IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 1152

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, JACQUI HAWKINS, Coroner having investigated the death of SKYE SUZANNE TURNER

without holding an inquest:
find that the identity of the deceased was SKYE SUZANNE TURNER
born on 20 November 1980
and the death occurred between 10 and 11 March 2017
at Elizabeth Street, Melbourne Victoria, 3000
from:

1 (a) MIXED DRUG TOXICITY

1. Skye Suzanne Turner was 36 years old at the time of her death. Ms Turner was the eldest of two children to Marie Farrow and James Turner. Ms Turner had two young daughters. The eldest daughter lived with her father who was her primary carer and she had fortnightly contact with Ms Turner's mother Marie Farrow. The youngest daughter lived with a different father. Ms Turner was able to have supervised visits with both children, in the presence of Ms Farrow, but her access to the youngest one was limited.

2. Ms Turner lived a chaotic life and had been in a relationship with Anthony White for approximately eight months. At the time of her death she was experiencing a period of homelessness after she and Mr White had been evicted from their rental property in Thomastown. Consequently, they were living in the back of Mr White's Toyota van.

3. Ms Turner had a medical history of Borderline Personality Disorder and a history of drug and alcohol abuse. According to Dr Vasilija Kojadinovic, Consultant Psychiatrist at the Eastern Health Psychiatric Triage and Psychiatric Assessment and Planning Unit, she had multiple admissions to the Delmont Private Hospital where she was regularly seen by a private psychiatrist. She also had a history of presenting in emergency departments due to self-harm and suicidal thoughts.

4. Ms Turner's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008.*

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The law is clear that coroners establish facts; they do not lay blame, or determine criminal or civil liability [1].

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Ms Turner's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses and submitted a coronial brief of evidence.

7. In writing this Finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

Identity

8. Skye Suzanne Turner was visually identified by Anthony White on 11 March 2017. Identity was not in issue and required no further investigation.

Medical cause of death

9. On 13 March 2017, Dr Matthew Lynch, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed a medical examination on the body of Ms Turner and reviewed the post mortem computed tomography (CT) scan and the Form 83 Victoria Police Report of Death.

10. Toxicological analysis of post mortem blood detected the presence of morphine, codeine, 6-monoacetylmorphine, fluvoxamine, diazepam, nordiazepam, and 7-amino clonazepam. Dr

[1] In the coronial jurisdiction facts must be established on the balance of probabilities 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.

Lynch provided an opinion that the medical cause of death was 1(a) MIXED DRUG TOXICITY.

Circumstances in which the death occurred

11. On Sunday 5 March 2017, Ms Turner attended her mother's home to see her eldest daughter and stayed overnight. The next morning Ms Turner and Ms Farrow dropped Ms Turner's daughter off to school. This caused Ms Turner to become upset as she explained to her mother that she just wanted to be like all the other mothers. Whilst driving home, Ms Turner became extremely upset and started crying and screaming hysterically. Concerned, Ms Farrow drove Ms Turner directly to the Maroondah Hospital.

12. Ms Turner was admitted to the Maroondah Hospital. [redacted] On presentation, Ms Turner had withdrawal symptoms from opiates and was irritable and tearful during the interview. She also expressed themes of hopelessness and helplessness and reported feelings of depression and anxiety, low energy and suicidal thoughts. Ms Turner commenced a new antidepressant and her withdrawal symptoms were accordingly addressed.

13. Ms Turner also engaged with a hospital social worker to assist her to obtain some safe accommodation. The social worker arranged accommodation for her at Lilydale Lodge. Ms Turner also accepted referral to Eastern Access Community Health (EACH) to obtain a case worker who could support her in different areas of her life, including her substance use, accommodation and work. They also arranged for her to see a new general practitioner who was proximate to Lilydale Lodge. A discharge summary was faxed to him, with a recommendation to organise psychological support with a Mental Health Plan. Ms Turner was aware of the recommended follow up and agreed with it. The plan was to discharge her on 8 March 2017, and for her to continue her treatment in the community.

14. On 8 March 2017 at approximately 3pm, Ms Turner was picked up by Mr White. After attending a medical appointment with Mr White, he said they divided up their prescription medications and took a number of them.

15. Later on 8 March 2017, a representative from Lilydale Lodge contacted Eastern Health and informed them that Ms Turner had not presented to the accommodation.

16. It appears that after leaving the medical appointment, Ms Turner and Mr White went to Victoria Street in Richmond and purchased some heroin, which they used as soon as they got into the back of Mr White's van.

17. On 9 March 2017 at 4.20pm, Mr White parked his van in Elizabeth Street in the city, where they both consumed some alcohol and more heroin together in the rear of the van. Closed Circuit Television (CCTV) in the area captured Mr White moving in and out of the van over a number of hours over the course of that afternoon, night and the next morning.

18. At 12.25pm on 10 March 2017, Mr White awoke because he received a parking ticket. He believes that Ms Turner was alive because he heard her snoring, but he said he could not be sure. He said it was not unusual for both of them to sleep for large periods of time. At 3.27pm, CCTV showed Mr White drive the van to the other side of the road so as to avoid another parking infringement.

19. At 5.59pm, CCTV captures Mr White attend a phone repair shop in Flinders Lane, Melbourne. He appears highly drug affected. Mr White then returned to the van and consumed some more heroin until he fell back to sleep.

20. Sometime later Mr White awoke and found Ms Turner purple and cold. He observed vomit or dribble coming out of her mouth. Mr White said he had seen Ms Turner overdose before and turn purple and he would usually just blow air into her mouth and give her oxygen which was usually enough to keep her alive. On this occasion, Mr White told police that he then did not know what to do, so he injected the remainder of the heroin, in the hope that he would overdose with Ms Turner. He said that he then fell asleep. He was not sure how long he was asleep, but he woke up and saw that Ms Turner was deceased.

21. On 11 March 2017, at 2.38am, Mr White is captured on CCTV driving his van along Elizabeth Street and into a 7-Eleven Service Station on Victoria Street, East Melbourne, where he purchased petrol, oil and sought directions to the nearest hospital.

22. At 3.04am, Mr White arrived at St Vincent's Hospital and informed an emergency department nurse, Jennifer Singleton that Ms Turner was in the back of his van, deceased. Ms Singleton went out to the van and confirmed that Ms Turner was deceased and may have been deceased for some time. She immediately requested their security department call the police. Intravenous marks were evident on Ms Turner's arm which was consistent with the circumstances of recent drug use.

Coronial investigation

23. Victoria police members attended Regent Street, Fitzroy near St Vincent's Hospital where Mr White's van was located and immediately commenced an investigation into Ms Turner's death on my behalf. Police conveyed Mr White to the Fitzroy Police Station and obtained a statement from him in relation to Ms Turner's movements in the previous days and the circumstances leading up to her death.

24. Mr White's explanation for not calling an ambulance is that he knew she was dead and that he did not want to waste the ambulance's time, so he decided to drive her to the hospital himself. He stated that his timing about things was not particularly accurate due to his consumption of illicit drugs and prescription medication.

25. Police seized and searched Mr White's van and found a number of personal items belonging to Ms Turner, including her handbag and prescription medication. Due to the clothing and items of food in the van, it was evident to police that it was being used as a place of residence.

26. Police confirmed there were no suspicious circumstances associated with Ms Turner's death.

Findings

27. Having considered the evidence I am satisfied that no further investigation is required.

28. Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

29. I find that:

    a. the identity of the deceased was Skye Turner born on 20 November 1980; and

    b. Ms Turner died between 10 and 11 March 2017 from 1(a) MIXED DRUG TOXICITY;

    c. in the circumstances described above.

30. I am satisfied that Ms Turner's death was the unintentional consequence of her intentional use of illicit drugs and prescription medication.

Comments

31. Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death.

32. Mr White's behaviour in not recognising that Ms Turner had died sooner and by not calling an ambulance was extremely unusual and particularly disappointing to the family of Ms Turner.

However, unfortunately his behaviour is not inconsistent with a person who was leading a chaotic and disordered life due to his addiction to heroin and other prescription medications.

33. I was concerned by Mr White's account of how he would respond to a heroin overdose, and that he would blow air into Ms Turner's mouth. On this basis, I suspect Mr White may never had received appropriate training in identifying and responding to symptoms of an overdose including the administration of naloxone. Although it is impossible to speculate in hindsight with any confidence, it is at least possible that if Mr White recognised Ms Turner's snoring in the van at approximately 12.25pm on 10 March 2017, as a sign of overdose, and was adequately educated and equipped to appropriately respond, Ms Turner may still be alive.

34. In my Finding into the death of Ms A, published in February 2017, I made three recommendations in relation to overdose deaths. In particular, I recommended that the Department of Health and Human Services Victoria review drug-related support services in the City of Yarra and expand the availability of naloxone to people who are in a position to witness and respond to overdoses. The Department accepted this and, I understand, is acting upon these recommendations, which is very positive and I hope may lead to a decrease in deaths in circumstances such as Ms Turner.

35. Regrettably, the extremely sad circumstances of Ms Turner's life and death are not uncommon in our society and people like Ms Turner are dying from overdoses, with frequent regularity. Ms Turner's death yet again highlights the impact that heroin related deaths have to the broader Victorian community. Drug addiction is a health problem and as a society we need to accept this and proactively offer more in terms of harm minimisation.

36. The Victorian Parliament's Legal and Social Issues Committee has now published its final report into the Inquiry into the Drugs, Poisons and Controlled Substances Amendment (Pilot Medically Supervised Injecting Centre) Bill 2017. The main body of the final report did not include any recommendations, but did include several findings that recognised the drug harm reduction potential, of supervised injecting facilities. These findings provide a solid rationale for the introduction of a supervised injecting facility in Victoria, which is consistent with a previous recommendation I made in the Finding into the death of Ms A.

37. Ms Turner's sister, Laura advised the Coroners Court that her sister was supportive of a safe injecting facility. It is possible that had Ms Turner used heroin in a safe environment, where medically trained people were supervising her use, they may have been able to prevent her from overdosing. They may also have assisted with providing her with community referral for her accommodation, medical treatment and safety.

38. While the Legal and Social Issues Committee work in this area is now complete, I note that the Law Reform, Road and Community Safety Committee's current Inquiry into Drug Law Reform is still underway, and has received a number of submissions highlighting the place of supervised injecting facilities among new strategies, policies and programs that should be considered to tackle Victoria's ever-growing toll of fatal and non-fatal drug harms. Therefore, I distribute this finding for information to the Law Reform, Road and Community Safety Committee in the hope that they will read it in light of the Legal and Social Issues Committee report and consider taking the final step of recommending that a supervised injecting facility be trialled in Victoria.

39. I have included the Minister for Mental Health in the distribution of this finding, as evidence of another death which supports the establishment of a safe injecting facility in Victoria.

40. I would like to acknowledge the strength and determination of Ms Turner's sister, Laura for her advocacy in her support for the establishment of a safe injecting facility, on behalf of her sister. I also wish to express my sincere condolences to Ms Turner's family. I acknowledge the grief and devastation that you have endured as a result of your loss.

41. 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:

(a) The family of Ms Turner
(b) Committee Secretariat, Inquiry into Drug Law Reform, Law Reform, Road and Community Safety Committee
(c) The Honourable Martin Foley MP, Minister for Mental Health
(d) Ms Kym Peake, Secretary, Department of Health and Human Services Victoria
(e) North Richmond Community Health
(f) Interested parties
(g) Coroner's Investigator, Victoria Police

Signature:

JACQUI HAWKINS
Coroner
Date: 16 October 2017

Coroners Court of Victoria