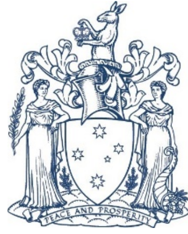

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 002120

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Simon McGregor
Deceased:	HYO[1]
Date of birth:	1975
Date of death:	18 April 2020
Cause of death:	1(a) Heroin toxicity
Place of death:	Endeavour Hills, Victoria
Keywords:	HEROIN, OVERDOSE, CUSTODIAL SENTENCE, CCO, COMMUNITY CORRECTIONS ORDER, JARO, JUSTICE ASSURANCE AND REVIEW OFFICE, DANDENONG COMMUNITY CORRECTIONAL SERVICES, RAPIDS, RESPONSIVE, ASSESSMENT, PLANNING INTERVENTION AND DIVERSION SERVICE, CAPS, COURT ASSESSMENT AND PROSECUTIONS SERVICE, VICTORIAN DEPARTMENT OF JUSTICE AND COMMUNITY SAFETY, NALOXONE

[1] This finding has been de-identified by order of Coroner Simon McGregor to replace the names of the deceased and their family members with pseudonyms of randomly generated three-letter sequences to protect their identity and redact identifying information.

INTRODUCTION

1. On 18 April 2020, HYO was 44 years old when he overdosed on heroin shortly after he had been released from jail on a Community Corrections Order (**CCO**). At the time of his death, HYO lived with his mother and his son in Endeavour Hills.

2. HYO was the middle of three siblings born to European refugee parents after they had settled in Melbourne.[2] He dropped out of high school to enrol in an apprenticeship at RMIT and began associating with drug users at this time. After failing to complete his apprenticeship, HYO took on labouring work as a renderer and began a relationship with his long-term partner around the time he turned 18, a relationship that was often coloured by intense disharmony.[3]

3. HYO had been on an Opioid Replacement Therapy (**ORT**) program, using Suboxone[4], for his heroin addiction from the time he was 20. He suffered several overdoses during his life and attempted rehabilitation several times.[5]

4. In 2004, HYO was involved in a motor vehicle collision where he suffered serious injuries. On his release from hospital, he moved in with his mother and father and began receiving a disability pension.[6] He continued using methamphetamine, heroin, and cannabis. HYO attended an appointment with his general practitioner in July 2019 for a non-specific mental health plan however he denied any symptoms of depression or suicidality during the session.[7]

5. Throughout HYO's adult life he had numerous interactions with the justice system, often due to his drug addiction. HYO served six custodial periods and was most recently released from Port Phillip Prison on 16 April 2020 after serving 37 days imprisonment for multiple charges. During HYO's sentence, he was not subjected to any drug testing.[8]

[2] Statement of FZN, Coronial Brief.
[3] Statement of Detective Senior Constable (**DSC**) Christopher Victory, Coronial Brief.
[4] A combination of buprenorphine and naloxone, used to treat opioid addiction.
[5] Statement of DSC Christopher Victory, Coronial Brief.
[6] Ibid.
[7] Report of Dr Sze Wong, Coronial Brief.
[8] JARO Report dated 23 July 2020.

THE CORONIAL INVESTIGATION

6. HYO'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.

7. Such deaths require a mandatory inquest if the deceased was in custody but section 6C(1) of the *Corrections Act 1986* gives a list of persons who are specifically not to be regarded as being in the Secretary's legal custody, and subsection (b) is '*a person who is serving a combined custody and treatment order and who is in the community under that order*'. Given that an inquest is not mandatory, I have exercised my discretion to close this matter at the investigation phase, because the material my investigator has gathered has been sufficient to enable me to complete my statutory tasks.

8. 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.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of HYO'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.

11. This finding draws on the totality of the coronial investigation into the death of HYO 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.[9]

---

[9] 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

12. In considering the issues associated with this finding, I have been mindful of HYO's basic human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and Responsibilities Act 2006* (Vic), in particular sections 8, 9 and 10.

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

Circumstances in which the death occurred

13. On 16 April 2020, HYO was released from Port Phillip prison and placed on an 18-month community corrections order (**CCO**) with conditions which included a nighttime curfew, that he reside with his mother, refrain from being drug or alcohol affected whilst at home, and undergo assessment, drug testing and treatment for his drug addictions.[10] Immediately after being released from prison however, HYO visited an associate and purchased drugs before he arrived at his mother's home.[11]

14. On 17 April 2020, HYO's son overheard him making a phone call to an unknown person which appeared to be an arrangement to purchase cannabis and heroin. His son confronted him about the phone call and the two men pushed and shoved each other. HYO's mother and his son left the home, and when they returned at 11.00pm HYO appeared drug affected.[12]

15. On 18 April 2020 at about 7.30am, HYO's mother observed him to be asleep on the couch and returned to bed.[13] At an unknown point in time during the morning, HYO got up from the couch and went to the toilet where he collapsed. At approximately 12.55pm, HYO's mother attempted to use the toilet and discovered HYO on the floor in an unresponsive state.[14] A syringe was located next to his body.[15]

16. HYO's son moved his father to the dining room and attempted to resuscitate him under instructions from the triple 000 call-taker.[16] At approximately 1.02pm, Ambulance Victoria paramedics attended the scene however HYO was unable to be revived and was verified as deceased at 1.22pm.[17]

---

evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[10] JARO Report dated 23 July 2020.
[11] Statement of FZN, Coronial Brief.
[12] Statement of CPL, Coronial Brief.
[13] Statement of FZN, Coronial Brief.
[14] Ibid; statement of DSC Chris Victory, Coronial Brief.
[15] Ambulance Victoria VACIS ePCR #10604, Coronial Brief.
[16] Statement of FZN, Coronial Brief.
[17] Ambulance Victoria Verification of Death form #10604, Coronial Brief.

Identity of the deceased

17. On 18 April 2020, HYO, born in 1975, was visually identified by his mother.

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

Medical cause of death

19. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 21 April 2020 and provided a written report of her findings dated 24 April 2020.

20. The post-mortem examination revealed findings consistent with the history given.

21. Toxicological analysis of post-mortem samples identified the presence of morphine, codeine and 6-monoacetylmorphine. Tapentadol and delta-9-tetrahydrocannabinol, a metabolite of cannabis, were also detected.

22. These results are consistent with the recent and potentially fatal use of heroin. In addition, there is an additive central nervous system (**CNS**) depressive effect with concurrent use of other CNS depressant drugs such as tapentadol and cannabis.

23. Dr Baber provided an opinion that the medical cause of death was from 1(a) heroin toxicity.

24. I accept Dr Baber's opinion.

REVIEW OF CARE

25. Given his history, and that the sentencing orders amounted to a significant curtailment of HYO's liberty, I further reviewed the circumstances of his custodial supervision upon release from gaol with the assistance of the Justice Assurance and Review Office (**JARO**)[18].

Compliance with the CCO and management by Dandenong CCS

26. On 16 April 2020, HYO began serving his CCO and was released from custody on the same day. He was directed to contact Dandenong Community Correctional Services (CCS) the following day for an induction appointment, however, he failed to report for this appointment.

[18] JARO provides independent oversight of Victoria's youth justice and adult corrections systems and conducts impartial reviews and finds new opportunities for improvement and change.

HYO's Case Manager made several attempts to contact him over the following days however there was no answer.[19]

Incident review and Manager's Review

27. On the morning of 21 April 2020, Dandenong CCS staff received a telephone call from HYO's mother informing them of his death. An incident report and Manager's Review were completed which identified three issues regarding HYO's management, including:

   a) A lack of documentation in HYO's Offender Management File;

   b) A missed opportunity to refer HYO to the Responsive, Assessment, Planning Intervention and Diversion Service (**RAPIDS**) for an urgent drug and alcohol assessment; and

   c) A lack of family violence perpetrator assessments conducted by the Court Assessment and Prosecutions Service (**CAPS**).[20]

28. Whilst the lack of documentation was viewed as an administrative issue, the failure to refer HYO to RAPIDS was highlighted as a key issue given his long-term polysubstance dependency and multiple accidental drug overdoses in the past 12 months. The Manager's Review highlighted that this missed opportunity, while significant, was not widespread and would be addressed via a reflective practice meeting.[21]

29. The JARO report noted that in response to the finding regarding a lack of family violence perpetrator assessments, a recommendation was made and implemented that involved the development of an action plan and a reflective practice group to review practice guidelines pertaining to this area in order to strengthen CAPS practices.[22]

---

[19] JARO Report dated 23 July 2020.
[20] Ibid.
[21] Ibid.
[22] Ibid.

FINDINGS AND CONCLUSION

30. Despite an undertaking to the Court to do so, HYO had not immediately engaged with Dandenong Community Correctional Services on release. Nonetheless, the Correctional Services internal Manager's Review identified that there was a missed opportunity immediately prior to his release to refer him to the Responsive, Assessment, Planning Intervention and Diversion Service (**RAPIDS**) for an urgent drug and alcohol assessment.[23]

31. Given his history, this is a proper concession for them to make and I am satisfied from the JARO report[24] and the further statement provided by Erica Paddle, Acting Director of Community Operations within Corrections Victoria,[25] that this missed opportunity has been addressed during their internal reflections processes following these events, and as such does not require formal comment or recommendation by this Court.

32. In light of HYO's decision to not engage with the other assistance offered to him upon release, 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, does highlight the importance of continuing the State's efforts to improve the health outcomes of prisoners upon release back into the community.

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

    a) the identity of the deceased was HYO, born 1975;

    b) the death occurred on 18 April 2020 in Endeavour Hills, Victoria, from heroin toxicity; and

    c) the death occurred in the circumstances described above.

34. Having reviewed the available evidence and considered all of the circumstances, I am satisfied that HYO's death was the unintended consequence of the deliberate ingestion of drugs.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

---

[23] Ibid.
[24] JARO Report dated 23 July 2020.
[25] Dated 28 October 2020, Coronial Brief.

35. In the matter of HG[26] I made two recommendations regarding the reduction of drug-related mortality amongst individuals released from prisons. Given the commonality between HYO's circumstances and those of HG, I am confident that these recommendations continue to be relevant in this matter.

36. The first recommendation concerned the establishment of a formal advisory group by the Victorian Department of Health (**VDH**) and the Victorian Department of Justice and Community Safety (**VDJCS**) with the objective of reducing drug-related mortality amongst those individuals released from prison, including having the capacity to address health information sharing.

37. I note with approval the responses received from VDH and VDJCS in which they both committed to developing shared governance, advisory, and information sharing mechanisms regarding forensic clients with a view to repurposing existing governance arrangements to meet the objectives of my recommendation.

38. The second recommendation concerned the expansion of the VDJCS pilot naloxone program state-wide to all Victorian prisoners.

39. In response to this recommendation, the VDJCS advised that following successful implementation of the 'Naloxone on Release' pilot program on 4 May 2020 at all public prisons, an independent review confirmed the value of the program and funding was confirmed to further support the rollout of the program to all private prisons, to identify opportunities to increase the prescription of Naloxone to prisoners prior to their release, and to monitor and contribute to the evaluation of the program. Additionally, the Penington Institute has been contracted to undertake a rapid review of the program to further inform program improvements.

[26] COR 2019 004949 (name redacted)

I convey my sincere condolences to HYO’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:

CPL, Senior Next of Kin

Marius Smith, VACRO

Alison Will, Department of Justice and Community Safety

Senior Constable Christopher Victory, Victoria Police, Coroner’s Investigator

Signature:

CORONER SIMON McGREGOR

CORONER

Date: 24 June 2022

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.