IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2015 6339

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of:	Sandra Michelle Liddy
Delivered On:	14 November 2017
Delivered At:	65 Kavanagh Street Southbank 3006
Hearing Date:	14 November 2017
Findings of:	Caitlin English, Coroner
Police Coronial Support Unit:	Leading Senior Constable Ross Treverton

I, Caitlin English, Coroner having investigated the death of Sandra Michelle Liddy

AND having held an inquest in relation to this death on 14 November 2017
at Melbourne
find that the identity of the deceased was Sandra Michelle Liddy
born on 3 September 1971
and the death occurred on 16 December 2015
at 44 Walsh Street, Broadmeadows, Victoria
from:

I (a) Heroin toxicity

in the following circumstances:

1. Sandra Michelle Liddy was aged 44 years old when she died. She resided at the Adult Mental Health Rehabilitation Unit (AMHRU) at Sunshine Hospital where she was an involuntary patient.

2. Ms Liddy was on unescorted day leave on 16 December 2015 when she took an overdose of heroin and was unable to be resuscitated.

The coronial investigation

3. Ms Liddy's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* ('the Act'). Her death was reportable on a number of grounds: it was unexpected and unnatural and in addition Ms Liddy was an involuntary patient at a mental health facility.

4. As Ms Liddy was an involuntary patient, she was therefore immediately before her death '*a person placed in custody or care*'.[1] In cases where a person is in custody or care an inquest is mandatory.

5. The intention of the legislation is to recognise the vulnerability of people placed in the care or custody of the State or its instruments, to accord them the protection afforded by the

[1] *Coroners Act 2008* (Vic) ss 3 and 4(2)(c).

independent scrutiny of the circumstances in which they have died and to promote accountability on the part of the State or its instruments.[2]

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.

7. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, the forensic pathologist who examined Ms Liddy, treating clinicians and investigating officers, as well as additional materials from Ambulance Victoria.

8. I have also sought additional statements from Ms Liddy's mother, her NorthWestern Mental Health case manager and the four Ambulance officers who attended 44 Walsh street on 16 December 2015. I have also asked the Coroners Prevention Unit to review Ms Liddy's care whilst at AMHRU.

9. I have based this finding on the evidence contained in the coronial brief. In the coronial jurisdiction facts must be established to the standard of proof which is the balance of probabilities. [3]

Identification of the deceased

10. On 16 December 2015, Lois Burns visually identified Ms Liddy's body as being that of her son's ex-partner Sandra Liddy, born 3 September 1971.

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

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[2] Whereas a coroner has a discretion to hold an inquest into any death they are investigating, a coroner *must* hold an inquest into a death which the deceased was immediately before death, a person placed in custody or care: *Coroners Act 2008* (Vic) s 52(2)(b).

[3] 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.

Circumstances in which the death occurred

12. Ms Liddy had an extensive psychiatric history and had been diagnosed with paranoid schizophrenia, antisocial personality disorder and polysubstance use disorder. She had a history of abusing alcohol, cannabis, methamphetamine and heroin.

13. Ms Liddy had four children who were not under her care and her finances were managed by State Trustees.

14. Ms Liddy had a lengthy criminal history including multiple incarcerations but in the final years of her life she had made significant progress in reducing her court appearances. Prior to 2011 she had appeared at least annually in court since 2000 (excepting 2006), but she did not appear in court again after September 2011. At the time of her death she was believed to have been abstinent from opiates and cannabis for over two years.[4]

15. Ms Liddy's first inpatient psychiatric admission was to the Royal Park Psychiatric Hospital in 1992. She was admitted a number of times in the following years and on 23 April 2012 was first admitted to the NorthWestern Mental Health (NWMH) Adult Mental Health Rehabilitation Unit (AMHRU) located at Sunshine Hospital.

16. She was discharged from AMHRU on 17 December 2014 and lived in a NWMH Community Care Unit (CCU) in Broadmeadows.

17. She left the CCU in June 2015 and was then reportedly living in shared accommodation in St Albans where she had conflict with her housemates.[5]

18. On 15 August 2015 Ms Liddy was admitted to the Sunshine Acute Adult Psychiatric Unit (SAAPU) and was commenced on the antipsychotic clozapine. She was then placed on an Inpatient Treatment Order pursuant to the *Mental Health Act 2014* and on 18 September 2015 she was transferred to AMHRU to complete clozapine titration and to source appropriate accommodation.

19. Consultant Psychiatrist Dr Naveen Thomas stated that:

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[4] Statement of Dr Naveen Thomas and Ms Fiona Connally dated 25 October 2017, Coronial Brief.
[5] Progress note dated 18 September 2015 at 1810hrs, Mid West Mental Health Medical Records.

'Her mental state on admission to AMHRU was stabilised, and she continued to present well at AMHRU. Whilst she had ongoing symptoms of paranoia and some delusions, these did not interfere with her daily activities or ability to access the community without risk of harm to others or herself. Her clozapine level was in the therapeutic range, and she was compliant with her medication regime. She engaged well with staff and co-clients and participated in her recovery activities. Ms Liddy presented no management issues to the team at AMHRU and was assessed by her consultant psychiatrists as being a low risk of harm to self and others in the community. Due to her long history of drug and alcohol use she received ongoing counselling regarding harm minimisation but refused to engage in any Drug & Alcohol services as she was adamant that she no longer had any problems in this area.'[6]

20. During her time at AMHRU, Ms Liddy was granted ground leave on a number of occasions as well as day leave. Dr Thomas reported that '*...she had been utilising these leaves without any serious incidents but did return intoxicated by alcohol several times. She had proved to be fairly responsible with this leave and although she often returned late to the unit she was contactable by phone*'.[7]

21. A few weeks before her death, Ms Liddy visited her mother Margaret Liddy. Mrs Margaret Liddy stated that at this time she '*...didn't think that [Sandra] was using drugs because of the way that she presented. Sandra had money to spend and this was unusual, as when she was supporting her drug habit she never had any money to spend*'.[8]

22. Ms Liddy was working with an AMHRU social worker to find appropriate accommodation for discharge, and one of her recovery goals was to refrain from illicit drug use.

23. In the time leading up to her death, Ms Liddy was being treated with clozapine at 400mg daily and depot paliperidone at 100mg every four weeks. There were no concerns about her mental state and after a risk assessment on 15 December 2015 she was granted 6 hours daily unescorted day leave at staff discretion.

24. Ms Liddy had also made plans to visit her mother on Christmas Eve and stay with her until Boxing Day.[9]

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[6] Statement of Dr Naveen Thomas dated 23 May 2016, Coronial Brief.
[7] Ibid.
[8] Statement of Margaret Liddy dated 4 September 2017, Coronial Brief.
[9] Ibid.

- ***Events proximate to death***

25. On the morning of 16 December 2015 Ms Liddy was given $600 from State Trustees and granted permission for unescorted day leave for Christmas shopping. She agreed to return by 4.00pm and left AMHRU. Ms Liddy had on previous occasions received sums of money from State Trustees and used it appropriately.[10]

26. Later that day she went to the home of Lois Burns at 44 Walsh Street, Broadmeadows. Ms Burns' son, David, was Ms Liddy's former partner and the father of her youngest child. Ms Liddy often visited Ms Burns' home on holidays. David Burns and a family friend, Guney Saliah, were also present at the house at the time.

27. The exact events which occurred next are unclear. Ms Burns states that Ms Liddy left the house and later returned appearing unwell,[11] while Mr Burns' and Mr Saliah's statements do not mention this. Both Mr Burns and Ms Burns recall Ms Liddy giving Ms Burns $50 as a Christmas gift.[12]

28. At some point Ms Liddy used heroin intravenously: it is unknown whether she did this herself or with assistance from another person. The source of the heroin is also unknown.

29. At around 1.00pm Ms Liddy lost consciousness on a bed and stopped breathing. Ms Burns described her as having '*fainted*' [13] on the bed. Mr Burns stated, '*She laid back on the bed and I saw her turn blue.*' [14]

30. Mr Saliah commenced CPR and Mr Burns contacted emergency services at 1.07pm.

31. Mr Saliah states that he then observed that Ms Liddy appeared to have overdosed on heroin. He instructed Mr Burns to mix salt and water and inject the solution into Ms Liddy, as Mr Saliah believed this to be an effective means to reverse heroin overdose. He reports that Mr Burns then injected Ms Liddy with the solution twice.[15]

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[10] Statement of Dr Naveen Thomas and Ms Fiona Connally dated 25 October 2017, Coronial Brief.
[11] Statement of Lois Burns dated 16 December 2015, Coronial Brief.
[12] Statement of Lois Burns dated 16 December 2015, Coronial Brief; Statement of David Burns dated 16 December 2015, Coronial Brief.
[13] Statement of Lois Burns dated 16 December 2015, Coronial Brief
[14] Statement of David Burns dated 16 December 2015, Coronial Brief.
[15] Statement of Guney Saliah dated 16 December 2015, Coronial Brief.

32. Ambulance Victoria paramedics arrived at the scene at 1.14pm. Paramedic Amanda Mills noted one male at the house was upset and behaving aggressively. Furniture had to be moved which was blocking access to the room where Ms Liddy was located.[16]

33. Upon entry to the room, paramedics noted Ms Liddy to be in cardiac arrest. Following Ambulance guidelines for patients in cardiac arrest,[17] naloxone was not administered and paramedics commenced CPR along with members of the Metropolitan Fire Brigade.

34. Ms Liddy could not be revived and paramedics declared her deceased at 2.00pm.

35. Aside from the $50 given to Ms Burns, the remainder of the $600 was not located.

36. Statements from the Ambulance Victoria paramedics indicate they did not recall visualising any syringes, needles or drug paraphernalia at the scene. [18]

Cause of death

37. On 21 December 2015, Dr Yeliena Baber, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an examination upon Ms Liddy's body and provided a written report, dated 4 January 2016. In that report, Dr Baber concluded that a reasonable cause of death was '*I(a) Heroin toxicity*'.

38. Toxicological analysis of the post mortem samples taken from Ms Liddy identified the presence of 6-monoacetylmorphine (a heroin-specific metabolite), morphine, codeine and the antipsychotics clozapine and hydroxyrisperidone.

39. Dr Baber commented that the presence of 6-monoacetylmorphine in the blood indicates '*very recent use of heroin*'.

40. In the three years prior to Ms Liddy's death, she had little opportunity to regularly use heroin without it being noted by staff in the mental health units in which she lived. Her only substance use during this period appears to have been a low-level intake of alcohol.

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[16] Statement of Paramedic Amanda Mills dated 18 September 2017, Coronial Brief.
[17] Clinical Practice Guideline D021 (version 3), Ambulance Victoria.
[18] Statements of Paramedic Amanda Mills dated 18 September 2017 and Clare Burns dated 14 September 2017, Coronial Brief.

41. It is likely that Ms Liddy had developed a lowered tolerance to opioids during this period and did not make a dose adjustment taking into account her lower tolerance, thus increasing the risk of overdose.

42. In view of Dr Baber's findings, the circumstances of death and the likelihood of her lowered tolerance, I am satisfied that Ms Liddy died from an accidental overdose of heroin.

Review of care

43. As Ms Liddy died whilst an involuntary patient of NorthWestern Mental Health, I referred her case to the Coroners Prevention Unit (CPU)[19] for a review of the appropriateness of her care and the circumstances of her leave. The CPU reviewed medical records from NorthWestern Mental Health as well as the materials in the Coronial Brief.

44. The CPU advised that the care provided to Ms Liddy by AMHRU was clinically sound and appropriate. The materials available suggest that Ms Liddy's participation in her rehabilitation program had resulted in significant gains in her functioning that had not been achieved prior.

45. The CPU further advised her history of planned leave had been uneventful. A risk assessment was conducted on 15 December 2015 there was no reason to suggest that Ms Liddy had deteriorated in mental state, had increased risks or high risk behaviours that would have indicated or warranted that her planned leave should have been cancelled. The decision to allow her to take this leave was appropriate. She had also been given funds to purchase Christmas presents for her family. There was no reason to question this decision as she had had access to similar amounts previously without incident.

46. I accept that Ms Liddy's care was appropriate as was the decision to allow her to utilise leave in preparedness for her ultimate discharge from AMHRU.

[19] 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

Finding

I find that Sandra Michelle Liddy died from heroin toxicity in the circumstances of an accidental overdose while on unescorted leave from an inpatient mental health facility where she was an involuntary patient.

I direct that a copy of this finding be provided to the following:
Mrs Margaret Liddy, Senior Next of Kin
Melbourne Health (NorthWestern Mental Health)
Office of the Chief Psychiatrist.
Senior Constable Stephanie Attard, Victoria Police, Coroner's Investigator

Signature:

CAITLIN ENGLISH
CORONER
Date: 14 November 2017