 June 2020, EZT made no further contact with either his Frankston CCS or ReConnect case worker despite multiple attempts to contact him through his emergency contact.[14]

Bridging support

24. I note that on 11 December 2019, EZT was recorded as a high alcohol and drug risk. Given that he reported daily use of alcohol and drugs prior to entering custody, it is reasonable to conclude that EZT may have benefited from a bridging service such as the Responsive Assessment Planning Intervention Diversion Service (**RAPIDS**). I note that there is no evidence that his case manager or ReConnect case worker suggested that RAPIDS be utilised, either before or after his release from custody, to assist him in refraining from drug use.

Manager's Review

25. Following EZT's death, Frankston CCS undertook an internal Manager's Review identifying key issues and opportunities for improvement including:

    a) coordinating transitional videoconferencing during the COVID-19 pandemic,

    b) localised support and development for EZT's assigned Advanced Case Manager to address areas of concern including reflective practice sessions, and

    c) a review of the changes and expectations of the new *Remote case management and service delivery* Practice Guideline.

[12] The ReConnect program provides assertive outreach and practical assistance to successfully reintegrate into the community. ReConnect targets prisoners with high and complex transitional needs.
[13] Report of the Justice Assurance and Review Office dated 17 November 2020, Coronial Brief.
[14] Ibid.

26. The Manager's Review also identified that escalation of his case to a Risk and Review meeting, or to the Professional Practice Stream (**PPS**) for a secondary consultation would have been appropriate given EZT's lack of engagement. JARO noted that a referral to a Risk and Review meeting or a secondary consultation from PPS may also have helped offset the added challenges for CCS staff in adapting to the new Remote Service Delivery model.[15]

FINDINGS AND CONCLUSION

27. After reviewing the circumstances of EZT's release and subsequent overdose, I agree with the JARO report that some aspects of EZT's management by Frankston CCS did not meet the standards prescribed by Corrections Victoria. As CCS has identified opportunities for improved management under the new Remote Service Delivery Model, I do not propose to make any recommendations about those aspects.

28. Furthermore, considering EZT's documented unwillingness to engage with the transition assistance offered to him, I find that the identified opportunities for improvement did not contribute to his death in any way. However, the circumstances of his death, in combination with other investigations conducted by this Court, do highlight the importance of continuing the State's efforts to improve the health outcomes of prisoners upon release back into the community.

29. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was EZT, born 1981;

    b) the death occurred on 7 July 2020 in Hastings, Victoria, from toxicity to gamma hydroxybutyrate; and

    c) the death occurred in the circumstances described above.

30. Having considered all of the circumstances, I am satisfied that his death was the unintended consequence of the deliberate ingestion of drugs.

[15] Ibid.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

31. In the matter of HG[16] I made two recommendations regarding the reduction of drug-related mortality amongst individuals released from prisons. Given the commonality between EZT's circumstances and those of HG, I am confident that these recommendations continue to be relevant in this matter.

32. The first recommendation concerned the establishment of a formal advisory group by the Victorian Department of Health (**VDH**) and the Victorian Department of Justice and Community Safety (**VDJCS**) with the objective of reducing drug-related mortality amongst those individuals released from prison, including having the capacity to address health information sharing.

33. I note with approval the responses received from VDH and VDJCS in which they both committed to developing shared governance, advisory, and information sharing mechanisms regarding forensic clients with a view to repurposing existing governance arrangements to meet the objectives of my recommendation.

34. The second recommendation concerned the expansion of the VDJCS pilot naloxone program state-wide to all Victorian prisoners.

35. In response to this recommendation, the VDJCS advised that following successful implementation of the 'Naloxone on Release' pilot program on 4 May 2020 at all public prisons, an independent review confirmed the value of the program and funding was confirmed to further support the rollout of the program to all private prisons, to identify opportunities to increase the prescription of Naloxone to prisoners prior to their release, and to monitor and contribute to the evaluation of the program. Additionally, the Penington Institute has been contracted to undertake a rapid review of the program to further inform program improvements.

I convey my sincere condolences to EZT's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

[16] COR 2019 004949 (name redacted).

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

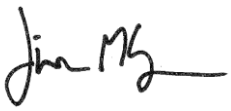
GDG, Senior Next of Kin

Marius Smith, VACRO

Alison Will, Department of Justice and Community Safety

Senior Constable Rohan Brock, Victoria Police, Coroner's Investigator

Signature:



Coroner Simon McGregor

Date : 19 July 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.