



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 4687

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

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

Findings of:	Paresa Antoniadis Spanos, Coroner
Deceased:	Scott David Fenech
Date of birth:	21 April 1983
Date of death:	16 September 2017
Cause of death:	Mixed drug toxicity
Place of death:	St Albans, Victoria

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of SCOTT DAVID FENECH without holding an inquest:

find that the identity of the deceased was SCOTT DAVID FENECH

born on 21 April 1983

and that the death occurred on 16 September 2017

at St Albans Hotel, 5 McKechnie Street, St Albans, Victoria

from:

1 (a) MIXED DRUG TOXICITY

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

Background

1. Mr Fenech was 34 years of age and living with his mother and siblings in St Albans following his release from prison about ten days before his death. Mr Fenech was the father of three daughters but had separated from their mother in about 2011.
2. Mr Fenech trained as a structural engineer and worked regularly from his later teenage years. However, he commenced using illicit drugs in his early 20's and spent a significant portion of his income on these substances.
3. In December 2013, Mr Fenech was imprisoned in relation to multiple offences. His mother thought he seemed well in prison and that he had managed to cease his drug use.
4. Mr Fenech was released on parole in May 2016. However, whilst in the community he recommenced using illicit drugs, breached the conditions of his parole, and was returned to custody in November 2016. He was subsequently released on parole again in 5 September 2017. On 6 September 2017, Mr Fenech attended the Sunshine Community Correctional Service (CCS) for induction.

Circumstances immediately proximate to death

5. About three days after Mr Fenech was released, his mother found him in the toilet of their house with a syringe in his arm. She was concerned for him and deflated that he may return to custody.

6. On 8 September 2017, Mr Fenech attended the Sunshine CCS to sign on for community work. He told his corrections officer that he had not returned to any drug use and was doing well with the support of his family and antidepressant medication.
7. On 9 September 2017, Mr Fenech visited a general practitioner, Dr Umit Cenap at the Cairnlea Medical Centre. He told Dr Cenap that he was stressed but would not disclose the source of his stress and anxiety. Mr Fenech said he could not see his regular practitioner, as there were no available appointments, and requested a prescription for oxazepam. Dr Cenap prescribed four oxazepam tablets only and advised Mr Fenech to consult with his regular general practitioner.
8. On 11 September 2017, Mr Fenech attended a pathology clinic for a CCS directed urinalysis. However, he was unable to produce a sample for testing.
9. On 13 September 2017, Mr Fenech attended the Sunshine CCS in a distressed state. He said he was concerned about relapse into heroin use and was considering pharmacotherapy treatment. That day he provided a urine sample for analysis which detected opiates (codeine and morphine) and benzodiazepines (oxazepam). A Senior Scientist advised CCS staff that the levels of drugs detected were indicative of prescribed medication that Mr Fenech had previously disclosed using.
10. On 14 September 2017, Mr Fenech returned to see Dr Cenap and requested more oxazepam. Dr Cenap prescribed a further four tablets, and again advised Mr Fenech to consult his regular practitioner. That day Mr Fenech also attended the Sunshine CCS for a supervision session.
11. At about 1.30pm on 16 September 2017, Mr Fenech went to the St Albans Hotel and entered the male bathrooms.
12. About seven hours later, at about 8.30pm a patron at the venue entered the bathrooms and noticed a jacket hanging over one of the cubicle doors. He could see a foot and two hands on the ground at the front of the cubicle and realised the cubicle was occupied. He thought this was unusual but left the bathrooms and returned about twenty minutes later to see if the person was still there. As the jacket was still there, he knocked on the door and called out. When there was no answer, he peered over the top of the cubicle and saw a man, later identified as Mr Fenech, slumped forward.

13. The patron notified security staff who opened the cubicle and observed Mr Fenech seated but slumped forward and bleeding from the nose. They could not see him breathing or detect a pulse and called emergency services. On closer inspection, they noticed a needle in the Mr Fenech's arm, which they removed on instructions from the emergency call operator.
14. Ambulance Victoria paramedics attended a short time later and confirmed that Mr Fenech was deceased and disposed of the syringe.

Medical cause of death

15. Dr Sarah Parsons, Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), conducted an external examination of Mr Fenech's body, reviewed a post mortem computed tomography scan (PCMT), and the Victoria Police Report of Death to the Coroner (Form 83).
16. Dr Parsons advised that she found numerous minor injuries on external examination and PCMT did not show any significant abnormalities.
17. Routine toxicological analysis of post mortem specimens detected 6-monoacetylmorphine (6MAM), morphine and codeine (consistent with recent heroin use),¹ methylamphetamine,² amphetamine,³ oxazepam,⁴ venlafaxine and its metabolite desmethylvenlafaxine.⁵
18. Dr Parsons advised that it would be reasonable to attribute Mr Fenech's death to '*mixed drug toxicity*', without the need for an autopsy.

¹ Heroin is an illegal drug produced from morphine obtained from the opium poppy. Within minutes of injection into a person, heroin is converted to morphine via the intermediate compound 6-acetylmorphine. The presence of a small amount of codeine in the blood, urine or other tissues of morphine positive cases is consistent with its presence from the use of heroin, in which it is a contaminant. However, the use of codeine cannot be excluded.

² Methylamphetamine is a strong central nervous system stimulant that acts like the neurotransmitter noradrenaline and the hormone adrenaline.

³ Amphetamine is a metabolite of methylamphetamine.

⁴ Oxazepam is a sedative/hypnotic drug of the benzodiazepine class.

⁵ Venlafaxine is indicated for the treatment of depression. Desmethylvenlafaxine is a metabolite of venlafaxine, however can also be prescribed as an antidepressant in its own right.

Mr Fenech's management by Corrections Victoria

19. As Mr Fenech was a parolee at the time of his death, the Justice Assurance and Review Office (JARO) conducted a review of his death and the case management provided to him throughout his incarceration and on his release into the community. Amongst other things, JARO considered the Offender Death File Review Action Plan prepared by Sunshine CCS following Mr Fenech's death.
20. JARO assessed that Mr Fenech was a high-risk offender, with a long standing and complex drug history and criminal history relating to his drug use. Mr Fenech appeared willing to comply with the conditions of his parole and self-reported concerns of relapse.
21. JARO concluded that Mr Fenech's custodial management met the required standards prescribed by Corrections Victoria, and that CCS Sunshine's response to Mr Fenech's death was appropriate in the circumstances. However, JARO identified that there were some missed opportunities to provide Mr Fenech with appropriate interventions to manage his risk of relapse, and made two recommendations, namely that Corrections Victoria:
 - a. Communicate the importance of timely pre-release transitional planning, including the consideration of advice or guidance contained within Prison Service Agreements and associated documentation, to all Community Corrections Staff.
 - b. Reiterate or emphasise the use of Community Corrections Staff professional judgement in prioritising the areas of greatest risk(s) to an offender. This may be informed by their offending history, level of service/risk, need, responsivity (LS/RNR) tool and the offender's presentation to staff.
22. Corrections Victoria accepted these recommendations. Moreover, the substance of these recommendations was identified in the Sunshine CCS's Review Action Plan, which has been implemented with ongoing monitoring.
23. In reaching these recommendations, JARO identified additional opportunities for Sunshine CCS to support Mr Fenech both in the pre-release period and after his release into the community. Mr Fenech's application for parole was approved on 18

July 2017, with the release date set for 5 September 2017, providing CCS with reasonable time for coordinating his transitional supports.

24. JARO noted that prior to his release, CCS and Mr Fenech completed multiple required programs and referrals. However, there were further opportunities for Sunshine CCS to schedule psychological, drug and alcohol appointments, and to facilitate discussions between Mr Fenech and his mother in preparation for his release.
25. Following his release, JARO identified additional opportunities for Sunshine CSS to support Mr Fenech via drug and alcohol appointments, bridging supports, and urinalysis. In particular, JARO identified lost opportunities to use Mr Fenech's supervision sessions for in-depth discussion about drug and alcohol issues and to arrange an urgent appointment with a general practitioner to facilitate timely commencement on opiate pharmacotherapy.

Findings

26. I find that Mr Fenech died from mixed drug toxicity, in circumstances where I find that his death was the unintended consequence of his intentional use of illicit drugs and prescription medication.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments on matters relating to public health and safety or the administration of justice.

1. Sadly, the phenomenon of recently released prisoners dying of drug overdose is well known to Victorian Coroners. It is generally accepted that this reflects the deceased's use of drugs, which are more freely available, at a time when the tolerance for the drugs is decreased due to a period of relative abstinence while in custody.
2. Corrections Staff appropriately identified that Mr Fenech was at risk of relapse into drug use and formulated strategies to manage this risk. However, there were some missed opportunities to provide access to additional transitional supports, and to implement these strategies at the earliest opportunities.
3. Sunshine Community Corrections Services are commended for their reflection on their management of Mr Fenech and their identification and introduction of improvements in their service delivery, in particular, their ongoing training of

Corrections Staff and the identification of system enhancements to improve their capacity to transition prisoners into the community safely.

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

Gina Fenech, Senior Next of Kin

Justice Assurance and Review Office

Sunshine Community Corrections

Senior Constable Jayden Gebbie (#38100) c/o O.I.C. Keilor Downs Police

Signature:



PARESA ANTONIADIS SPANOS

Coroner

Date: 16 October 2019

