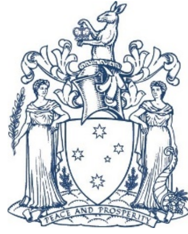

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 003914

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	XRR[1]
Date of birth:	1991
Date of death:	24 July 2021
Cause of death:	1(a) Mixed drug toxicity (heroin and methamphetamine)
Place of death:	Yallambie, Victoria, 3085
Keywords:	OVERDOSE, HEROIN, COVID

[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 pseudonyms of randomly generated three-letter sequences to protect their identity and redact identifying information.

INTRODUCTION

1. On 24 July 2021, XRR was 29 years old when he was found deceased at home in circumstances suggestive of an unintentional drug overdose. At the time of his death, XRR lived in Yallambie with his family.

2. According to his siblings, XRR had a history of using recreational drugs, experimenting with cannabis and ecstasy as a teenager.[2] He later developed an addiction to opioids in his late 20s after suffering a lower back injury whilst at work.[3] XRR also suffered from anxiety and panic attacks which contributed to his dependence on substances.[4]

3. XRR suffered several seizures throughout his life which were investigated however no obvious cause was diagnosed. Medical records from Alfred Health indicated that the most likely cause of XRR's seizures was due to tramadol use and abrupt withdrawal of high-dose benzodiazepines.[5]

4. Despite his struggles with drugs, XRR maintained his employment, relationships, and lived a normal life, however he eventually confided in his family about his addiction and told his mother that he hated being addicted to heroin and was embarrassed about it.[6] XRR also began using alcohol to sate his heroin cravings and began drinking most days.[7]

5. XRR later attempted detoxification at home due to restrictions in services caused by the ongoing COVID pandemic. He was placed on the methadone opioid replacement therapy programme until early 2020 and used anxiety and sleeping tablets to control his symptoms.[8]

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[2] Coronial brief, statement of YLK dated 2 December 2021, page 28; statement of GIO dated 2 December 2021, page 39.
[3] Coronial brief, statement of BBH dated 2 December 2021, page 15, 18.
[4] Coronial brief, statement of Dr Anthony Michaelson dated 21 November 2021, page 54.
[5] Coronial brief, Alfred Health report dated 24 March 2021, page 62.
[6] Coronial brief, statement of BBH dated 2 December 2021, page 17, 22; statement of YLK dated 2 December 2021, page 28.
[7] Coronial brief, statement of YLK dated 2 December 2021, page 28.
[8] Coronial brief, statement of BBH dated 2 December 2021, page 18; statement of Dr Anthony Michaelson dated 21 November 2021, page 54.

6. XRR attended sessions with a psychologist during which he denied any thoughts of self-harm or suicidality.[9] In June 2021, XRR advised his psychologist, Kaitlyn McCabe, that he wanted to practice his coping skills independently and discharged from her services. Ms McCabe encouraged XRR to contact her in the future if required, however.[10] XRR also accessed drug and alcohol counselling from his local Community Health Centre.[11]

7. To assist with his addiction, XRR's mother took responsibility for dispensing his medication. In 2020, BBH suffered a heart attack however XRR performed cardiopulmonary resuscitation until paramedics arrived. During his mother's recovery period, XRR began looking after his own medication again.[12] According to XRR's general practitioner, Dr Anthony Michaelson, XRR's compliance with his medication was appropriate as evidenced by checks conducted through Safescript.[13]

THE CORONIAL INVESTIGATION

8. XRR'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.

9. 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.

10. 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.

[9] Coronial brief, statement of GIO dated 2 December 2021, page 40.
[10] Coronial brief, statement of Kaitlyn McCabe dated 21 June 2021, page 57.
[11] Coronial brief, statement of Dr Anthony Michaelson dated 21 November 2021, page 54.
[12] Coronial brief, statement of BBH dated 2 December 2021, pages 16-17.
[13] Coronial brief, statement of Dr Anthony Michaelson dated 21 November 2021, page 54.

11. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of XRR'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.

12. This finding draws on the totality of the coronial investigation into the death of XRR 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.[14]

13. In considering the issues associated with this finding, I have been mindful of XRR's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006* (Vic), in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

14. On 19 July 2021, XRR spoke to his partner, FZZ, telling her that he had an 'abnormally tough day at work', having to fire a workmate. Over the next few days, however, his spirits appeared to improve, and he told FZZ he was looking forward to spending time with her on the weekend.[15]

15. On 23 July 2021, XRR came home at about 5.30pm but later left the house after borrowing his mother's car to visit FZZ.[16] After sharing a bottle of wine together, XRR told FZZ that he needed to go home but would meet her the following day for lunch. FZZ stated that XRR appeared to be exhausted when he left.[17]

16. At 11.42pm, XRR texted FZZ to let her know that he had returned home safely.[18] BBH stated that he prepared a meal for himself and went into his room, leaving the bedroom light on.[19] At about 2.30am, YLK sent XRR a text message but did not receive a response.[20]

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[14] 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.

[15] Coronial brief, statement of FZZ dated 2 December 2021, pages 50-51.

[16] Coronial brief, statement of BBH dated 2 December 2021, pages 20-21.

[17] Coronial brief, statement of FZZ dated 2 December 2021, page 51.

[18] Coronial brief, statement of FZZ dated 2 December 2021, page 52.

[19] Coronial brief, statement of BBH dated 2 December 2021, pages 20-21.

[20] Coronial brief, statement of YLK dated 2 December 2021, page 33.

17. On 24 July 2021, BBH got up at around 9.30am and saw that XRR's bedroom light was still on. Concerned, she opened the door and discovered him deceased on his bed with a torniquet near his arm.[21]

18. Emergency services attended the address and verified that XRR was deceased. Numerous items of drug paraphernalia were located in XRR's room.[22]

Identity of the deceased

19. On 24 July 2021, XRR, born in 1991, was visually identified by his mother.

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

Medical cause of death

21. Forensic Pathologist Dr Judith Fronczek from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 27 July 2021 and provided a written report of her findings dated 13 September 2021.

22. The post-mortem examination revealed findings consistent with the history given. The post-mortem computed tomography scan demonstrated cerebral oedema and increased interstitial markings.

23. Toxicological analysis of post-mortem samples identified the presence of 6-monoacetylmorphine, morphine, and codeine. Ethanol (alcohol), methylamphetamine, and amphetamine were also identified.

24. Dr Fronczek noted that the results were consistent with the recent use of heroin in combination with alcohol and amphetamines.

25. Dr Fronczek provided an opinion that the medical cause of death was 1 (a) mixed drug toxicity (heroin and methamphetamine).

26. I accept Dr Fronczek's opinion.

[21] Coronial brief, statement of BBH dated 2 December 2021, page 22.
[22] Coronial brief, statement of Detective Senior Constable Jeremy Redfern dated 2 December 2021, pages 68-69.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was XRR, born in 1991;

    b) the death occurred on 24 July 2021 in Yallambie, from *mixed drug toxicity (heroin and methamphetamine)*; and

    c) the death occurred in the circumstances described above.

28. Having considered all of the circumstances, I am satisfied that XRR's death was the unintended consequence of the deliberate ingestion of drugs.

COMMENTS

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

29. During the coronial investigation into her son's death, XRR's mother expressed well-recognised concerns regarding complex and long-standing issues with the societal response to drug, alcohol, and psychiatric services. Whilst these concerns lacked the necessary specificity to give rise to a course of coronial investigation, I believe that they are, in essence, well-founded and deserving of address.

30. It is important to acknowledge the pain and needless suffering of people of all ages who suffer from addictions of all kinds, and, in especial relevance to this matter, those that battle with a heroin addiction. It is well recognised that there is substantial room for improvement in the systems and resources available to support and manage people with addiction.

31. It is well-known that the oversupply of prescription medications significantly contributes to the addiction burden faced by the Australian (and international) community. It is heartening to see that the medical profession, supported by regulators, increasingly encourages alternative to opioids and benzodiazepines for most conditions.

32. This alternative approach should be encouraged, as should a multidisciplinary approach to the identification and treatment of such addictions, both during the acute and withdrawal phases, which is well-supported by the medical literature.

I convey my sincere condolences to XRR'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.

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

TZF, Senior Next of Kin

BBH, Senior Next of Kin

Royal Australian College of General Practitioners

Detective Senior Constable Jeremy Redfern, Victoria Police, Coroner's Investigator

Signature:

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CORONER SIMON McGREGOR

CORONER

Date: 8 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.