IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 6058

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	**CORONER DARREN J BRACKEN**
Deceased:	XY
Date of birth:	27 July 1989
Date of death:	21-22 DECEMBER 2016
Cause of death:	COMBINED DRUG TOXICITY
Place of death:	A Street

TABLE OF CONTENTS

HIS HONOUR:

BACKGROUND

1. XY was 27 years old when she died at A Street between 21 – 22 December 2016. XY lived at B Street, with a housemate, and was in the process of moving into a Salvation Army house in C Street

2. Until a month prior to her death, XY lived with her parents, YZ and ZA Redding and XY's son WX for whom her parents were full-time carers.

3. XY's family noted a change in XY's behaviour dating from her involvement with WX's father at which time she began using drugs and alcohol. XY did not use drugs or drink alcohol during her pregnancy but relapsed into their use some 12-18 months after WX's birth. She eventually lost her driving licence and her job and then separated from WX'sfather.

4. In 2015, XY underwent opioid replacement therapy with suboxone[1] under the management of her regular general practitioner at [redacted] Medical Centre. XY's last prescription for suboxone was dated 20 August 2015.

5. On 26 December 2015, XY was the victim of an aggravated burglary during which she was tied up and threatened with a firearm and a baton. The offenders were eventually charged, and XY gave evidence at their trial in 2016.

6. XY was traumatised by this event and returned to live with her parents who noted that she was depressed and anxious. She was treated at [redacted] Medical Centre and prescribed mirtazapine[2] which was changed to fluoxetine[3] on 2 December 2016 because XY was concerned about having gained weight.

7. In September 2016, XY's parents arranged for her to attend a five-week drug and alcohol rehabilitation program. However, the anxiety caused by the trial of those accused of the aggravated burglary and assault caused XY to relapse and her family reported that she would disappear from home for increasingly lengthy periods.

[1] A combination medication containing buprenorphine and naloxone
[2] An antidepressant medication
[3] An antidepressant medication

THE PURPOSE OF A CORONIAL INVESTIGATION

8. XY 's death constituted a '*reportable death*' pursuant to section 4 of the *Coroners Act* (2008) (Vic) ("the Act"), as her death occurred in Victoria, was violent, unexpected, appears to have resulted, directly or indirectly, from an accident or injury, and was not from natural causes.[4]

9. The Act requires a coroner to investigate reportable deaths such as XY 's and, if possible, to find:

   (a) The identity of the deceased.

   (b) The cause of death and

   (c) The circumstances in which death occurred.[5]

10. For coronial purposes, '*circumstances in which death occurred*'[6] refers to the context and background the death including the surrounding circumstances. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, required findings in relation to circumstances are limited to those circumstances which are sufficiently proximate to be considered relevant to the death.

11. The coroner's role is to establish facts, rather than to attribute or apportion blame for the death.[7] It is not the coroner's role to determine criminal or civil liability,[8] nor to determine disciplinary matters.

12. One of the broader purposes of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by making recommendations.

13. Coroners are also empowered to:

   (a) report to the Attorney-General on a death;[9]

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[4] Section 4 *Coroners Act 2008*.
[5] See Preamble and s 67, *Coroners Act* (2008).
[6] Section 67(1)(c).
[7] *Keown v Khan* (1999) 1 VR 69.
[8] Section 69 (1).
[9] Section 72(1).

(b) comment on any matter connected with the death investigated, including matters of public health or safety and the administration of justice;[10] and

(c) make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[11]

14. Coronial findings must be underpinned by proof of relevant facts on the balance of probabilities.[12] The strength of evidence necessary to so prove facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.[13]

15. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demand a weight of evidence commensurate with the gravity of the facts sought to be proved.[14] Facts should not be considered to have been proved on the balance of probabilities by inexact proofs, indefinite testimony, or indirect inferences,[15] rather such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.[16]

16. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into XY 's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence.

17. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings and necessary for narrative clarity.

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[10] Section 67(3).
[11] Section 72(2).
[12] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[13] *Qantas Airways Limited v Gama* (2008) 167 FCR 537 at [139] per Branson J but I note that His Honour was referring to the correct approach to the standard of proof in a civil proceeding in a federal court with reference to section 140 of the *Evidence Act 1995* (Cth); *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brenna, Deane and Gaudron JJ.
[14] *Anderson v Blashki* [1993] 2 VR 89, following *Briginshaw v Briginshaw* (1938) 60 CLR 336, referring to *Barten v Williams* (1978) 20 ACTR 10; *Cuming Smith & Co Ltd v Western Farmers Co-operative Ltd* [1979] VR 129; *Mahon v Air New Zealand Ltd* [1984] AC 808 and *Annetts v McCann* (1990) 170 CLR 596.
[15] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.
[16] *Briginshaw v Briginshaw* (1938) 60 CLR 336, at pp. 362-3 per Dixon J.; *Cuming Smith & CO Ltd v Western Farmers Co-operative Ltd* [1979] VR 129, at p. 147; *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 170-171 per Mason CJ, Brennan, Deane and Gaudron JJ.

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

Identity of the Deceased - Section 67(1)(a) of the Act

18. On 22 December 2016, VW identified the deceased as her friend XY, born on 27 July 1989.

19. XY 's identity is not in dispute and requires no further investigation.

Cause of death - Section 67(1)(b) of the Act

20. On 30 December 2016, Dr Michael Burke, Senior Pathologist at the Victorian Institute of Forensic Medicine, conducted a post-mortem examination upon XY 's body. Dr Burke provided a written report, dated 25 January 2017, in which he opined that the cause of XY 's death was '*Combined drug toxicity*'. I accept Dr Burke's opinion.

21. Toxicological analysis of post-mortem samples detected the presence of methylamphetamine, methadone, diazepam, mirtazepam, fluoxetine and sertraline. Ethanol (alcohol) was not detected.

22. XY 's general practitioner, Dr [redacted] provided a statement to police in which he states that XY had been prescribed fluoxetine, mirtazapine and methadone. There is no evidence as to how or when XY may have obtained diazepam and sertraline.

Circumstances in which the death occurred - Section 67(1)(c) of the Act

23. Initial statements were obtained at the scene from VW, Mr AB and Mr BC the residents of A Street and XY 's housemate.

24. In her initial statement, VW said that on 20 December 2016, she visited B Street where XY had:

> *"...just finished injecting ice* [methylamphetamine] *into her left arm I think... she got out of rehab 2 months ago for drug use. She has been really depressed lately".*

25. VW also stated that at approximately 5pm, XY consumed (by what means is not stated) an unstated number of Physeptone tablets (she did not specify from where or how these were obtained)

26. In his statement, XY 's housemate confirmed using methylamphetamine with XY at B Street on 17 or 18 December 2016.

27. Again, according to her initial statement, on 21 December 2016, VW and were together all day. They went shopping and then went to visit Mr AB and Mr BC at A Street

28. During the morning XY drank:

> *"a couple of glasses of a dry wine 4 litre box. She had two cans of Woodstock*[17] *with me around 3-4pm. We had a 'cone' with the boys around 5pm. She was sitting on the table. About 10-15 minutes later she put her head down on the table... I think around 6-7pm she fell into a deep sleep. I tried to wake her she would just grunt and moan. I just thought she was tired. She was sort of snoring. I thought from the way she was laying her head on her arm her airways were getting blocked".*

29. On 1 February 2017, VW attended the [redacted] police station to amend her initial statement. She stated that

> *"The reason I have come forward now to tell you exactly what happened is that I wanted Bill* [William Nevin] *to come forward and tell you. But he hasn't."*

30. In her second statement, dated 1 February 2017, VW stated that, on 21 December 2016 she and XY went to A Street to obtain cannabis from Mr AB and Mr BC. When they arrived at the address, Mr AB and Mr BC were injecting crushed methadone tablets (under the brand name Physeptone). Mr AB (who was on the methadone program and prescribed Physeptone tablets) offered methadone filled syringes to both VW and XY saying: *"Merry Christmas girls"*. XY accepted a syringe. VW warned XY that *"You shouldn't have that because you're not used to opiates"* to which XY responded *"Get fucked. You are not my mother"* and then injected the contents into her left arm. All four then smoked cannabis and XY fell asleep at the table.

31. In Mr AB's second statement to police dated 16 March 2017, police put to him VW's account of events as told to police on 1 February 2017. Mr AB denied offering or giving

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[17] Pre-mixed drink of bourbon whiskey and cola.

physeptone to either XY or VW . In both statements, he said that between 8.00-9.00pm on 21 December 2016, he and Mr BC went out to the pub. He concluded:

> *"If* XY *or* VW *used Physeptone it was not to my knowledge and would have been used whilst I was out but not when I was with them".*

32. In his statement, Mr BC noted that, on 21 December 2016:

> *"For most of the night she* XY *was sitting at the kitchen table just talking. I didn't see her take anything or smoke anything. At about 8 or 8.30pm I told her to get comfy and to have a seat in the lounge'.*

33. Mr BC does not refer to going to the pub with Mr AB at any stage during the evening.

34. VW 's description of what happened then is similar in both her statements.

35. VW said that Mr AB and Mr BC moved XY into an armchair. After appearing to wake, XY went straight back to sleep and was noted to be snoring. At an unspecified time, XY vomited and was sweaty. At approximately 9-10pm she: *"..was breathing heavily and raspy.".* At approximately 2.00am VW said that:

> *"I checked* XY *, she was breathing but gave no verbal response her hands were still cold"*

36. VW went to sleep until approximately 6.30am. When she woke-up she tried to rouse XY and noted that she was not breathing and had no pulse. Emergency services were called, came to the house and at 6.50am declared XY dead.

37. On 5 January 2017, Crime Stoppers received information alleging that XY had deliberately been given a cocktail of drugs. This information resulted in the additional statements being obtained from VW and Mr BC. Further investigations, including a search of the unit A Street , were conducted and an amount of cannabis and crushed physeptone seized.

38. If VW 's second statement describing XY being given a syringe containing crushed Physeptone tablets is accepted two things follow. First, that would explain how XY came to have methadone, it being an ingredient of Physeptone, in her system and second in the circumstances described by VW , the person who gave XY the syringe may have committed an indictable offence.

39. I am satisfied, and find, that, on 21 December 2016, XY 's death was due to the unintentional consequences of her use of illicit drugs and prescription medication.

40. I am satisfied, having considered all of the available evidence, that no further investigation into XY 's death is required in order that I can make relevant findings.

41. Further, on the basis of the material contained in the Coronial Brief, I believe that an indictable offence may have been committed in connection with XY 's death.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

42. I asked the Coroner's Prevention Unit **(CPU)**[18] to review the case, in particular to identity issues regarding methadone diversion with a view to me making recommendations to reduce such diversion or ameliorate the effects of that diversion.

43. The CPU identified a prevention opportunity regarding overdose recognition and response. The witnesses recognised signs of overdose in XY (unrousable sleep, snoring, grunting and vomiting) but took no action. Had they done so, XY 's death may have been prevented.

44. The CPU suggested that targeted education for pharmaceutical opioid users and their families together with their taking part in a trial naloxone program may assist in reducing the harms associated with pharmaceutical opioid overdoses.

RECOMMENDATIONS:

Pursuant to section 72(2) of the Coroners *Act 2008*:

- I recommend that the Department of Health and Human Services consider expanding its heroin focussed overdose education and naloxone programs to those, including their immediate family members prescribed strong opioids such as methadone, physeptone and similar drugs and their families.

SECTION 49(1) CORONERS ACT

45. Section 49(1) of the Act provides that Court's Principal Registrar:

[18] A specialist service created for coroners to strengthen their prevention role and provide assistance on issues pertaining to public health and safety. The CPU is staffed by professions researchers and a multidisciplinary team of case investigators.

> *"...must notify the Director of Public Prosecutions if the coroner investigating the death or fire believes an indictable offence may have been committed in connection with the death or fire."*

46. The previous iteration of this provision, Section 21(3) *Coroners Act 1985* ("the 1985 Act") obliged a coroner to report

> *"...to the Director of Public Prosecutions if the coroner believes that an indictable offence has been committed in connection with a death which the coroner investigated."* and was only exercisable at the end of an inquest.

47. The test in the 1985 Act and the Act are significantly different. The obligation in the Act is not limited to being exercised at the end of an inquest and the requisite state of the coroner's mind is substantially reduced from 'a belief that an indictable offence has been committed' to 'a belief that an indictable offence may have been committed'. The Act confers separate roles on two actors; the coroner investigating the death forming a belief and separately the court's principal registrar notifying the Director of that belief. The principal registrar's obligation is not dependent upon the coroner directing the registrar to notify the Director.

48. The provision contains no obligation on the coroner or the registrar to extrapolate the belief by, for example nominating who is believed to have committed what offence, upon what basis the belief is held or even how the offence is believed to be connected with the death.

49. The test in the Act does not confer a discretion and its operation should not be considered in the same vein as the exercise of a judicial discretion. Section 49 sets-out a subjective test for the coroner investigating the death and mandates events that are to follow-on if the test is satisfied.

50. The section contains no explicit qualification of the requisite belief, for example that, it be a reasonable or that it be reasonably held. The lack of such a qualification should not be considered to permit a coroner to unreasonably hold a belief or indeed to hold an unreasonable belief. Any such belief must be reached and held 'judicially'.

51. The coroner's task is to consider the evidence upon which any such belief may be based together with how 'speculative' 'may' is and how remote 'in connection with the death' is. The unadorned phrase 'in connection with the death' provides a wide scope of indictable

offences to be considered.[19] It is not for example qualified by a requirement that the offence be 'substantially' or 'immediately' connected with the death. Indictable offences, all of which are axiomatically serious, include, inchoate, and completed offences.

52. Holding the belief that triggers the principle registrar's obligation is very different in nature from, for example, forming a view on the balance of probabilities as informed by the *Briginshaw* principles that an event occurred. Limiting a coroner's ability to form the requisite belief by applying the *Briginshaw* principles to the formation of the belief seems counter-intuitive given the terms of the provision; it is inapposite. The provision does not require that the coroner nominate the offence which is believed to have been committed nor the basis for the belief. The terms of the provision explicitly set the bar for the holding of the belief quite low by amongst other things using 'may' and 'in connection with'.

53. The section's function is to simply alert the Director of the possibility that an indicatable offence may been committed 'in connection with the death' so that the Director can consider the need for perhaps further investigation or prosecution.

54. Having read the entirety of the Inquest Brief I believe that an indictable offence may have been committed in connection with Ms Reddings's death.

FINDINGS AND CONCLUSION

55. Having investigated the death, without holding an inquest, I make the following findings pursuant to section 67(1) of the *Coroners Act 2008*:

(a) The identity of the deceased was XY , born on 27 July 1989;

(b) XY 's death occurred;

i. Between 21-22 December 2016;

ii. from combined drug toxicity; and

iii. in the circumstances described above.

56. Pursuant to section 73(1) of the **Coroners Act 2008,** I order that this finding be published on the internet.

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

[19] *Patric Cini v The Commissioner of the Australian Federal Police* [2016] VSCA 227 [51].

(a) YZ , senior next of kin;

(b) Ms Karyn Cook, South West Healthcare Mental Health Services;

(c) Secretary, Department of Health and Human Services Victoria; and

(d) Detective Sergeant Jason Von Tunk, Coroner's Investigator, Victoria Police.

Signature:

DARREN J BRACKEN

CORONER

Date: 31 January 2020