IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 004949

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	HG
Date of birth:	August 1981
Date of death:	11 September 2019
Cause of death:	1(a) Mixed drug toxicity
Place of death:	Victoria

INTRODUCTION

1. On 11 September 2019, HG was 38 years old when he died of a mixed drug overdose, including heroin, shortly after he was released from prison. At the time of death, HG lived with his mother in Victoria.

THE CORONIAL INVESTIGATION

2. HG's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury. The death of a person in care or custody is a mandatory report to the Coroner, but HG had been released from custody the day before he died.

3. 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.

4. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

5. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of HG's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. Given that HG had recently been released from gaol, additional statements were requested from his correctional and medical supervisors during that process.

6. This finding draws on the totality of the coronial investigation into the death of HG including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only

refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

7. HG was born one of three (now adult) children. His father passed away in 2018, but he remained close to his mother.

8. He was diagnosed with a hearing impairment at the age of 3 that required him to wear hearing aids. He dropped out of high school after year 8 and was removed from his mother's care when he was 13 years old. Around this time, he started using heroin.[2]

9. HG spent most of his teenage years in the corrections system, initially in juvenile facilities and then at Barwon Prison.[3]

10. Whilst in custody, an attempt was made to treat his heroin use with a Naltrexone implant, but this led to methylamphetamine consumption, hallucinations, paranoia and depression.[4]

11. He told his mother that he had attempted to commit suicide in custody in 2017, but was coaxed off a bridge by a police officer.[5]

12. In November 2017, HG returned to Barwon Prison. During this incarceration, he was treated for an abdominal stab wound. In March 2019 he was prescribed olanzapine for his paranoia and aggression.[6]

13. In preparation for his discharge he was assessed on 23 July 2019 by a psychiatric nurse who reported he was feeling really good and said he would never take methylamphetamine again.[7]

14. HG was discharged on 10 September 2019 from Barwon Prison with a prescription medication pack that did not include any opiate substitutes.[8]

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[1] 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.
[2] Statement of Mother, Coronial Brief.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Statement of Dr, 6 March 2020, Coronial Brief
[7] Ibid.
[8] Ibid.

15. He spent the day shopping with his sister then got the train to Ferntree Gully to see a friend. His sister picked him up around 8:30 PM and bought him home to Victoria.[9]

16. The next day, HG was up early and spent the day shopping with his mother and sister. Around 2:00 PM, he had take-away lunch at home, then went to his room for an afternoon nap at about 3:30 PM. At around 9:00 PM, his brother went upstairs to wake him but he could not. His mother immediately called 000 and attempted CPR following the operator's instructions until the paramedics arrived.[10]

17. He could not be resuscitated and was pronounced deceased at 10:02 PM on the 11th of September 2019. My investigators located three small foil packages in the bedside table of the bedroom where he was found. Whilst one foil was empty, the remaining two foils contained heroin. An expended syringe that had been recapped and replaced in its packaging was found in the drawer. A search of his body located a used alcohol wipe and more packaging in his pants' pocket. [11]

Identity of the deceased

18. On 11 September 2019, HG, born August 1981, was visually identified by his mother.

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

Medical cause of death

20. Senior Forensic Pathologist Dr Joanna Glengarry from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 18 September 2019 and provided a written report of her findings dated 9 January 2020.

21. She noted that the body showed needle puncture wounds. Whilst the body's other physical dimensions satisfied WHO class III obesity, with a fatty liver, there was no other evidence of violence or injury contributing to death, nor any fatal natural disease.

22. Toxicological analysis of post-mortem blood samples identified the presence of morphine and codeine, which can occur as metabolites of heroin. Analysis of urine samples found the heroin-specific metabolite 6-monoacetylmorphine (**6-MAM**). 6-MAM only occurs when heroin is consumed. The other toxicological results were consistent with his medical history of

[9] Statement of Mother, Coronial Brief.
[10] Ibid.
[11] Other statement, Coronial Brief.

antidepressant medications, and their sedative effect on the central nervous system when combined with heroin is well established.

23. Dr Glengarry provided an opinion that the medical cause of death was 1(a) Mixed drug toxicity.

24. I accept Dr Glengarry's opinion.

REVIEW OF CARE

25. The proximity between HG released from prison and death by opioid overdose caused me to investigate further the medical aspects of his release planning.

26. The records clearly show that HG declined offers for medical appointments to be organised for him within the community, [12] and having had his liberty fully restored to him at this time, there were no other opportunities for the State to intervene.

27. Nonetheless, and without forejudging what the ultimate result might have been, I note that there was no record of this man with a well documented history of heroin abuse being assessed as to whether he was suitable for opioid replacement therapy as part of his release.[13]

28. In light of his decision to not engage with other release assistance offered to him, I find that this omission did not contribute to his death in any way. However, the circumstances of his death, in combination with other investigations conducted by this Court,[14] does highlight the importance of continuing the State's efforts to improve the health outcomes of prisoners upon release back into the community.

RECOMMENDATIONS OF CORONER HAWKINS

29. On 24 February 2021, Coroner Jacqui Hawkins made findings into the death of Shae Paszkiewicz, another person who died of mixed drug toxicity shortly after release from prison. As part of her investigation, she received advice from the Coroners Prevention Unit, as well as a number of other organisations, on opportunities to prevent similar deaths from occurring in the future. Based on this advice, Coroner Hawkins made several recommendations to the

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[12] Statement of Dr, 6 March 2020, and letter from Acting Deputy Melissa Westin of the Dept. of Justice & Community Safety dated 27 July 2020, Coronial Brief.

[13] Supplementary statement of Dr, 13 August 2020, Coronial Brief.

[14] *Finding into death without inquest of Shae Paszkiewicz* (COR 2017 6235) [2021] VicCorC 26944; 24 February 2021 per Coroner Hawkins. The finding and responses to its recommendations are available on the Coroners Court of Victoria website.

Victorian Department of Health and the Victorian Department of Justice and Community Safety (**DJCS**). Both departments provided responses to her recommendations.

30. Her first recommendation was that:

> *the Department of Health adopt formal responsibility for improving health outcomes and reducing drug-related mortality among people who are released from prison*.

31. In response to this, the Department of Health noted that responsibility for these matters would require work by both the Department of Health and by DJCS, as DJCS was responsible for health services provided within Victorian prisons, while the Department of Health was responsible for health service delivery upon release, which includes the Opioid Substitution Therapy program and naloxone access in the community.

32. Her second recommendation was that:

> *the Department of Health convene a formal advisory group to guide the identification, prioritisation, implementation and evaluation of policies and programs to reduce drug-related mortality among people who are released from prison. This advisory group should include representatives from government departments and nongovernment organisations whose work intersects with support of people leaving prison, as well as academic experts*.

33. The Department of Health responded that they would implement this recommendation. They advised that they had previously established an Expert Advisory Committee on potential misuse of drugs of dependence, and that they would support DJCS to establish an advisory group specific to the forensic population.

34. As it is unclear from their response to what degree the advisory group's formation will be the responsibility of the Department of Health, and to what degree it will be the responsibility of DJCS, I will reiterate Coroner Hawkins' recommendation to both bodies.

35. Coroner Hawkins' third recommendation was that:

> *the Victorian Department of Health collaborate with the Victorian Department of Justice and Community Safety to link information they hold on all people who enter Victoria's prison system, with a view to producing accurate and timely information on these people and their health outcomes including death within 10 years of release from prison. This information should be collated in consultation with the advisory group*

(see Recommendation Two) and should be publicly reported on (at least) an annual basis, as well as being made available to researchers who are engaged in efforts to improve these health outcomes.

36. The Department of Health responded that they '*accept[] the need for linked data to evaluate health outcomes and guide strategic reform'* and *'will work with DJCS to identify mechanisms to link and utilise data in improving health outcomes for people who enter Victoria's prison system'.*

37. DJCS also accepted this recommendation in principle, but noted that progress toward its implementation was dependent on the second recommendation. They advised that DJCS would consult with the Department of Health to '*determine the appropriate advisory group to consider health information sharing, including any applicable requirements of the* Health Records Act 2001'.

38. Based on these responses, I will clarify in my reiteration of Coroner Hawkins' second recommendation that the advisory body should have appropriate capacity and authority to address health information sharing, including any applicable requirements of the *Health Records Act 2001*.

39. Coroner Hawkins' fourth recommendation was:

> *the Victorian Department of Justice and Community Safety should immediately introduce a take-home naloxone program (including training in overdose awareness and naloxone administration) to be made available to all people in Victorian prisons who have a history of opioid use and who are preparing to exit prison.*

40. DJCS accepted this recommendation in principle and informed the Court of a naloxone pilot program which had commenced on 3 May 2020 at four sites, and which was later expanded to Ravenhall Correctional Centre in February 2021. DJCS noted that '*as at 1 March 2021, 155 prisoners have participated in the pilot. DJCS is exploring options to expand the pilot statewide*'.

41. It is clear from Coroner Hawkins' investigation that such an expansion would likely be valuable in reducing drug-related mortality in people leaving prison, and I will make a recommendation below that the pilot be expanded statewide.

FINDINGS AND CONCLUSION

42. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was HG, born August 1981;

    b) the death occurred on 11 September 2019 in Victoria, from mixed drug toxicity; and

    c) the death occurred in the circumstances described above.

43. Having considered all of the circumstances, I am satisfied that his death was the unintended consequence of the deliberate ingestion of drugs.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

Recommendation One:

> That the Victorian Department of Health and the Victorian Department of Justice and Community Safety work together to convene a formal advisory group to guide the identification, prioritisation, implementation and evaluation of policies and programs to reduce drug-related mortality among people who are released from prison. This advisory group should include representatives from government departments and non-government organisations whose work intersects with support of people leaving prison, as well as academic experts. This advisory group should have the necessary capacity and authority to address health information sharing, including any applicable requirements of the *Health Records Act 2001*.

Recommendation **Two:**

> That the Victorian Department of Justice and Community Safety should expand its pilot naloxone program statewide to all Victorian prisoners.

I convey my sincere condolences to HG's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Senior Next of Kin

Rebecca Falkingham, Secretary, Department of Justice and Community Safety

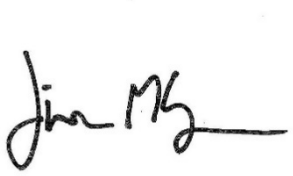
Professor Euan Wallace, Secretary, Victorian Department of Health

Marius Smith, VACRO

Kellie Dell'Oro, solicitor, on behalf of Correct Care Australasia Pty Ltd

Senior Constable Stephen Miotla, Coroner's Investigator

Signature:



CORONER SIMON McGREGOR

CORONER

Date: 29 September 2021

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.