IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 1382

# FINDING INTO DEATH WITH INQUEST

*Form 37 Rule 60(1)*

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

Amended pursuant to *Section 76 of the Coroners Act 2008* on 8 April 2019[1]

**Inquest into the Death of: Hannah Rachel CHARLES**

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| Delivered On: | 28 October 2015 |
| Delivered At: | Coroners Court of Victoria<br>65 Kavanagh Street Southbank,<br>Melbourne 3006 |
| Hearing Date: | 19 & 20 March 2014 |
| Findings of: | IAIN TRELOAR WEST, DEPUTY STATE CORONER |
| Representation: | Deanna Caruso & Markotich Lawyers on behalf of Matthew Nettleton |
| Police Coronial Support Unit | Leading Senior Constable Amanda Maybury |

[1] This document is an amended version of the finding into Hannah Rachel Charles' death dated 28 October 2015, made pursuant to section 76 of the *Coroners Act 2008* (Vic). A name has been removed.

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of Hannah Rachel CHARLES

AND having held an inquest in relation to this death on 19-20 March 2014

at MELBOURNE

find that the identity of the deceased was Hannah Rachel CHARLES

born on 2 February 1993

and the death occurred on 13 April 2010

at 11/206 Whitehorse Road Balwyn 3103, Victoria

**from:**

1 (a) COMBINED DRUG TOXICITY (HEROIN, CODEINE, METHADONE, BENZODIAZEPINES)

**in the following circumstances:**

1. Hannah Charles was a 17-year-old female who was the daughter of Mr Anthony Charles and Ms Joanne Charles. Hannah was a happy child who attended Sandringham Primary School. Her parents separated in 2003 with the separation at times presenting difficulties.
2. When Hannah completed primary school, Ms Charles relocated to a property in Tooborac and Hannah attended the Kilmore International School. Mr Charles resided at Docklands with his partner Ms Sonya Lappin and her two children from a previous relationship.
3. In 2008, Hannah decided to reside with her father and the whole family moved to Brighton. Ms Charles moved to Perth to be closer to family. Hannah enrolled at St Leonards College where she had a large social network and socialised a lot. In 2009, Hannah had issues with truancy and was behind in her schoolwork. Mr Charles took her to see a psychologist but she had no interest in the session. In May 2009, Hannah was expelled for truancy and came to the attention of police a number of times for offences including theft and obtaining property by deception through using a stolen credit card.
4. In July 2009, Mr Charles confronted Hannah regarding the theft of money from his bank account, as it was clear to him that she was responsible for it. Hannah left home for a

number of weeks, refusing to state where she was staying. She eventually reconciled with her father and moved back to live with him.

5. Mr Charles first became aware that his daughter might have been involved with drugs when she came home one night in October and was aggressive, erratic and tried to strike him. He also located a single Xanax tablet in her bedroom, which Hannah denied was hers and stated she had no idea how the tablet came to be there.

6. In November 2009, Hannah went to stay with her mother in Perth. At this time, Ms Charles discovered a bottle of Xanax and two Seraquel tablets in Hannah's bag and a confrontation ensued. Ms Charles believed that Hannah might have been addicted to these tablets as she was out of control during the confrontation. Hannah stated that she was not addicted but that she and her friends would take the tablets occasionally with alcohol when they went out.

7. On 3 December 2009, Hannah appeared before the Melbourne Children's Court and was placed on a deferral of sentence. A pre-sentence report was requested through Youth Justice and Hannah was assigned Youth Justice Case Manager, Ms Rachael Schubach. Hannah disclosed to Ms Schubach that she had begun experimenting with illicit substances around the time of her offending with some of her friends. She stated that she had tried amphetamines, ecstasy and Xanax and that she would engage in using one or more substances at a time.

8. Hannah was referred to the Youth Substance Abuse Service (YSAS) on 4 January 2010 and had a drug and alcohol assessment done. On 23 March 2010, Hannah informed YSAS that she no longer felt that they were of benefit to her but shortly afterwards continued sessions with them, when Ms Schubach advised her that the Court might impose the drug and alcohol counselling as a condition, in any event.

9. The end of the school holidays appeared to signal a downfall in Hannah's life. She was not returning home for a number of days at a time, telling her father that she was staying with various friends. A friend of Hannah's stated that she and Hannah would inject heroin together and she knew that Hannah would take multiple Xanax tablets with alcohol. Hannah had informed her that she had a friend who worked in a pharmacy and could buy bottles of Xanax without prescription.

10. In late March 2010, Hannah met Mr Matthew Nettleton and Mr Anthony Lang when she was in the Camberwell area. Both were long-term drug users who resided at 11/206

Whitehorse Road in Balwyn. Hannah stayed at their premises on a number of occasions and they would meet about 3 times a week. Mr Nettleton stated that when they did meet, Hannah would usually bring drugs with her, including heroin. He believed she was obtaining the heroin from a person in North Richmond. He had also seen Hannah taking multiple Xanax tablets on a number of occasions.

11. On 10 April 2010, Hannah was assisting her father to search for rental properties for Ms Charles who was moving back to Melbourne from Perth. Mr Charles dropped Hannah off near the Camberwell Junction and Hannah stated that she would stay at a friend's home. Mr Charles attempted to contact her a number of times in the days following, but she did not take his calls, however, this was not uncommon.

12. Hannah was due to appear at the Melbourne Children's Court on 14 April 2010 for a consolidation of charges from incidents throughout 2009. Ms Charles had a number of conversations with her daughter in the week prior to her arrival in Melbourne and stated that she noticed a visible change in her daughter's behaviour, as Hannah was slurring her words but denied that she was using drugs.

13. Ms Charles arrived in Melbourne on 12 April 2010 and at 9.30pm phoned her daughter in order to meet with her. She was aware that Hannah was in the company of two males and asked her to attend the home of family friend Mr Dave Williams in Chadstone so that she could meet her there. Hannah attended Mr Williams' home with Mr Lang at approximately 10.45pm. Mr Williams stated that Hannah was either drunk or drug affected as she was talking slowly and slurring her words. Hannah asked Mr Williams if he had any marijuana and when he told her no, she left in the company of Mr Lang and Mr Nettleton who had been waiting outside.

14. Ms Charles contacted her daughter again and Hannah told her to meet her at the Quest Apartments in Box Hill and to contact her on Mr Lang's number as her phone was inoperable. Ms Charles arrived in Box Hill and contacted Mr Lang. Hannah informed her that they were not ready to see her yet. At 12.30am, Ms Charles again contacted Mr Lang but there was no reply. She called again and Hannah answered and said they were still not ready which resulted in a heated discussion with her mother. She told her mother she would not be too much longer and would come to see her by tram.

15. The trio had returned home to Balwyn after leaving Mr Williams' house. Mr Nettleton stated that Hannah had brought five bottles of Xanax to the premises. She had kept two

bottles for herself, gave one to Mr Lang and two to Mr Nettleton. Mr Nettleton stated that he and Hannah were drinking together in the lounge room. They had an argument regarding Hannah's drug use and he stated; '*it would have been the fourth day in a row she had taken heroin and she would have started withdrawal symptoms.*' Mr Nettleton had consumed half of his methadone bottle and had planned to drink the other half before sleeping, but lost consciousness before taking it. Mr Nettleton maintained at inquest that when he went to bed he had 2 ½, 100ml bottles of methadone. He stated that he had stored the methadone in his bag, which he kept in the corner of his room.

16. After leaving the premises for a short time, Mr Lang returned and observed Mr Nettleton and Hannah in the lounge room. Not wanting to disturb either of them, he went to his room and stated he did not hear anyone get up that night.

17. Ms Charles had further contact with Hannah via text message and phone conversation that night, with her last conversation being at approximately 1.40am. She stated that Hannah sounded upset and was crying, stating that Mr Nettleton and Mr Lang had fallen asleep. She told her mother that she loved her; that she was tired and would see her the next day.

18. Mr Lang woke at 7.00am the next morning on 13 April 2010 and went to the lounge room to see if his phone was there. He noticed Hannah lying on the floor on her back and believed her to be asleep. The blinds were shut and Mr Nettleton was still asleep on the couch. Mr Nettleton woke at 7.42am and saw Hannah on the carpet with her knees up and her head between her knees. He called her name but she did not answer. Mr Lang heard Mr Nettleton calling '*Han, Han*' and went to in the lounge room. Mr Nettleton attempted cardio pulmonary resuscitation, however it was ineffective, as but Hannah's tongue had slid back in her throat.

19. Ambulance paramedics arrived at 7.47am and found Hannah lying in a foetal position in the lounge room beside the couch, not breathing and without a pulse. At 7.49am a Mobile Intensive Care Ambulance arrived to assist, however following further assessment, Hannah could not be revived and was pronounced deceased at the premises.

20. Police arrived to secure the scene and stated that both Mr Lang and Mr Nettleton were agitated, slow in speech and appeared confused and upset. They found significant drug paraphernalia in the lounge room including 2 syringes on top of the table, 5 empty bottles of Kalma tablets without prescription, 1 empty bottle of Xanax tablets without prescription, R11 revia (naltrexone) tablets, an empty bottle of diazepam 50 tablets, an

empty bottle of Xanax tri score 50 tablets, 1 empty box of Xanax 2mg tablets, 1 empty blister pack of Valpam tablets and 1 empty pack of Serepax tablets. They located 2 empty methadone liquid bottles and 1 methadone liquid bottle containing some liquid, all in the name of Matthew Nettleton.

21. Forensic Pathology Registrar Dr Julie Teague from the Victorian Institute of Forensic Medicine conducted an autopsy on Hannah's body on 15 April 2010 and provided a written report of her findings. She identified multiple bruises of varying ages predominantly involving the upper limbs. Many of the bruises showed inflammatory reactions, indicating that they had occurred prior to death. Dr Teague stated '*whilst the injuries identified are not explained by the circumstances provided, there are no injuries present which are identifiable as the cause of or significant contributor to death, unless secondarily as a result of forcible injection or ingestion of a substance.*' She also identified antecubital fossa needle puncture marks. There was no evidence of natural disease, which may have caused or contributed to the death.

22. Toxicological analysis of body fluid revealed 0.3mg/L of alprazolam (antidepressant of the benzodiazepine class), which is within toxic ranges; 6-monoacetylmorphine was detected in urine, consistent with recent use of heroin. Codeine (a common contaminant of heroin) was also detected in urine, methadone was detected in blood at 0.2mg/L and EDDP (a methadone metabolite) was also detected in blood. 11-nor-Δ9-carboxy-tetrahydrocannabinol (a metabolite of cannabis) was detected in urine at 14ng/mL. Metabolites can be detected in urine for weeks following use of cannabis. Citalopram at trace levels was also detected in blood. Diazepam was also detected in blood at 0.1mg/L as well as Nordiazepam. Oxazepam was detected in blood at 0.3mg/L.

23. Dr Teague stated that it is difficult to estimate an independently toxic concentration of methadone or its derivatives (as tolerance occurs and people are more likely to develop a toxic reaction in the first week of usage), however, the concurrent use of other depressant drugs such as benzodiazepines may contribute to the toxicity of methadone. As Hannah was not prescribed methadone, there is a possibility that this was new or sporadic usage, making toxic reactions more likely.

24. Dr Teague further stated that the presence of a number of central nervous system depressant drugs including heroin, morphine, codeine and methadone have variable toxic levels related to individual tolerance to the drugs. Benzodiazepines (diazepam,

nordiazepam and oxazepam) were below levels thought to be independently toxic however, their presence with other central nervous system depressant drugs amplifies each others' toxic effects. Alaprazolam was present at a level that can be independently toxic and would amplify the toxic effects of the other drugs. The combination of these drugs is likely to produce fatal central nervous system depression. The actual mechanism of death may be a decreased rate of breathing, culminating in respiratory arrest, decreased heart rate culminating in cardiac arrest or complications of loss of consciousness (such as positional asphyxia, hypothermia etc.) The most common mechanism of death is respiratory arrest due to decreased rate of breathing as a direct result of central nervous system depression. Dr Teague believed this is to be the likely mechanism in causing Hannah's death.

**Methadone at the Premises:**

25. Mr Nettleton had methadone prescribed and dispensed to him, for unsupervised dosing, as part of the opioid replacement therapy program. He would get five bottles of takeaway methadone per week to bring home and denied in his police statements that Hannah had taken any it. However, in a conversation with Detective Senior Constable Grant O'Dwyer, he stated that Hannah might have consumed some of his methadone after he had fallen asleep, as the partially consumed bottle in the lounge room appeared to have less liquid than when he last noticed.

26. Ms Campbell told police investigators that on an occasion approximately 3 months after Hannah's death, she contacted Mr Nettleton who informed her that on the night prior to her death, Hannah had told him that she was upset and could not sleep and he told her to have a sip of methadone. He had fallen asleep and had not seen Hannah ingesting the methadone. A few days after this conversation, Ms Campbell attended Mr Nettleton's residence where he allegedly injected her with Oxycontin and offered her some of his methadone. She took approximately 50ml of his methadone and passed out and was conveyed to Box Hill Hospital where she recovered. Mr Nettleton strenuously denied ever sharing his methadone or injecting Ms Campbell with Oxycontin. Ms Campbell's evidence was not tested at inquest, although Mr Nettleton was questioned by Leading Senior Constable Amanda Maybury at inquest and maintained that he would not share his methadone with anyone.

**Victorian Methadone Deaths:**

27. The Coroners Prevention Unit (CPU) provided information from their database, which identified that there were 462 deaths from acute drug toxicity including methadone, which were investigated by Victorian coroners between 2000 and 2011. These included 73 deaths (13.8%) in which methadone was the only drug found to have contributed and 389 deaths (84.2%) from multiple drug toxicity including methadone. The annual frequency of methadone deaths has had a consistent year-on year increase between 2006 and 2011. In the same 12 year period, the annual frequency of Victorian Opioid Replacement Therapy (ORT) clients receiving methadone increased from 7647 to 9330. This increase was of a lower magnitude than the increase in methadone deaths.

28. The CPU has recently completed further research into the sources of methadone that contributed in all methadone overdose deaths investigated by Victorian coroners between 2000 and 2013. The research showed:

    - There were 608 Victorian deaths from acute drug toxicity, including methadone, over this period
    - Of these deaths, 81 were confirmed to involve diversion of unsupervised ORT methadone doses
    - Of these 81, overdose deaths involving diverted ORT methadone has increased notably over time. Between 2000 and 2005 there were 12 such deaths (two per year), then 30 between 2006 and 2010 (five per year), then 39 between 2011 and 2013 (13 per year).

**The Methadone Diversion Program:**

29. Diversion of methadone dispensed for unsupervised dosing in ORT is frequently encountered in Victorian coroners' death investigations, and is a manifestation of a tension between two principles that inform the delivery of ORT in this State.

30. The first principle is that ORT delivery should be integrated into the community to remove negative connotations and inconvenience the client as little as possible. Unsupervised dosing is argued to promote community integration in a range of ways:

    - The prospect of accessing unsupervised doses can provide incentive for the client to maintain engagement in treatment, thereby achieving sustained social and health benefits.

- Being relieved of the need to attend the dosing point every day, means the client can meet work and family commitments with less disruption.
- Unsupervised dosing enables clients to attend holidays, work commitments and so on away from the dosing point. [2]

31. The second principle is that methadone is a particularly toxic drug when misused, and there is broad acknowledgement that unsupervised dosing can create opportunities for misuse including:
    - Facilitating methadone hording and consumption outside the recommended dosing schedule.
    - Clients can inject methadone when it is provided for unsupervised consumption away from the dosing point.
    - Unsupervised doses can be diverted (shared with or sold to other people).
    - Unsupervised doses can be accessed by people who live with or visit the client.
    - Clients can consume unsupervised methadone in a risky manner, for example in combination with alcohol and/or other central nervous system depressants.[3]
32. The guidance on methadone dosing in both the 2006 and 2013 Victorian *Policy for Maintenance Pharmacotherapy for Opioid Dependence* reflects the need to strike a balance between the principle of community integration and the principle of risk mitigation. As stated in both versions of the policy:

    > "Arrangements for takeaway doses should balance the need to minimize the risk to the community with the stable patient's need to normalize their lives".[4]

33. In recent years, coroners have concluded that this balance has not been achieved and in particular that risk minimization has been sacrificed in pursuit of the community integration imperative.

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[2] Drugs and Poisons Regulation Group, Victorian Department of Human Services, *Policy for Maintenance Pharmacotherapy for Opioid Dependence*, 2006, p.22.

[3] Ibid p.22

[4] Ibid p.23

34. Associate Professor Michael McDonough, the head of Addiction Medicine and Toxicology at Western Health provided a report to the Coroners Court on 29 April 2014 regarding a series of questions posed to him by the Court's Health and Medical Investigation Team (HMIT)[5] in relation to methadone diversion programs. He stated that the broader issue of prescription medication borrowing and sharing has been identified as behaviour that is widespread in Australia and other countries, conservatively estimated as having a prevalence between 10% and 30% of the general population. Further, methadone treatment for heroin addiction/opioid dependence is a drug therapy with one of the highest levels of evidence base regarding positive health outcomes and particularly reducing mortality because of this fact. Methadone syrup diversion is a well recognised problem for ORT programs around the world and because of this phenomenon, has been the subject of considerable research.

35. In regards to the query of whether a Victorian doctor or pharmacist could identify that an ORT client was diverting takeaway methadone other than the client volunteering information, Professor McDonough stated that this '*can need a level of evidence acquisition requiring detective-like skills which are outside the scope of routine clinical or pharmacy practice.*' With regards to doctors, he stated that suspicion relating to diversion behaviour may arise when methadone usage appears to be quite high for an individual, this being further confirmed by the practitioner communicating with the pharmacist and therein, also potentially learning that the patient is not attending regularly for methadone dispensing (because the dose is more than adequate for a 24-hour period).

36. In regards to the query of whether a doctor or pharmacist could identify that an ORT client was not safely storing their takeaway methadone, Professor McDonough stated '*pharmacists are able to undertake medication reviews when requested by a doctor (however, only certain pharmacists are accredited to perform this task) and this procedure often involves a visit to the patient's home. For this process to occur is very*

[5] The role of the Health and Medical Investigation Team (HMIT) is to assist the Coroner's investigation into the nature and extent of deaths, which occurred during the provision of healthcare, and identify potential system factors in healthcare related deaths. HMIT personnel comprise of practising Physicians and Clinical Research Nurses who draw on their medical, nursing and research experiences, skills and knowledge to independently evaluate clinical evidence for the investigation of reportable healthcare deaths and to assist in identifying remediable factors that may assist in prevention and risk management in health services settings.

*rare and is generally utilised by doctors treating patients who are taking multiple medications, or are suspected of having 'out of date' or unnecessary medications.*'

37. He identified three possible ways that a prescribing doctor may be able to confirm the safe storage of methadone syrup takeaway doses at home:

    - By having all patients eligible to receive takeaway methadone doses agree to the pre condition of themselves being occasionally subject to home visitation by a program clinician.
    - By having all patients eligible to receive takeaway methadone doses agree to the precondition of themselves allowing home medication reviews performed by appropriately selected, corroborative informants like family members or other potentially reliable informants who visit the patient's home on a regular basis.
    - By routinely requiring all patients eligible to receive takeaway doses to agree to the precondition of allowing whenever requested, appropriately selected family members/others to attend the patient's clinic appointment as at such time, the treating doctor may ask with the appropriate witness being present about where the medication is stored and about the appropriate safety of such a location.

**Issues Regarding the Safe Storage of Methadone:**

38. Mr Nettleton conceded at inquest that his methadone was not safely stored. He gave evidence that he stored the methadone at the bottom of his zipped up bag in his bedroom. He agreed that keeping this methadone in a sports bag was not secure, particularly in the presence of other drug addicts. When questioned about his knowledge of safe storage, he stated that he had never received any education from either his doctor or a pharmacist as to how the methadone should be stored, nor had he been told that his methadone should be in a locked box or cupboard.

39. Professor McDonough in his report indicated that a very recent but uncompleted study identified that unsafe storage of takeaway methadone was not an uncommon practice. He also stated that he would not be surprised by Mr Nettleton stating that he had never been given education about the safe storage of methadone. Further, Professor McDonough stated that; '*research has yet to identify Best Practice Methods regarding safe methadone syrup home storage.*'

**Reducing the incidence of takeaway methadone diversion:**

40. In relation to whether there are any measures in Victoria which could be introduced to reduce the incidence of clients diverting takeaway methadone doses, Professor McDonough stated that this is another fertile question for clinical research. He speculated that in Hannah's case, a system requirement to return all un-used Methadone bottles to the pharmacist might have mitigated against the apparent storage of large quantities of methadone bottles at home. Unfortunately, however, one might also argue that it may be easier to divert/sell properly packaged methadone syrup to potential customers than it might be with plain syrup in a bottle. Furthermore, a requirement to return empty methadone dose bottles/containers might also lead some patients to divert their methadone syrup into an inappropriate and un-labelled bottle (i.e. having returned the empty bottles/containers) wherein potentially multiple doses could be stored and later consumed with greater risk for dosing error.

41. Professor McDonough advised that potentially, '*stricter adherence to risk assessment and management strategies as described in our State Opioid Pharmacotherapy Clinical Guidelines might help further reduce inappropriate clients accessing takeaway methadone doses because there is some evidence to suggest doctor adherences to these State guidelines is rather poor, a phenomenon not unique to medical practice with methadone because there is now a log of evidence that doctors generally are poorly adherent to many clinical guidelines.*'

42. To Professor McDonough's knowledge, there is no empirical evidence which indicates that reducing access to takeaway methadone increases the frequency of fatal (and/or non-fatal) heroin overdose, but he stated that '*it might be inferred that further reducing access to takeaway methadone doses might subsequently reduce program effectiveness, particularly by acting as a potential deterrent to maintaining patients in potentially life-sustaining treatment and dissuading people with heroin addiction who remain outside of treatment, from considering all the benefits associated with methadone treatment. It has been demonstrated that patients outside methadone treatment and those likewise who 'drop out from treatment, have higher mortality rates, principally related to drug (including heroin) overdose. Heroin overdose mortality is significantly reduced when a patient is in treatment with methadone/ORT.*'

**Concerns in relation to Hannah's case:**

43. Professor McDonough opined that the sequences of events in Hannah's case provoke questions regarding;

    - whether or not Mr Nettleton received comprehensive assessment to determine methadone takeaway suitability;
    - whether he was subject to ongoing review for takeaway stability and;
    - whether the prescribing doctor was in contact with the pharmacist and/or any other sources of corroborative informants about the patient's adherence with methadone takeaway dosing and safe storage in the house.

44. Further, Professor McDonough was unable to comprehend how in this case, given a previous drug-related death at Mr Nettleton's residence of Mr Darcy Thornton, this sequence of events did not raise concern in the mind of the prescribing doctor (that is assuming that the doctor had knowledge of these events) and prompt an urgent review of treatment and medication safety in the home situation.

45. Hannah's father, Mr Anthony Charles, raised a number of concerns regarding the circumstances surrounding his daughter's death, prefixing them with the following comment: *'I hold a strong belief and agree that drug addiction is in almost all circumstances an illness and that those addicts have a right to community and health agency support in the treatment of that illness. This right should not however extend to the extent that it unacceptably compromises the safety (often fatal) of the broader community'.*

46. Mr Charles' primary concern relates to the medical assessment of Mr Nettleton as being suitable for participation in the 'takeaway program', or representing an acceptable risk to the community. He could see no evidence of:

    - Commitment by Mr Nettleton to his treatment
    - Mr Nettleton's life normalizing
    - Hardship, given he was unemployed and lived in inner Melbourne and
    - Proper or effective case management to ensure his ongoing suitability.

47. Mr Charles makes the point that while supervised dosage remains the underlying principle of the guidelines relating to maintenance pharmacotherapy for opioid dependence, he believes the principle has been abandoned in favour of practitioner and addict convenience. '*Participation in the takeaway program has transitioned from a privilege*

*carefully granted and monitored to those who could argue commitment and hardship, to a right after a short period of apparently unmonitored treatment.'*

48. In addition, Mr Charles found it *'extraordinary that even a death caused by the diversion of Nettleton's methadone apparently failed to initiate any meaningful review of his ongoing participation in the takeaway program'.*

**CPU Recommendations concerning the Methadone Diversion Programs:**

49. The CPU outlined further opportunities for prevention despite the 2013 Victorian Department of Health revision of its *Policy for Maintenance Pharmacotherapy for Opioid Dependence.* These are;

    - The Victorian Department of Health to investigate whether a requirement that new Victorian ORT clients must commence on buprenorphine/naloxone unless there is a compelling clinical reason for using methadone. Clinical research has demonstrated that buprenorphine has similar efficacy to methadone in treating Opioid dependence. Major advantages over methadone include that it is safer in overdose, it has a longer duration in action and withdrawal symptoms are less severe. It is even safer in overdose and less likely to be diverted or used illicitly (such as via injection).
    - The Victorian Department of Health should revise its *Policy for Maintenance Pharmacotherapy for Opioid Dependence* so that an ORT client is eligible to receive at most two take-away methadone doses per week and no consecutive take-away doses.
    - The Australian Government Department of Health and Ageing to ensure that dispending of methadone for ORT is captured in the Electronic Recording and Reporting of Controlled Drugs system to assist prescribers and dispensers to identify and manage risks associated with drugs taken in combination with methadone.
    - To enable prescribers to manage the risk of harm and deaths associated with combining methadone and benzodiazepines, the Australian Government Department of Health and Ageing should ensure its Electronic Recording and Reporting of Controlled Drugs system captures all benzodiazepine dispensing in real time, as well as dispensing of Schedule 8 poisons.

- To reduce the risk of death from combined drug toxicity including both methadone and benzodiazepines, the Victorian Department of Health revise its Opioid replacement therapy policy to specify that clients who are treated on greater than 5mg per day of diazepam or equivalent are ineligible for takeaway methadone dosing.

**Submissions Directed to Recommendations:**

50. It was submitted by Counsel appearing on behalf of Matthew Nettleton that it would be appropriate to make the following recommendations:

    - All doctors to provide education to methadone recipients when they prescribe take-away doses about the secure storage of their methadone.
    - Provision of safe storage education should be a condition of a doctor's licence to prescribe methadone and that the doctor evinces that advice has been given to the patient in the form of a checklist.
    - The Victorian Department of Health has a pamphlet entitled "Methadone Treatment in Victoria-User Information Booklet" which states 'if you have a takeaway dose, it should be stored in a secure or locked cupboard at all times for safety reasons. The only time a takeaway dose should be removed from the secure or locked cupboard is immediately before you take the dose.' Counsel submitted that the current user information booklet be updated to state that methadone **must** be safely stored in a locked cupboard or box.
    - A document should be produced to be given to patients specifically about take-away doses and safe storage.
    - All patients who are prescribed take away doses are required to be provided with a locked box with a combination safe lock before being dispensed with take away doses. Locked boxes should be made available either at the prescribing clinic or at the dispending pharmacy.

**Previous cases outlining the problems of Methadone Diversion:**

51. In October 2013, Coroner Jacinta Heffey delivered her finding into the death of Helen Stagoll (20101624) who was aged 16 years when she died in 2010 after overdosing on diverted takeaway ORT methadone. During the course of the inquest a comprehensive review was undertaken of the legislative framework and underlying policy behind

pharmacotherapy for opioid dependence. In addition, shortcomings were identified and highlighted, culminating in Coroner Heffey making numerous recommendations for change.

52. Coroner Heffey addressed the issue of diverted unsupervised ORT dosing, with her central recommendation being :

> *"That the Victorian Department of Health urgently review its policy with respect to the takeaway dosing component of the Opioid Replacement Therapy programme, taking into account the number of deaths that have occurred due to the widespread availability of methadone in the community and the lack of any real safeguards to protect vulnerable third parties from the risks associated therewith."*

53. Three subsequent coronial recommendations [6] requested that the Victorian Department of Health consider revising the takeaway dosing component of the Victorian ORT Policy as it relates to methadone.

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

54. In his written statement to the Court, Hannah's father said: '*In my opinion the take away methadone program has been fatally corrupted by a lack of regulatory oversight and what appears a process of negligent and potentially wilful expediency by some prescribing physicians and pharmacists who place treatment and practice convenience ahead of community safeguards. As a result many, many Victorians are dead and families devastated. The program must be effectively regulated and enforced or it must be ceased. I am aware that the Court has made clear recommendations with respect to the takeaway methadone program in 2010,2011 and 2013 and in each case these recommendations appear to have been ignored which I find as upsetting as it is outrageous.*'

55. I have much sympathy for the views expressed. Hannah was one of twelve Victorian children under the age of 18 who died from methadone overdose between 2000 and 2013. In five of these twelve deaths, the contributing methadone was confirmed to be diverted and was originally dispensed to an ORT patient for unsupervised dosing. In a further three

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[6] Relating to the deaths of Shannon Less 2010 20485; Peter Oelfke 2013 5488; Brenton Grosser 2013 0786

deaths, diverted unsupervised ORT methadone doses were suspected to be the drug source.

56. I have referred to the recent history of recommendations that have been made by coroners, experts, the CPU and interested parties in this inquest, in order to demonstrate the concern that effective safeguards are not in place to minimise diverted unsupervised ORT dosing. It is clear that the vulnerable are not being protected under the current Policy, with the number of deaths increasing annually at an alarming rate.

57. In Victoria, the Department of Health is responsible for formulating policy for this State and has had two policy statements issued in 2006 and 2013. I note that between June 2014 and February 2015 the Department reconvened its Advisory Group for Drug Dependence. This was done to review the Victorian Policy for Maintenance Pharmacotherapy for Opioid Dependence in the light of Victorian coroners' recommendations on reducing harms and deaths connected to diversion. According to Acting Secretary Kym Peake[7], the Advisory Group has now completed its review and a revised policy is awaiting Ministerial approval.

58. As the review has been completed and it is indicated a revised ORT Policy will be released in the near future, I believe there is nothing to be gained by making a further recommendation regarding takeaway methadone dosing.

59. I await the release of the revised Policy and flag in advance for the Department of Health, that Victoria's coroners remain extremely concerned by the number of methadone overdose deaths and that the Policy will be closely scrutinised to establish whether it will prevent deaths in similar circumstances to Hannah's death.

60. I find that Hannah Charles died from combined drug toxicity following the taking of heroin, codeine, methadone and benzodiazepines. The evidence does not support a finding that she intended the tragic consequences of her actions. I further find that Matthew Nettleton contributed to Hannah's death by failing to appropriately secure his takeaway doses of methadone.

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

**Mr Anthony Charles**

**Ms Joanne Charles**

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[7] Letter dated 21 September 2015

**The Secretary of the Victorian Department of Health & Human Services**

**The Secretary of the Commonwealth Department of Health**

**Detective Leading Senior Constable Grant O'Dwyer, Boroondara C.I.U**

**Markotich Lawyers**

**Dr Michael Soon, Brighton Family & Women's Clinic**

**Mr Bernie Geary, Office of the CSC**

**Professor Jeremy Oats**

**Dr Adrian Reynolds, Alcohol & Drug Services Department of Health & Human Services**

**Associate Professor Michael McDonough, Department of Addiction Medicine Western Health**

**Associate Professor David Best, Turning Point Drug & Alcohol Centre**

Signature:


IAIN WEST
DEPUTY STATE CORONER
Date: **8 April 2019**