Media Release

Coroners Court of Victoria

Monday 24 August 2020

More than 690 Victorian methadone-related overdose deaths in the past decade, finds coroner

A finding released today by Victorian Coroner Audrey Jamieson has revealed that methadone has been one of the most frequent contributing drugs to Victorian overdose deaths in the past 10 years.

The finding follows an investigation into the death of Wayne Marshall, a 54-year-old Heidelberg Heights man who suffered respiratory distress at his home on 15 November 2018. Ambulance Victoria paramedics attended the scene, however Mr Marshall lost consciousness and could not be revived.

Coroner Jamieson determined that Mr Marshall's death resulted from the combination of two pre-existing respiratory conditions and the use of methadone that was not prescribed to him.

Methadone is a strong opioid medication prescribed to treat serious pain, as well as manage opioid cravings in drug dependent people. While methadone use brings clinical benefit to many people, it also has a heightened risk of dependence, misuse and overdose.

This risk is reflected in new Victorian overdose death data spanning 2010─2019, which the Coroners Prevention Unit (CPU) prepared as background for Coroner Jamieson's investigation. The data shows that methadone contributed to 695 deaths over the 10 year period. This is more than methamphetamine, oxycodone, codeine, alprazolam or MDMA, which tend to attract more public attention and concern.

Coroner Jamieson commented that a substantial number of the methadone-involved overdoses were due to consumption of diverted methadone, including methadone that was gifted or sold to the deceased, and methadone that was accessed without permission from the owner.

In 2018, the year Mr Marshall died, a third of all Victorian methadone-involved overdose deaths were likely to have resulted from diverted methadone. In 2019, the proportion of deaths where diverted methadone was implicated declined to 25 per cent, but still totalled 19 deaths ─ a tragically high toll.

In the finding, Coroner Jamieson drew attention to the many efforts of coroners to reduce the fatal toll of methadone diversion through repeated recommendations aimed at addressing shortcomings in how methadone is prescribed, dispensed and stored.

Her Honour did not make any additional recommendations regarding the case of Mr Marshall, as the investigation was unable to establish exactly where and how he accessed the methadone that contributed to his death. However, she directed a copy of the finding and data report to the Victorian Department of Health and Human Services, which is responsible for regulating methadone.

Coroner Jamieson also directed that a copy of the CPU's overdose data report be released publicly with the finding, to improve awareness and understanding of methadone-related deaths and support government and community efforts to reduce overdose deaths in Victoria more generally.

A copy of the finding and data report can be found at:

https://www.coronerscourt.vic.gov.au/sites/default/files/2020-08/Finding%20-%20MARSHALL%20Wayne%20Laurence%20-%20COR2018%205754%20-%2024082020.pdf

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