IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 000850

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Nathan James Thomas
Date of birth:	29 May 1984
Date of death:	15 February 2020
Cause of death:	1(a) Heroin toxicity
Place of death:	29 Williams Road, Laverton, Victoria, 3028

INTRODUCTION

1. On 15 February 2020, Nathan James Thomas was 35 years old when he died at 29 Williams Road, Laverton, of an apparent heroin overdose. At the time, Mr Thomas lived at home with his father after his mother passed away in 2019. Mr Thomas was one of five children.

2. Mr Thomas suffered with a long-standing drug addiction. His general practitioner, Dr Heather Dawd, reported that he was open about his addiction and the fact that he had used heroin with his brother who had subsequently accidentally overdosed. Mr Thomas told Dr Dawd that he felt guilty that he had not overdosed as well.

THE CORONIAL INVESTIGATION

3. Mr Thomas' 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.

4. 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.

5. 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.

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Thomas' 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

7. This finding draws on the totality of the coronial investigation into the death of Nathan James Thomas 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

Identity of the deceased

8. On 15 February 2020, Nathan James Thomas, born 29 May 1984, was visually identified by his father, Robin Thomas who signed a formal Statement of Identification to this effect before a member of Victoria Police.

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

Medical cause of death

10. Senior Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of Mr Thomas' body in the mortuary on 18 February 2020 and provided a written report of his findings dated 19 February 2020.

11. Dr Lynch advised that he findings on external examination consistent with the known circumstances, including a suggestion of recent and remote vascular access at the left cubital fossa (inside the crook of the left elbow).

12. Toxicological analysis of post-mortem samples identified 6-monoacetylmorphine[2] at a level of ~0.01mg/L, morphine at ~0.2mg/L), and codeine at ~0.02mg/L, all of which are metabolites of heroin, but no ethanol/alcohol or other commonly encountered drugs or poisons.

13. The toxicologist's report advised that these results are consistent with the recent and potentially fatal use of heroin. Further, that heroin and morphine are depressants of the central nervous system (CNS) causing a reduced rate and depth of breathing and may cause cessation of the breathing reflex altogether.

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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] According to the toxicologist's report "Within minutes of injection into a person, heroin is converted to morphine via the intermediate compound 6-acetylmorphine (6-AM). Morphine is the principal form detected in blood, although 6-AM may be detected in urine for about six hours after an injection and in blood only for a short time. 6-AM is not always present in urine of recent heroin users." Note that 6-AM is therefore a heroin-specific metabolite which indicates recent heroin use, whereas morphine and codeine are drugs in their own right which may indicate the ingestion of morphine and/or codeine proper.

14. Dr Lynch provided an opinion that it would be reasonable to attribute Mr Thomas' cause of death to *heroin toxicity*, without the need for an autopsy.

15. I accept Dr Lynch's opinion.

Circumstances in which the death occurred

16. In 2017, Dr Dawd assisted Mr Thomas to access the methadone program but noted that his engagement was intermittent. In the months leading up to his death, Mr Thomas had not been filling his methadone scripts. Dr Dawd attempted to link Mr Thomas with psychological support in 2018, but he did not engage despite attempts by services to contact him.

17. Mr Thomas' mother was a positive influence on his life and her death upset him greatly. Mr Thomas attended sessions with a mental health nurse in 2019 after his sister was admitted to a psychiatric unit following a suicide attempt. Dr Dawd noted that, whilst Mr Thomas did not express any suicidal ideation, he did speak of a sense of hopelessness, describing constant life pressures and frustration with the methadone system.

18. Following his mother's death, Mr Thomas lived with his father, Robin Thomas. Whilst the two did not talk much, Mr Thomas' father said that they had a pretty good relationship. Whilst Mr Thomas' father was aware that his son was using heroin, he only used in his bedroom and did not talk to his father about it.

19. On 15 February 2020, at about 10.30am, Mr Thomas' father found Mr Thomas lying on the floor of his room. Emergency services were called and responding Ambulance Victoria paramedics assessed him at the scene and verified that Mr Thomas was deceased.

20. Victoria Police Acting Sergeant (**SGT**) Gareth Mullins attended the scene at 11.45am and noted that there was drug paraphernalia, including a recently used syringe, in the vicinity of Mr Thomas' body.

21. SGT Mullins found no evidence that anyone else was involved in Mr Thomas' death or that he had otherwise died in suspicious circumstances.

FINDINGS AND CONCLUSION

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

    a) The identity of the deceased was Nathan James Thomas, born 29 May 1984.

b) The death occurred on 15 February 2020 at 29 Williams Road, Laverton, Victoria 3028.

c) The cause of Mr Thomas' death was *heroin toxicity*.

d) The death occurred in the circumstances described above.

e) The available evidence supports a finding that Mr Thomas died of an accidental or inadvertent overdose, that it his death was the unintended consequence of the deliberate ingestion of heroin.

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

Robin Thomas, Senior Next of Kin

Acting Sergeant Gareth Mullins, Victoria Police, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 18 November 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.