FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 5712/09

Inquest into the Death of MELISSA DEBORAH IRWIN

Delivered On:	16th December 2010
Delivered At:	Melbourne
Hearing Dates:	19th October 2010
Findings of:	CORONER K. M. W. PARKINSON
Place of death:	8-12 Fosbery Crescent, Viewbank, Victoria 3084
Police Coronial Support Unit PCAU:	Sergeant D Dimsey

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Court reference: 5712/09

In the Coroners Court of Victoria at Melbourne
I, KIM PARKINSON, Coroner

having investigated the death of:

Details of deceased:

Surname:	IRWIN
First name:	MELISSA
Address:	8 Thelma Avenue, Essendon North, Victoria 3040

AND having held an inquest in relation to this death on 19th October 2010 at Melbourne

find that the identity of the deceased was MELISSA DEBORAH IRWIN

and death occurred on 6th December, 2009

at 8/12 Fosbery Crescent, Viewbank, Victoria 3084

from
1a. METHADONE TOXICITY

in the following circumstances:

1. An inquest was conducted into the death of Ms Melissa Irwin on 19 October 2010. The following witnesses were called to give evidence in the proceeding: Mr Aristidis Laliotis, Registered Pharmacist; Mr Paul Wesley Day; Mr Matthew Graham; Dr Amrooha Hussain.

2. Ms Melissa Irwin was born on 3 May, 1974 and she was 35 years of age at the time of her death. She resided at 8 Thelma Avenue, Essendon North, Victoria 3040. She had been employed as a project manager within the Victorian Public Service. Ms Irwin had a previous medical history of depression and also suffered with alcoholism.

3. On 6 December 2009, Ms Irwin had attended at 8 - 12 Fosbery Crescent, Viewbank the home of Mr Roman Walczuk, aged 80 years, who suffers with dementia type illness. Ms Irwin had two purposes for attending the premises, to stay overnight in order to assist with cleaning the premises and to see her cousin, Mr Matthew Graham, who resides there as a carer for Mr Walczuk. Mr Graham is a recovering heroin addict and is on the methadone program.

4. Ms Irwin arrived at the house with her mother, Ms Lorraine Coelho, in the morning of 5 December 2009. Mr Graham was not home when Ms Irwin arrived. He and his two year old son were visiting elsewhere. Prior to leaving the house, Mr Graham left a 200ml bottle containing 110mg of methadone on a bedside table in his bedroom.

5. Ms Coelho left the premises and returned that day with her partner, Mr Martin Graham, who is the father of Matthew Graham, to drop off some food. Whilst there she noticed that Melissa was in bed and was snoring and observed to Mr Martin Graham, that this was unusual for Melissa. They left the premises at approximately 12.30pm. Mr Matthew Graham returned to the house at approximately 3.20pm on 6 December 2009 and noted that Ms Irwin was asleep in his bed. He placed the child next to her in the bed and then left the room. He returned to the room shortly afterwards and noticed that the methadone bottle he had left on the bedside table was ¾ empty. He emptied the remains of the container as it was time for his dose. He then located a note from Melissa on the bedside table which indicated she had drunk the methadone. He thought he had heard Melissa snoring and thought that when he felt for a pulse he had detected one. Mr Graham's evidence was that, whilst he knew that a full dose of methadone might kill Ms Irwin, he thought that ¾ of 110ml would not have been quite so bad. He thought she was just asleep and was fine.

6. A short time later Ms Coelho rang. Mr Graham said she was asleep. Ms Coelho made her way to the premises. When she arrived she could not rouse Melissa. She called for an ambulance and commenced CPR. Ambulance and police attended the premises, however Ms Irwin could not be resuscitated and was deceased.

7. Police located the empty methadone container was on the bedside table next to the bed where Ms Irwin and the child were sleeping. The methadone bottle was appropriately labelled and identified as methadone, with the prescribed dosage indicated. According to Mr Laliotis, the prescribing pharmacist, Mr Graham was receiving five take away methadone doses a week, no more than three days in a row. His prescribed dose was 110mg and it was delivered in liquid form.

8. Police also located the note addressed to Mr Graham, evidenced to be in Ms Irwin's handwriting and advising that she had taken his methadone as she had no money to purchase alcohol.

9. Family and friends report that whilst Ms Irwin had suffered from depression, she appeared to be relatively stable in mood at the time of her death. There were no indications in any of the evidence that Ms Irwin had intended to take her own life.

10. The evidence is that Ms Irwin had some knowledge of the toxicity of methadone as she had cared for Mr Graham when he was detoxing from heroin and had assisted in administering his methadone medication. His evidence was that they had discussed the nature of the methadone and its potential for harm. However, unlike Mr Graham, as she was not a registered program recipient she had never received any formal education from a medical practitioner or pharmacist as to the effects of methadone and its possible toxicity.

11. An autopsy was conducted by Dr Malcolm Dodd, Forensic Pathologist with the Victorian Institute of Forensic Medicine. Dr Dodd reported that the cause of death was methadone toxicity. He commented that there was no evidence of any injuries that may have caused or contributed to death. Dr Dodd noted that his examination revealed hypoxic changes to the liver, which were consistent with drug induced hypoxia which may have lead to death.

12. The toxicology report identified morphine present in post mortem specimens: Methadone Blood ~ 0.5mg/L, and methadone metabolite ADP in blood at 0.5mgL. The antidepressant peroxiding was detected in blood at 0.5mgL. This is consistent with therapeutic use.

13. Morphine at the levels detected has the capacity to depress respiratory function, more so when combined with other drugs such as alcohol. This is particularly so in the case of a person who has no developed tolerance to the drug. The toxicologist also commented that persons who have recently started a methadone program are more likely to develop a toxic response to the drug than those on long term maintenance doses.

14. Ms Irwin had no history of illicit substance abuse and nor was she a prescribed methadone user. As the pathologist and the toxicologist have reported this made her more susceptible to toxic effects of the methadone and I accept that this is so.

15. There is no evidence to suggest that the death was anything other than accidental. Nor am I able to conclude on the evidence that intervention at an earlier time would have altered the outcome for Melissa.

16. I am satisfied that Ms Melissa Irwin died as a result of methadone toxicity as a result of the effects of the methadone she voluntarily consumed.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death (including any notification to the Director of Public Prosecutions under Section 69(2) of that Act):

1. Ms Irwin died as a result of methadone toxicity. An issue arises in this case as to the appropriateness of the storage of the methadone at the premises and the supervision by any authority of the safety of that storage. The ready availability of the methadone in this case has contributed to her death.

2. Whilst I accept that Mr Graham had no reason to suspect that Ms Irwin would take his methadone, as she did not have any history of illicit drug use, the fact that it was not secured away from non-authorised access is of serious concern and in this case contributed to the death.

3. Methadone is a prescribed drug pursuant to Schedule 8, of the Drugs, Poisons and Controlled Substances Act 2006. The supply of methadone is regulated under the Drugs, Poisons and Controlled Substances Act 1981 and Regulations 2006. Medical Practitioners and Pharmacists prescribing or dispensing pharmacotherapies (methadone and buprenorphine) require approval from the Drugs and Poisons Group (DPRG) of the Department of Health (DH).

4. Whilst there is no prohibition upon an authorised prescriber directing take away dosage, regulatory authority guidelines provide criteria as to the circumstances in which take away dosage is appropriate. These include the following guidelines issued by the Department of Health and Department of Human Services (Victoria) and by the National Pharmacy Board of Australia.

- Policy for Maintenance Pharmacotherapy Dependence (2006)
- National Clinical Guidelines and Procedures for the Use of Methadone in the Maintenance Treatment of Opioid Dependence (2003)
- National Clinical Guidelines and Procedures for the Use of Buprenorphine in the Treatment of Opioid Dependence (2003)

5. These guidelines are an attempt to insure against a number of concerns, including the very circumstance which has arisen in this case, that persons other than those for whom the medication is prescribed may be able to access the drug.

6. Whilst there is a presumption in the legislation and the regulatory mechanisms that the provision of methadone for take away doses comes with a level of supervision of the patient and that there are satisfactory arrangements for secure storage, it appears to me that there is little effective supervision of the manner in which takeaway doses of methadone are stored.

7. The guidelines do not specifically identify who is responsible for the oversight of matters such as safe storage or what steps are required to be taken to ensure safety prior to take away doses being allowed. To leave the decision making and storage arrangements solely in the hands of the addicted person seems to be an approach which is fraught with risk, given the unreliability often associated with persons suffering with substance addiction.

8. That lack of supervision and lack of regulation of the storage arrangements is in my view an extremely dangerous practice which has the potential to result in the death of persons other than the patient and in particular children. It was fortunate that the young child present in the bedroom did not also access the remainder methadone in the bottle. In this case I am satisfied that the lack of supervision of these matters contributed to the death.

RECOMMENDATIONS

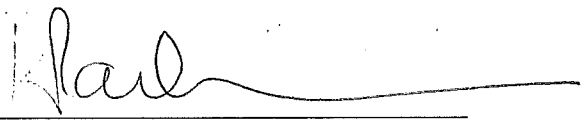
Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. That regulatory authorities establish a clear mechanism of supervision of the safety arrangements for storage of take away dosage of methadone.

2. That there be a prohibition upon take away methadone dosage unless a responsible regulatory authority is satisfied that safe storage arrangements are in place in the premises in which the drug is to be stored.

3. I direct that a copy of these findings be provided to the Honourable Mr David Davis MLC Minister for Health (Victoria); The Honourable Ms Mary Wooldridge MP, Minister for Community Services Victoria; The Health Practitioner's Board Australia and The National Pharmacy Board of Australia.

Signature:



K.M.W. Parkinson
Coroner
16th December 2010