IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2016 2722

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

I, AUDREY JAMIESON, Coroner having investigated the death of DAVID LESLIE CHAPMAN

without holding an inquest:
find that the identity of the deceased was DAVID LESLIE CHAPMAN
born 6 May 1977
and the death occurred on 17 June 2016
at St Vincent's Hospital Melbourne, 41 Victoria Parade, Fitzroy Victoria 3065
from:

1 (a) HYPOXIC ISCHAEMIC BRAIN INJURY

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

1. David Leslie Chapman was 39 years of age at the time of his death. Mr Chapman lived in Vermont. His medical history included schizophrenia and heroin use.

2. At approximately 10.45am on Thursday 9 June 2016, Mr Chapman was observed by a cleaner; he had a syringe and was sitting down in Anderson Court, Richmond, at the back of a building. The cleaner subsequently informed nearby Wilson Security personnel about Mr Chapman's presence. A short time later, a loud sound – like bins falling over – was heard. Mr Chapman

was located collapsed and unconscious on the ground next to a bin enclosure. A needle mark was observed within Mr Chapman's left cubital fossa and a used syringe was located nearby.

3. Security staff contacted emergency services and commenced cardiopulmonary resuscitation (CPR). Mobile Intensive Care Ambulance (MICA) paramedics arrived shortly afterwards, to find Mr Chapman in pulseless electrical activity (PEA) arrest. After five to six minutes of CPR, Mr Chapman reverted back to sinus tachycardia. Metropolitan Fire Brigade (MFB) members were also present, but police were not in attendance.

4. Mr Chapman was transported by ambulance to the Emergency Department of St Vincent's Hospital Melbourne, and admitted to the Intensive Care Unit (ICU). Mr Chapman was found to have sustained a hypoxic ischaemic brain injury. Over the following days his neurology assessment failed to improve. A meeting with Mr Chapman's family was held on 16 June 2016, and it was agreed that active treatment be withdrawn. At approximately 1.06pm on Friday 17 June 2016, Mr Chapman was declared deceased.

INVESTIGATIONS

Forensic pathology investigation

5. Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM) performed a full post mortem examination upon the body of Mr Chapman, reviewed a post mortem computed tomography (CT) scan and e-Medical Deposition Form from St Vincent's Hospital Melbourne, and referred to the Victoria Police Report of Death, Form 83. At autopsy, Dr Burke observed hypoxic ischaemic brain injury, bronchopneumonia and evidence or prior intravenous drug use. There was no evidence of any injury or natural disease process which would have led to Mr Chapman's collapse and subsequent death.

6. Toxicological analysis of Mr Chapman's post mortem specimens detected morphine,[1] methadone,[2] nordiazepam,[3] midazolam,[4] levetiracetam,[5] metoclopramide,[6] doxylamine[7] and

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[1] Morphine is a narcotic analgesic used to treat moderate to severe pain. It is also a metabolite of codeine, and may derive from the use of heroin.

[2] Methadone is a synthetic narcotic analgesic used for the treatment of opioid dependency or for the treatment of severe pain.

[3] Nordiazepam is a metabolite of diazepam, a sedative/hypnotic drug of the benzodiazepines class.

[4] Midazolam is a short acting benzodiazepine used intravenously in intensive care patients.

[5] Levetiracetam is an antiepileptic used for the control of partial onset seizures.

[6] Metoclopramide is an anti-emetic drug used for the treatment of nausea and vomiting.

lignocaine.[8] Dr Burke noted that the presence of morphine may reflect morphine being taken by Mr Chapman (as morphine or heroin), or could have been administered by ambulance or hospital personnel.

7. In a report dated 17 March 2017, Dr Burke ascribed the cause of Mr Chapman's death to hypoxic ischaemic brain injury.[9]

Police investigation

8. Senior Constable (SC) Kylie Bevan, the nominated coroner's investigator,[10] conducted an investigation into the circumstances surrounding Mr Chapman's death, at my direction, including the preparation of the coronial brief. The coronial brief contained, *inter alia*, statements made by Mr Chapman's father Terry Chapman and General Practitioner at Malvern Medical Centre Dr Gregory Frean.

9. Police obtained closed circuit television (CCTV) footage from the Richmond Housing Estate, which showed Mr Chapman walking by himself from Victoria Street Richmond, through a back laneway and into Anderson Court, on 9 June 2016. The footage was not very clear, but indicated movement near the bin enclosure, with security guards attending the area and later emergency services personnel. SC Bevan stated that police did not identify any evidence of third party involvement in Mr Chapman's death.

10. In the course of the investigation, police learned that Mr Chapman began using heroin around the age of 18, and continued to use it, on and off, for the rest of his life. Terry Chapman stated that his son got onto the methadone program for a while, and it helped. He added that Mr Chapman was diagnosed with depression during his twenties, and was subsequently diagnosed with paranoid schizophrenia.

11. Dr Gregory Frean reported that Mr Chapman was a patient at Malvern Medical Centre from 2004. He had a long history of multi-substance abuse; primarily alcohol, marijuana and

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[7] Doxylamine is an antihistamine which has sedative and relaxant properties.

[8] Lignocaine is a local anaesthetic.

[9] In an earlier report dated 31 January 2017, Dr Burke had ascribed Mr Chapman's death 1(a) hypoxic brain injury, secondary to 1(b) toxicity to morphine. However, in the amended report dated 17 March 2017, Dr Burke noted the earlier report had been based on the erroneous belief that the toxicological analysis had been performed on hospital admission samples.

[10] A coroner's investigator is a police officer nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions direction from a coroner and carries out the role subject to the direction of a corner.

occasionally heroin. Dr Frean stated that the diagnosis of Mr Chapman's psychiatric problems was not entirely clear; various labels of drug induced psychosis, schizo-affective disorder and borderline personality disorder had been ascribed throughout the years. He noted that Mr Chapman had periods of deep depression. Mr Chapman had sporadic contact with mental health services, but Dr Frean stated that he felt they were unhelpful and at times believed they were conspiring against him. Mr Chapman's current medications included acamprosate calcium, diazepam, pregabalin, methadone and olanzapine.

12. SC Bevan's summary indicated that Mr Chapman had come to the attention of police at various points since 1997. In May 2015, police found him unresponsive in the driver's seat of his parked vehicle in Lygon Street, Carlton. Ambulance paramedics attended on this occasion and administered Narcan; numerous syringes were found in the vehicle. On occasions in November 2015 and January 2016, Mr Chapman was spoken to by police in Elizabeth Street, Richmond, and conceded to having recently used heroin.

13. Terry Chapman stated that his son had recently moved in with a new girlfriend, but when she learned that he was using drugs again, she had made him leave. He stated that Mr Chapman's life had deteriorated from this point. Dr Frean was also aware of this relationship, and stated that Mr Chapman's girlfriend had been able to impose a degree of discipline on him while they were together. He gained weight and reported a considerable drop in his substance usage. During this period, Dr Frean was able to reduce Mr Chapman's methadone dose to 10mg per day.

14. Dr Frean last saw Mr Chapman on 17 May 2016; at this consultation he was in an excellent mood.

COMMENTS

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

1. On 20 February 2017, Coroner Jacqui Hawkins delivered the Finding following an Inquest into the death of Ms A,[11] whose death was ascribed to global cerebral ischaemia secondary to mixed drug toxicity including a substance consistent with heroin. The Finding noted that Ms A attended the City of Yarra regularly, particularly the North Richmond area, to purchase and use heroin. I note that Mr Chapman was also located in this vicinity, following a suspected heroin overdose.

[11] COR 2016 2418.

2. As part of Coroner Hawkins' investigation, the Coroners Prevention Unit (CPU)[12] conducted a review of fatal heroin overdoses in Victoria, to consider whether any broader prevention issues could be identified that were relevant to the circumstances in which Ms A died. Her Honour noted that the CPU advised *inter alia* that over the past seven years, the City of Yarra has consistently been the local government area with the highest frequency of heroin overdose deaths in Victoria. A large number of deaths occurred in a relatively well defined area, centred on Victoria Street, and surrounding streets in Richmond and Abbotsford. In addition, Her Honour noted that in 2015, 20 of the 172 fatal heroin overdoses in Victoria occurred in the City of Yarra.

3. At the conclusion of the investigation and Inquest, Coroner Hawkins recommended *inter alia* that a safe injecting facility trial be established in North Richmond, and that the availability of naloxone be expanded to people in a position to intervene and reverse opioid drug overdoses in the City of Yarra.

4. Following the publication of Coroner Hawkins's finding with recommendations, the CPU has produced further data to elucidate the burden of fatal heroin overdose in the City of Yarra compared to other Victorian Local Government Areas (LGA). In particular:

    a. The CPU compiled data showing that in 2016, the highest frequency of heroin-involved Victorian overdose deaths occurred in the City of Yarra (18 of 190 deaths; the next highest frequency was 13 heroin overdose deaths in Port Phillip).

    b. The CPU identified the 10 Victorian LGAs with the highest frequencies of heroin overdose deaths across the period 2012 to 2016, and analysed the location of each fatal overdose to determine what proportion occurred in the deceased's own residence, another person's residence, and in non-residential locations. Table 1 in Attachment A shows the results of the analysis. The City of Yarra had the highest proportion of overdose deaths in non-residential locations (48.4%), followed by the City of Melbourne (32.8%) and the City of Maribyrnong (25.5%); otherwise the vast majority of heroin overdose deaths occurred in private residences, usually the residence of the deceased.

    c. Extending the analysis described immediately above, for each of the 10 LGAs, the CPU compared the LGA where each fatal overdose occurred to the LGA of usual residence for the

[12] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

deceased. Table 2 in Attachment A shows the results of the analysis. For 68.6% of fatal heroin overdoses in the City of Yarra, the deceased's usual place of residence was an LGA other than the City of Yarra. At least two-thirds of deceased in each of the other nine LGAs, usually resided in the LGA where they fatally overdosed.

5. This data highlights the distinctive features of fatal heroin overdose in the City of Yarra. Compared to other Victorian LGAs examined, over the past five years a much greater proportion of fatal heroin overdoses in the City of Yarra involved people who travelled there from other areas; and a much greater proportion occurred in non-residential locations such as parks, carparks, public toilets, restaurant toilets, cars, and on streets. The death of Mr Chapman, who travelled from Geelong to fatally overdose in Anderson Court, tragically typifies this trend.

6. In this light, I must support Coroner Hawkins's recommendations relating to safe injecting facilities and complimentary interventions. The City of Yarra is clearly a destination for heroin use among the broader Victorian population of people who inject drugs, and thus bears a disproportionate burden of associated drug-related harms including fatal heroin overdose. Investing in new harm reduction strategies in the City of Yarra to address this serious public health issue, will reduce overdose risk among vulnerable drug-using members of the community well beyond the City of Yarra's borders. Additionally, if a safe injecting facility can shift drug injecting from public locations to a clinically supervised environment, this would be hoped to lessen the traumatic impact of injecting drug use and overdose and death on local residents who are exposed to these activities in their everyday life.

FINDINGS

The investigation has identified that Mr Chapman had a lengthy history of substance abuse, including alcohol and heroin. On 9 June 2016, Mr Chapman was located collapsed in an area of Richmond that has been the location of a significant number of fatal heroin overdoses. While ante mortem specimens have not been made available for toxicological analysis, the circumstances in which Mr Chapman was found, with a needle mark and a used syringe, lead me to find on the balance of probabilities that the collapse, which precipitated his death on 17 June 2016, occurred following a heroin overdose.

I acknowledge that Mr Chapman had a history of mental ill-health, including depression. However, there is no evidence to suggest that his death was intentional. In the circumstances, I find that Mr Chapman's death was the unintentional consequence of his intentional use of illicit substances.

I accept and adopt the medical cause of death as identified by Dr Michael Burke and find that David Leslie Chapman died from hypoxic ischaemic brain injury.

I direct that pursuant to Section 49(2) *Coroners Act 2008 (Vic)*, the Principal Registrar notify the Registrar of Births, Deaths and Marriages of the prescribed particulars of my Findings following my investigation and accordingly that the Registrar amend the currently registered cause of death to reflect my Findings in the cause of death of David Leslie Chapman.

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

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

Mr Terry Chapman
Ms Robyn Beckwith
Ms Melanie Kyezor, Clinical Risk Manager, St Vincent's Health
Dr Gregory Frean
The Honourable Martin Foley MP, Minister for Mental Health
Ms Kym Peake, Secretary of the Department of Health and Human Services
Ms Margaret Fitzherbert MLC, Chair, Standing Committee on Legal and Social Issues
Mr Demos Krouskos, Chief Executive Officer, North Richmond Community Health
Mr Greg Denham, Executive Officer, Yarra Drug and Health Forum
Ms Judy Ryan, Residents for Victoria Street Drug Solutions
Senior Constable Kylie Bevan

Signature:

AUDREY JAMIESON
CORONER
Date: **8 May 2017**

Coroners Court of Victoria

ATTACHMENT A

Table 1. Frequency of overdose deaths by local government area of fatal overdose, and type of location where the fatal overdose occurred, Victoria 2012-2016.

Local government area of fatal overdose	**Type of location at which the deceased fatally overdosed**							
	Own home		Another's home		Non-residential		*Total*	
	N	%	N	%	N	%	*N*	*%*
Yarra	18	28.1	15	23.4	31	48.4	*64*	*100.0*
Melbourne	34	58.6	5	8.6	19	32.8	*58*	*100.0*
Port Phillip	35	72.9	9	18.8	4	8.3	*48*	*100.0*
Brimbank	28	63.6	8	18.2	8	18.2	*44*	*100.0*
Greater Dandenong	32	80.0	4	10.0	4	10.0	*40*	*100.0*
Greater Geelong	20	60.6	9	27.3	4	12.1	*33*	*100.0*
Darebin	25	80.6	4	12.9	2	6.5	*31*	*100.0*
Maribyrnong	18	64.3	3	10.7	7	25.0	*28*	*100.0*
Whitehorse	18	75.0	2	8.3	4	16.7	*24*	*100.0*
Frankston	14	60.9	7	30.4	2	8.7	*23*	*100.0*

Table 2. Frequency of overdose deaths by local government area of fatal overdose, and local government area of deceased's usual residence, Victoria 2012-2016.

Local government area of fatal overdose	**Local government area of usual residence**					
	Same as LGA of fatal overdose		Different to LGA of fatal overdose		*Total*	
	N	%	N	%	N	%
Yarra	20	31.3	44	68.8	*64*	*100.0*
Melbourne	40	69.0	18	31.0	*58*	*100.0*
Port Phillip	36	75.0	12	25.0	*48*	*100.0*
Brimbank	36	81.8	8	18.2	*44*	*100.0*
Greater Dandenong	33	82.5	7	17.5	*40*	*100.0*
Greater Geelong	32	97.0	1	3.0	*33*	*100.0*
Darebin	28	90.3	3	9.7	*31*	*100.0*
Maribyrnong	19	67.9	9	32.1	*28*	*100.0*
Whitehorse	19	79.2	5	20.8	*24*	*100.0*
Frankston	17	73.9	6	26.1	*23*	*100.0*