IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 2418

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Findings of:	CORONER JACQUI HAWKINS
Deceased:	Ms A
Delivered on:	20 February 2017
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	14 December 2016
Counsel assisting the Coroner:	Leading Senior Constable Joanne Allen, Police Coronial Support Unit
Representation:	Mr Robert Richter QC of counsel for Mr Greg Denham. Mr Sam Stafford of counsel for the Department of Health and Human Services.
Catchwords:	HEROIN OVERDOSE DEATHS, NORTH RICHMOND, CITY OF YARRA, SAFE INJECTING FACILITIES, NALOXONE TREATMENT, DRUG AND ALCOHOL OUTREACH PROGRAMS

CORONER HAWKINS:

BACKGROUND

1. Ms A was 34 years old when she died at St Vincent's Hospital on 30 May 2016.

2. At the time of her death, Ms A was unemployed and lived with her mother and brother at the family home located in Dallas, Victoria. She had two children who resided with their father.

3. Ms A was the middle child of three and was born in Turkey. Her family relocated to Australia in early 1996, when Ms A was 14 years old and resided in Coburg, Victoria when they first arrived in Australia.

4. At the age of 24, Ms A married a man who had a history of heroin and other drug abuse, and she starting using drugs, namely heroin. In 2007, when Ms A ended her marriage, she was emotionally unstable and addicted to heroin.

5. In 2008, Ms A met the man with whom she had two children. Due to incidents of alleged family violence, Ms A left him in 2010.

6. Ms A was described by her family as having no physical or mental health issues during her childhood or teenage years. She completed high school, but did not pursue any further study. Her medical records depict a history of regular drug abuse, mental health issues and being the victim of family violence. On several occasions she sought treatment for heroin dependence, and ceased using heroin for periods of time. Medical records indicate that she first received methadone maintenance therapy for opioid dependence in 2008, and she intermittently took part in methadone programs until the end of 2015. She was also prescribed naltrexone tablets on one occasion, and made inquiries with her general practitioner about a naltrexone implant.

7. Ms A's cycle of heroin use, engagement and disengagement with drug treatment services appears to have been, at least in part, linked to traumatic events that she experienced including being a victim of family violence and having her children taken into the custody of the Department of Human Services.[1] She regularly came into contact with the criminal justice system as a consequence of her heroin use. According to Victoria Police, they had 35 reported field contacts with Ms A between 2007 and 2016, the majority of which involved her being drug affected and/or found with drug paraphernalia in areas of high drug use. In 2015, she spent some time in custody for property and heroin related offences.

---

1 Now known as the Department of Health and Human Services.

8. In the six month period leading up to Ms A's death, she was residing in West Heidelberg but attended the City of Yarra regularly, particularly the North Richmond area to purchase and use heroin. She was known to outreach workers at North Richmond Community Health (NRCH), who provided both medical and social support to her. Approximately three weeks prior to her death, outreach workers administered naloxone to her when she overdosed. She discussed with NRCH outreach workers her efforts to obtain treatment for her drug dependence, and her hope to start a new life with her children.

THE PURPOSE OF A CORONIAL INVESTIGATION

9. Ms A's death constituted a '*reportable death*' pursuant to section 4 of the *Coroners Act 2008* (Vic) (Coroners Act), as her death occurred in Victoria and was unexpected and unnatural.

10. The jurisdiction of the Coroners Court of Victoria (Coroners Court) is inquisitorial[2]. The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

11. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

12. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

13. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

14. The broader purpose 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 the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

15. Coroners are also empowered:

---

2 Section 89(4) *Coroners Act 2008.*

3 *Keown v Khan* (1999) 1 VR 69.

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

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

(c) to 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. These powers are the vehicles by which the prevention role may be advanced.

16. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[4] 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 that they caused or contributed to the death.

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

Identity of the Deceased

17. On 30 May 2016, Ms A was visually identified by her former partner. Her identity is not in dispute and required no further investigation.

Medical cause of death

18. On 31 May 2016, Dr Sarah Parsons, Forensic Pathologist, at the Victorian Institute of Forensic Medicine (VIFM) conducted an examination on the body of Ms A.

19. Toxicological analysis of Ms A's ante-mortem blood and urine found a combination of drugs including free morphine 0.3mg/L (blood) and 0.5mg/L total morphine (urine), 0.05mg/L of codeine, 0.03mg/L of nitrazepam and 0.07mg/L of diphenhydramine. These findings are consistent with the recent use of heroin.

20. Ms Grace Wang, Toxicologist at VIFM reported that heroin and morphine are depressants of the central nervous system (CNS) causing reduced rate and depth of breathing and eventually cessation of the breathing reflex. Use of multiple drugs that depress the CNS such as alcohol, benzodiazepines and morphine-like drugs (opiates/opioids) will increase the risk of death. The concentration of free morphine in deaths attributed to heroin have ranged from 0.01mg/L to well over 1mg/L, with a mean of about 0.02- 0.03mg/L. There is no clearly defined safe or

4 (1938) 60 CLR 336.

toxic concentration of morphine in blood, or any other tissue. Any concentration has the potential to be fatal, depending on the circumstance and the tolerance to the drug.[5]

21. According to Ms Wang, there are a number of ways death can follow an injection of heroin:

- Death can be immediate. In these cases the needle may still be in situ. The mechanism is unknown but may be related to the injection rather than the pharmacological properties of heroin.

- Death is the result of an overdose of heroin ie. a result of the pharmacological properties of the drug. The usual mechanism here is depression of that part of the brain controlling respiration by the high levels of morphine. This effect may be compounded if other drugs or alcohol are present.

- Death is a complication of unconsciousness caused by a non-fatal overdose. Any unconscious person is at risk from death if the airways become obstructed either as a consequence of posture or obstruction by vomit.[6]

22. Dr Parsons provided a written report dated 10 June 2016, which concluded that Ms A's medical cause of death was 1a) GLOBAL CEREBRAL ISCHAEMIA SECONDARY TO PROBABLE HEROIN TOXICITY.

23. After discussing the toxicology results with Dr Parsons, she stated that given some benzodiazepine medications were detected, she would amend the medical cause of death to 1a) GLOBAL CEREBRAL ISCHAEMIA SECONDARY TO MIXED DRUG TOXICITY INCLUDING A SUBSTANCE CONSISTENT WITH HEROIN.

24. Accordingly, I will request the Principal Registrar to notify the Registrar of Births, Deaths and Marriages to amend the medical cause of death.

---

5 Exhibit 9 - Coronial brief, Toxicology Report dated 18 July 2016, p22E

6 Exhibit 9 - Coronial brief, Toxicology Report dated 18 July 2016, p22E

Circumstances in which the death occurred

25. On 29 May 2016 at approximately 12.20pm, Ms A attended Hungry Jacks on Hoddle Street, Richmond. CCTV footage depicts Ms A entering the Hungry Jacks toilet by herself at 12.21pm. Ms A then leaves the toilet to obtain a spoon from the store counter before returning to the toilet 20 seconds later, on her own.

26. At approximately 1pm, Ms A was located unconscious in the toilets by a staff member, with a syringe sticking out of the top of her leg and fresh track marks in the groin area. Emergency services were called and staff commenced cardiopulmonary resuscitation (CPR). Attending paramedics assisted by the Metropolitan Fire Brigade (MFB) assessed Ms A to be in asystole and took over resuscitative efforts.

27. Ms A was transferred to St Vincent's Hospital where a computed tomography (CT) scan showed hypoxic brain injury. She was admitted to the intensive care unit and given inotropic support and continued ventilation, however despite maximal medical treatment her clinical condition deteriorated. On 30 May 2015 at approximately 3.05am, Ms A suffered a cardiac arrest and died.

The Coroners Prevention Unit Investigation into heroin overdose deaths in the City of Yarra

28. The Coroners Prevention Unit (CPU) is 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 professional researchers and a multi-disciplinary team of case investigators.

29. The CPU conducted a review of fatal heroin overdoses in Victoria, to consider whether any broader prevention issues could be identified that are relevant to the circumstances in which Ms A died.[7] The review included collating and analysing several years of coronial data from the Victorian Overdose Deaths Register, and an in-depth analysis of heroin overdose deaths that occurred in 2015.

30. The CPU advised that Ms A's life and death shared commonalities with a large number of other heroin overdose deaths reported to the Coroners Court and investigated by Victorian coroners in recent years. Some commonalities included:

---

7 I would like to thank Coroners Prevention Unit Acting Manager Dr Jeremy Dwyer and Project Officer Ciara Millar for their assistance in conducting the review to inform my investigation. I would also like to acknowledge the assistance and support of Kate Mellier, Coroner's Legal Officer.

- Ms A fatally overdosed on heroin. In 2015, there were 172 heroin overdose deaths in Victoria – the greatest annual frequency since the height of the heroin related deaths at the end of the 1990s.

- Ms A was not a naïve drug user. She had an approximate 10 year history of heroin use leading up to her death. Approximately 75% of Victorians who fatally overdosed using heroin in 2015, had a 10 year or greater history of drug dependence. The average age of the deceased was just over 41 years; Ms A was aged 34.

- Ms A experienced a range of complex, interrelated health and social issues, which is a recurring theme in heroin overdose deaths investigated by Victorian coroners. Her heroin dependence brought her into contact with the Department of Health and Human Services (DHHS), Victoria Police and the criminal justice system. She had contact with a range of different drug treatment services, but this contact was usually intermittent. She also experienced family violence and relationship breakdown.

31. From a prevention perspective, the most crucial commonality related to the location where Ms A travelled regularly to use heroin, and where she fatally overdosed, being the City of Yarra in North Richmond near Victoria Street.

32. Over the past seven years, the City of Yarra has consistently been the local government area with the highest frequency and rate of heroin overdose deaths in Victoria. A large number of deaths occurred in a relatively well defined area, centred on Victoria Street, and surrounding streets in Richmond and Abbotsford; these included fatal overdoses that occurred in carparks, toilet blocks, alleys, restaurants and other publically accessible locations, as well as private residences.

33. In 2015, 20 of the 172 fatal heroin overdoses occurred in the City of Yarra. The deceased included both local residents and people who resided elsewhere but attended Richmond to purchase illegal drugs. Like Ms A, 14 of those 20 deceased fatally overdosed in public locations. In addition, the CPU identified a further 15 overdose deaths in 2015 where the deceased died outside the City of Yarra, however there was positive evidence that the heroin contributing to the death was purchased or otherwise sourced in the City of Yarra. This is believed to be a conservative estimate, as the source of where the heroin was purchased could not be identified or confirmed in the majority of cases.

34. Ambulance Victoria attendance data provided by Turning Point is consistent with the overdose data; it shows that over the past five years, the City of Yarra has been the local government area with the highest frequency of heroin-related ambulance attendances.

Scope of Inquest into the death of Ms A

35. I determined to conduct an Inquest into the death of Ms A to explore the nexus between heroin-related harms and deaths and the City of Yarra, with particular focus on potential prevention opportunities in the Richmond area. My primary purpose is to, if possible, "*contribute to the reduction of the number of preventable deaths and the promotion of public health and safety*" as espoused in the preamble to the Coroners Act.

36. Consequently, I invited a number of people and organisations to provide submissions in relation to their knowledge and observations of what is currently being done in the Richmond area, what more could be done to prevent such deaths and explore any opportunities for me to make any potential recommendations. I would like to acknowledge and thank all the parties and organisations that provided submissions to me as part of this investigation.

37. The following witnesses were called to give *viva voce* evidence to address the scope of the Inquest:

- Dr Jeremy Dwyer, Acting Manager of the Coroners Prevention Unit, Coroners Court of Victoria
- Professor Paul Dietze, Deputy Director for Population Health, Burnet Institute
- Mr Demos Krouskos, Chief Executive Officer, North Richmond Community Health
- Mr Greg Denham, Executive Officer, Yarra Drug and Health Forum
- Ms Judith Abbott, Director of Prevention, Population, Primary and Community Health, Department of Health and Human Services
- Dr Marianne Jauncey, Medical Director, Sydney Uniting Medically Supervised Injecting Centre

What is currently being done in the City of Yarra to reduce heroin-related deaths?

38. There was general consensus among organisations and individuals who provided written submissions to me, that the City of Yarra - and particularly the North Richmond area - is a

'hot-spot' for heroin use and related harms including fatal overdose, and attracts heroin users from across Melbourne.

39. There was consistency between the 18 written submissions I received, and the evidence heard at Inquest, regarding the strategies that are currently being employed to reduce injecting drug related harms in the City of Yarra. The most frequently discussed strategies were:

- Needle and syringe programs;
- Specialist outreach to engage injecting drug users;
- Naloxone distribution and peer education;
- NRCH response to heroin-related overdoses; and
- Policing.

Needle and syringe programs

40. There is strong evidence that injecting drug users' access to sterile injecting equipment reduces the risk of blood borne disease transmission and injection-related injuries. A number of organisations currently deliver needle and syringe programs (NSP) in the City of Yarra. The DHHS funds NSP programs throughout Victoria. Three health services in the City of Yarra have been recipients of one-off grants to expand after-hours access to clean injecting equipment.[8]

41. NRCH is one such service. As a comprehensive primary health care facility, it provides a suite of services including a NSP, inclusive of after-hours vending machine access. The NRCH NSP currently distributes approximately 70,000 syringes per month to drug users who attend Richmond.[9]

42. In addition, cohealth Ltd (cohealth) deliver NSP services at four locations during the day and via outreach workers in the evenings.[10] The Youth Support and Advocacy Service (YSAS) also operates a secondary NSP. Their submission noted that "*as a secondary needle*

8 Exhibit 8 - Statement by DHHS dated 5 November 2016, p77.
9 Transcript of evidence, p38
10 Exhibit 9 - Coronial brief, submissions of cohealth dated 9 November 2016, p84

exchange, YSAS has experienced a ten-fold increase in the demand for clean injecting equipment over the past two years."[11]

43. Victoria Police recognised in their written submission that NSPs are essential to harm reduction and consequently do not patrol or conduct surveillance near those locations unless essential. Additionally, police are instructed that they "*may only conduct a search of a person visiting or leaving a NSP where there are reasons for the search other than the person's presence near the NSP*".[12]

44. The sheer quantity of clean injecting equipment being distributed via NSPs in Richmond, including needles and syringes as well as filtered water, cotton wool, spoons and other equipment, provides cogent evidence of the level of injecting drug related activity in the area.

Specialist outreach to engage injecting drug users

45. As an important component of targeted drug harm reduction strategies, a range of health and community organisations have established outreach programs to engage actively with injecting drug users who attend the City of Yarra, and either deliver services or assist them to access services across the health (including safe drug use education, general medical and dental care) and social (including housing and legal advice) spheres. A number of these programs are specifically funded by the DHHS.

46. The DHHS funds drug outreach workers who provide information and education on drug harms to injecting drug users in the community, as well as "*mobile drug safety and overdose response workers who promote harm minimisation strategies for drug users*"[13]. The DHHS funded outreach workers also facilitate drug users' access to case management and referral to a range of drug treatment and other health and social services.

47. NRCH is an organisation that performs outreach and provides health services, including general medical services, overdose response training,[14] a nurse to treat drug use related health issues (such as wounds and infections), priority appointments for drug users to see general practitioners and pharmacotherapy.[15]

48. As well as providing a needle exchange, the NRCH outreach workers talk to the users:

---

11 Exhibit 9 - Coronial brief, submission of YSAS dated 3 November 2016, p57
12 Exhibit 9 - Coronial brief, submissions of Chief Commissioner of Police dated 24 November 2016, p109
13 Exhibit 8 - Statement by DHHS dated 5 November 2016, p77.
14 Exhibit 8 - Statement by DHHS dated 5 November 2016, p77
15 Exhibit 3 - Statement of Demos Krouskos dated 2 November 2016, Inquest brief, p51

> *... to gauge current issues in the community such as increased purity of drugs, or changes in types of drugs used. Having this understanding means the ... program can respond with appropriate strategies to mitigate risk to service users and tailor education and overdose prevention messages to the issues that are relevant at the time.*[16]

49. Mr Krouskos stated that there is very strong social stigma towards the drug users in the Richmond area and his staff are highly skilled in engaging with the drug users. He stated *"we have a responsibility of care to those clients, just like any other client and therefore, we treat them ...with respect."*[17]

50. Within walking distance of Victoria Street, YSAS operates a range of alcohol and other drug focused services including primary health service, forensic and non-forensic outreach and supported accommodation programs.[18] Other current examples of outreach and education programs include cohealth, where their NSP workers deliver overdose education to people who inject drugs, including the Community Overdose Prevention and Education (COPE) program.[19]

51. The Fitzroy Legal Service (FLS) has family and community lawyers at the Neighbourhood Justice Centre, who work collaboratively with drug and alcohol workers, mental health workers and others to deliver legal services through a holistic health partnership model.[20] The FLS has a drug outreach lawyer funded by the DHHS, who *"has now been providing legal services to vulnerable people who use drugs and who are disengaged from traditional in-house legal services for 15 years"*.[21]

52. The evidence identifies that outreach programs are vital to connecting with, engaging and supporting people who are addicted to drugs in our community. There are vulnerable drug users - particularly those who are experiencing mental ill health and/or crises such as exposure to family violence, loss of employment or housing, relationship breakdown, and criminal legal issues - who do not know how to access services, or who fear being stigmatised by service providers, or who are unable to navigate services and disengage before receiving the help they need. Through helping these people, outreach programs are potentially saving lives.

---

16 Exhibit 4 - Statement of Demos Krouskos dated 2 November 2016, Inquest brief, p50
17 Transcript of evidence, p.33
18 Exhibit 9 - Coronial brief, submissions of YSAS dated 3 November 2016, p58
19 Exhibit 9 - Coronial brief, submissions of cohealth dated 9 November 2016, p84
20 Exhibit 9 - Coronial brief, submissions of FLS dated 6 November 2017, p117
21 Exhibit 9 - Coronial brief, submissions of FLS dated 6 November 2017, p117

Naloxone distribution and peer education

53. Naloxone (often referred to by the brand name Narcan) is an opioid antagonist drug that is listed by the World Health Organisation as an essential medicine and is available through the Pharmaceutical Benefits Scheme (PBS).[22] When naloxone is administered by injection (intramuscularly into the upper arm or outer thigh), it temporarily reverses life-threatening depression of the central nervous system and respiratory systems that occurs in opioid overdose. Any doctor may prescribe naloxone, and any person can safely and legally administer naloxone.[23]

54. NRCH's alcohol and drug team, in collaboration with Harm Reduction Victoria (HRV), has trained approximately 70 people who inject drugs, how to respond to overdose, including how to administer naloxone. These trained users are given naloxone to take with them free of charge, for them to administer in the community when someone is recognised to have overdosed. The cost of this program is borne by NRCH. Additionally, NRCH's outreach workers are trained to administer naloxone.[24]

55. The DHHS supports the use and treatment of naloxone. In evidence, Ms Abbott stated that "*we see naloxone as being a really important part of an overdose response.*"[25]

56. Peer education is another vital harm reduction strategy in the North Richmond area. The DHHS funds HRV to operate a peer networker program in the City of Yarra in which registered drug users speak to their peers about the NSP, safe injecting, naloxone and where to obtain support and treatment[26]. HRV runs the Drug Overdose Peer Education (DOPE) program, which is funded to educate 250 people who inject drugs per annum about overdose prevention, recognition and response.[27]

57. The DHHS is also funding a peer-led network trial at six sites across Melbourne including the City of Yarra, which involves using peer workers to "*engage individuals who might be hard to reach or disconnected from mainstream health services.*"[28] At the time of writing, the trial was still in its planning stages.

---

22 Exhibit 9 - Coronial brief, p198
23 Exhibit 9 - Coronial brief, p185
24 Exhibit 3 - Statement of Demos Krouskos dated 2 November 2016, Inquest brief, p51.
25 Transcript of evidence, p127
26 Exhibit 8 - Submissions of the DHHS dated 5 November 2016, p78.
27 Exhibit 9 - Coronial brief, submissions of HRV dated November 2016, p168
28 Exhibit 8 - Submissions of the DHHS dated 5 November 2016, p78.

NRCH response to heroin-related overdoses

58. At Inquest, Mr Krouskos gave evidence about how drug users in the North Richmond area are observed to inject drugs. Of particular interest, he noted that when people purchase drugs such as heroin, they often use those drugs within a very short period of time after purchase.[29] He related the observation that many users will purchase their drugs in and around Victoria Street, then obtain sterile injecting equipment from NRCH and find a location in the immediate area to inject as quickly as they can. Consequently, NRCH outreach workers are frequently called to respond to overdoses in the North Richmond area. They often arrive before ambulance paramedics. The outreach workers administer naloxone, in some cases commence CPR and generally manage the situation. This is central to their prevention strategy.

59. NRCH reported that between 2014 and 2015 they responded to 101 overdoses, being 45 overdoses in 2014 and 56 overdoses in 2015.[30]

60. An emergency response by NRCH usually requires the involvement of up to 10 staff from a variety of programs including two general practitioners, two nurses, four outreach workers and at least two emergency response coordinators.[31] Mr Krouskos stated that due to the efforts of his staff, they have saved a significant number of lives. His evidence was impressive, and I commend Mr Krouskos and his staff at NRCH for their lifesaving efforts.

Policing

61. Victoria Police has a presence in the North Richmond area and regularly conducts targeted operations. Victoria Police members are advised not to target people in the vicinity of NSPs just because they have visited an NSP, and are also asked to consider whether prosecuting a person who has overdosed would be in the best interests of the community.[32] According to Victoria Police they have "*a long standing and recognised use of drug diversion and referral pathways for low level offenders, providing early interventions before the harms associated with drug use become more problematic*".[33]

62. The Victoria Alcohol and Drug Association (VAADA) noted that despite the police presence in North Richmond, public drug injecting persists at very high levels. The VAADA raised

29 Transcript of evidence, p35
30 Exhibit 3 - Statement of Demos Krouskos dated 2 November 2016, Inquest brief, p49
31 Exhibit 3 - Statement of Demos Krouskos dated 2 November 2016, Inquest brief, p50
32 Exhibit 9 - Coronial brief, submissions of Chief Commissioner of Police dated 24 November 2016, p109
33 Exhibit 9 - Coronial brief, submissions of Chief Commissioner of Police dated 24 November 2016, p114

concerns about the policing strategies, reporting there is potential for these endeavours to result in more harmful behaviour by the users. For example, when police are conducting targeted operations, users will consume their drugs rapidly so that they are not found in possession, and this results in higher risk of overdose. A related issue is that injecting drug use can be displaced from easier to access locations to more difficult locations where there is less likelihood somebody will be found quickly if they overdose.[34]

63. The submission of the YSAS was consistent with the VAADA concerns. They stated:

> *Most of the responses to this population [of injecting drug users] have been justice-based enforced by Victoria Police. In fact, more money is spent on policing this population than treating this population. Every attempt to address this problem has led to displacement of street-based users into residential streets and lanes, impacting negatively - and sometimes terrifyingly - on the residents of North Richmond.*[35]

64. Police face an extremely challenging situation in North Richmond, as they are required to enforce laws and address criminal behaviour, where law enforcement responses can potentially lead to other community harms. The current policy of Victoria Police to not actively target someone who is in the vicinity of an NSP, appears to be an appropriate response consistent with harm reduction principles.

Other place-based interventions to reduce heroin overdose deaths in the City of Yarra

65. Those who gave evidence at Inquest and through submissions provided to the Coroners Court, made a number of suggestions for place-based interventions that could be considered in North Richmond. The interventions identified, *inter alia*, were:

- The introduction of a safe injecting facility;
- Expansion in naloxone distribution and education;
- Review of drug treatment programs to ensure demand and client needs are met

The introduction of a safe injecting facility

66. A safe injecting facility (also referred to by a range of other terms including medically supervised injecting centre, injecting room, drug consumption room) is a place where injecting drug users can go to use drugs under clinical supervision, without fear of being arrested. There are now more than 100 safe injecting facilities around the world, including in

34 Exhibit 9 - Coronial brief, submissions of VAADA dated 4 November 2016, p62
35 Exhibit 9 - Coronial brief, submissions of YSAS dated 3 November 2016, p59

Sydney.[36] They feature a range of different implementation models, but generally include at least some of the following features:

- safe, clean injecting equipment is freely available, which reduces risks associated with sharing equipment and using non-sterile equipment;
- trained staff are present to provide appropriate treatment if an overdose occurs, and to provide education to users on safe injecting practices, risks of drug injection, and overdose awareness; and
- support workers are co-located with the facility to assist in linking users with health and mental health treatment, housing, legal advice, and other services.

67. Safe injecting facilities are currently not permitted in Victoria.[37]

68. In advance of the Inquest, I received reports from two of Australia's foremost experts on injecting drug use and harm reduction, being Professor Paul Deitze and Dr Alex Wodak. Between them, they comprehensively summarised the existing literature and evidence regarding the efficacy of safe injecting facilities. I do not intend to reproduce in detail the contents of their reports, but note the following general themes. Safe injecting facilities are generally found to reduce instances of injecting in public places, reduce drug paraphernalia in public places, reduce injuries and overdoses associated with drug injection and increase users' engagement with health and social services. Safe injecting facilities are invariably implemented in areas where there are high levels of injecting drug activity already. The academic research and literature into this area does not support a proposition that a safe injecting facility attracts more drug use or dealers to those areas.

69. Professor Deitze concluded that supervised injecting facilities have been shown to reduce overdose fatalities in local-area analyses and would be an appropriate place-based intervention to consider in the City of Yarra.[38] Dr Wodak similarly advised that establishing a drug consumption room would be a critical step to reducing opioid and heroin overdose deaths.[39]

70. Consistent with the evidence of these two experts, the majority of organisations and individuals who provided written submissions to the Coroners Court recommended or

36 Exhibit 9 - Coronial brief, submissions of Dr Alex Wodak undated p42
37 *Drugs, Poisons and Controlled Substances Act* 1981 (Vic)
38 Exhibit 2 - Statement of Professor Paul Dietze, Burnet Institute dated 17 November 2016, p95
39 Exhibit 9 - Coronial brief, submissions of Dr Alex Wodak undated p43

supported the introduction of a safe injecting facility in North Richmond. No submissions opposed a safe injecting facility. Several organisations noted that there have been longstanding calls for a safe injecting facility to be established in the City of Yarra, with strong support from the Council, local traders and residents.

71. The FLS submission reflected a general theme in the evidence before me: that a safe injecting facility presents opportunities to engage with and help injecting drug users beyond merely supervising the act of injecting. They stated:

> *such a facility could include a holistic and localised range of services including medical, pharmacotherapy, needle syringe program, housing and legal services, as well as social reintegration services such as training, education and employment. Importantly it would also provide an opportunity for harm reduction and naloxone peer to peer education.*[40]

72. Mr Krouskos indicated that NRCH would be a "willing partner" in the establishment of a pilot program at NRCH's health centre. NRCH believe if implemented, a safe injecting facility would have an immediate impact on heroin overdose deaths in the City of Yarra.[41]

Sydney Medically Supervised Injecting Centre

73. To learn more about safe injecting facilities, how they work in practice and what their potential is for overdose death prevention, I invited Dr Marianne Jauncey, Medical Director of the Sydney Medically Supervised Injecting Centre (MSIC), to provide a written submission. Dr Jauncey also attended the Inquest to give evidence.

74. The MSIC is located in Kings Cross, Sydney and is the only legally supervised injecting facility in Australia. It was recommended in 1999 New South Wales Drug Summit report, and it commenced operation under Uniting Care on a trial basis in May 2001, after necessary legislative amendments were introduced through the *Drug Summit Legislative Response Act 1999 (NSW)*.

75. Following a number of independent evaluations, a final evaluation report was published in September 2010,[42] which found that the MSIC had:

- Successfully managed more than 4,400 drug overdoses without a single fatality.

---

40 Exhibit 9 - Coronial brief, submissions of FLS dated 6 November 2017, p122

41 Exhibit 3 - Statement of Demos Krouskos dated 2 November 2016, Inquest brief, p52-53

42 KPMG, *NSW Health Further evaluation of the Medically Supervised Injecting Centre during its extended Trial period (2007-2011): Final Report*, 14 September 2010.

- Reduced the average number of overdoses in public locations around the area where it was located.

- Reduced the number of ambulance call outs to the Kings Cross area by 80 percent.

- Provided more than 9,500 referrals to health and social welfare services, including drug treatment services, particularly among people who historically had no contact with these services, with an increased rate of drug treatment uptake from these referrals.

- Reduced the number of needles and syringes collected in the surrounding area, as well as reduced the number of residents who reported witnessing public injecting in the area.

- Won strong approval from local residents and business owners as well as local ambulance and health services.

76. In November 2010, after a 10 year trial period the *Drug Summit Legislative Response Act 1999 (NSW)* was repealed and replaced by the *Drug Misuse and Trafficking Amendment (Medically Supervised Injecting Centre) Act 2010 (NSW)* to allow the MSIC to legally and permanently operate. Dr Jauncey noted that MSIC is now "*the only physical location where the State law has been changed so that it allows people to be in possession of small quantities for personal use, and it allows self-administration.*"[43] Importantly, health care workers are able to be aware of the use and self-administration without breaching any criminal law as well.[44]

77. In practical terms, Dr Jauncey explained that the area where a person injects drugs looks like a medical clinic, with a nurses station centrally located and stainless steel booths nearby. Before a client can inject, he or she must register, be provided with clean injecting equipment and sit in a booth and self-administer their drug. A nurse or trained carer is physically present to ensure the safety of the client.[45] If, for whatever reason the client does overdose, the nurses and carers are immediately able to provide assistance in the form of oxygenation or resuscitation and, if required, administer naloxone.[46] Dr Jauncey stated that the centre averages around 150 visits a day[47] and has managed 6,500 overdoses.[48] In 16 years of operation, there have been no overdose deaths.[49]

---

43 Transcript of evidence, p63
44 Transcript of evidence, p63
45 Transcript of evidence, p68-69
46 Transcript of evidence, p75
47 Transcript of evidence, p86

78. After the client has injected, they then move through to a recovery area. Dr Jauncey noted that clients who attend are usually at their most vulnerable, in terms of their own shame and self-stigma, and the counsellors in the recovery area are able to provide support for them in their presenting mental state as well as assist with outreach support and linkage to medical, housing and legal advice.

79. Dr Jauncey stated that "*there really isn't anybody sensible that doesn't acknowledge that supervised injecting facilities will save lives.*"[50] Further, she stated "*you've got every medical organisation, every research organisation, every scientific community ... in Australia that's come out and acknowledged the evidence is, that they save lives.*"[51] However, she noted that it was not in and of itself a "*silver bullet*"[52] for solving injecting drug harms.

80. Regarding the question of where a safe injecting facility should be located, Dr Jauncey stated that in general terms:

> *...we know from Australia, from all over the world, people use drugs where they buy drugs. And so the inevitable link between the sale, purchase and use of drugs is ... very much place based. So you have to locate the solution where the problem is.*[53]

DHHS evidence on safe injecting facility

81. The DHHS submission did not mention safe injecting facilities. At Inquest Ms Abbott explained that a safe injecting facility is not current government policy, and that the State Government "*currently isn't proposing [the] establishment of a safe injecting facility.*"[54] Ms Abbott indicated that the DHHS had conducted research with respect to safe injecting facilities,[55] however she was unable to answer questions about the content of any such work.[56] I concluded from Ms Abbott's evidence that the DHHS was unable to explore safe injecting facilities as a drug harm reduction strategy because they are bound by government policy.

Conclusions on safe injecting facilities

82. In their written submission, Victoria Police noted that as with other harm reduction strategies, safe injecting facilities are likely to be considered as part of the upcoming Victorian

---

48 Transcript of evidence, p94
49 Transcript of evidence, p76
50 Transcript of evidence, p76
51 Transcript of evidence, p76
52 Transcript of evidence, p86
53 Transcript of evidence, p82
54 Transcript of evidence, p125
55 Transcript of evidence, p126
56 Transcript of evidence, p125

Parliamentary Inquiry into Illicit and Synthetic Drugs and Prescription Medication (the Inquiry).[57] I agree with Victoria Police that this Inquiry might provide a good opportunity to examine safe injecting facilities in more detail. However, I note the terms of reference for the Inquiry are very broad whereas my specific focus in this Inquest has been on reducing heroin-related deaths in the City of Yarra.

83. On the evidence before me, I am convinced that a safe injecting facility in North Richmond is an essential intervention that could reduce the risk of future heroin overdose deaths occurring in circumstances similar to those of Ms A. I note particularly that Dr Jauncey was an excellent witness and I found her evidence compelling. It is clear from her evidence that MSIC has been successful in Sydney and has helped save many lives. In conclusion, I support the establishment of a pilot safe injecting facility in North Richmond and accordingly have made that recommendation.

Expansion of naloxone distribution and education

84. Another positive harm reduction initiative, with excellent prospects for reducing harms associated with opioid overdose, is naloxone distribution and education. Naloxone is (as noted previously in this finding) a lifesaving drug. Dr Wodak reported that "*naloxone has an important role in assisting the reduction of opioid and heroin overdose deaths.*"[58] In this respect I note the Neighbourhood Justice Centre submission that "*increasing the availability of Naloxone to members of the intravenous drug using community and associated front-line service partners could decrease the mortality rates associated with overdoses in the City of Yarra.*"[59]

85. NRCH currently fund their naloxone program for staff and peer networkers. Mr Krouskos noted that if they had the resources, they could greatly expand their program to engage members of the public, the business community, council staff, local residents, family members, friends and a whole range of people to be educated, trained and provided with naloxone.[60] Many of the submissions also suggest that drug users, emergency workers and health workers should be trained in the use of, and be able to access and carry naloxone.

86. At Inquest, Ms Abbott stated that the government is committed to reducing the harm associated with drug use. She noted the government has increased investment in drug

57 Exhibit 9 - Coronial brief, submissions of Chief Commissioner of Police dated 24 November 2016, p113
58 Exhibit 9 - Coronial brief, submissions of Dr Alex Wodak undated p43
59 Exhibit 9 - Coronial brief, submissions of Neighbourhood Justice Centre, p81
60 Transcript of evidence, p45

treatment and harm reduction, and the current DHHS focus includes expanding peer networks,[61] which are one of the avenues through which naloxone distribution and associated training occurs.

87. On the basis of the written submissions and the evidence at Inquest, I have accepted the general principle that if more injecting drug users and people who come into contact with injecting drug users in the North Richmond area were trained in overdose recognition and naloxone administration, less lives would be lost to heroin overdoses. I support the expansion of the naloxone program and I have made a recommendation in support of this.

Review of drug treatment programs to ensure demand and client needs are met

88. A range of interrelated issues were identified with delivery of drug treatment programs to drug users who attend the North Richmond area, which if addressed could potentially lead to better health outcomes and reduced mortality and morbidity among injecting drug users.

89. The first issue pertained to the availability of drug treatment services in the local area, including access to pharmacotherapy for opioid dependence. The FLS noted that their clients can experience significant barriers to accessing drug treatment services, particularly opioid replacement therapy, for which demand far exceeds supply. They called for delivery of opioid replacement therapy to be expanded and improved in the City of Yarra, to meet demand.[62] This was echoed in the submissions of the Neighbourhood Justice Centre, NRCH and VAADA, with VAADA Chief Officer Mr Sam Biondo writing that "*individual agencies providing services within North Richmond should be consulted with regard to the composition of any additional treatment capacity.*"[63]

90. A related issue pertained to client access to existing services. Neighbourhood Justice Centre Director Kerry Walker explained that a range of alcohol and other drug treatment related services are available in the City of Yarra (including residential withdrawal programs, pharmacotherapy, NSPs and counselling and recovery programs), but "*access to them can often be onerous for the affected individual to navigate independently*".[64] The Neighbourhood Justice Centre's solution to this has included maintaining dedicated alcohol and other drug clinicians to assist clients with treatment access.

---

61 Transcript of evidence, p125

62 Exhibit 9 - Coronial brief, submissions of FLS dated 6 November 2017, p120

63 Exhibit 9 - Coronial brief, submissions of Neighbourhood Justice Centre dated 27 October 2016, p62

64 Exhibit 9 - Coronial brief, submissions of VAADA dated 4 November 2016, p80

91. UnitingCare ReGen and the FLS both identified the recent recommissioning of alcohol and drug services as a contributor to client access issues. The new model of service delivery requires users to access a central intake and assessment point rather than attending a local drug and alcohol treatment service. According to the FLS, this model "*directly disadvantages individuals who struggle with ... issues ... and are therefore less likely to contact a central intake point.*"[65] The UnitingCare ReGen submission explained:

> *The new intake model appears to be working well for many people, but has created new access barriers to people with complex needs, particularly those who are homeless and other vulnerable groups within the Inner North catchment.*[66]

92. The solution proposed by UnitingCare ReGen to this issue, was that the DHHS:

> *... urgently address the accessibility of recommissioned services for particularly vulnerable groups with complex needs and ensure system capacity for targeted harm reduction services for this group is returned. Such targeted harm reduction services would include the re-establishment of the outreach programs, such as those previously delivered by [NRCH]...*[67]

93. The need for increased outreach workers in the North Richmond area was a theme across multiple submissions from organisations involved directly in caring for injecting drug users in the community. Benefits included providing assistance to vulnerable injecting drug users to navigate relevant services, as well as providing safe injecting equipment, education, and building relationships of trust with users.

94. Outreach and access were also explored in the evidence of Ms Abbott. I was greatly assisted by Ms Abbott's overview of the DHHS involvement in and funding of a range of alcohol and other drug services delivered in the City of Yarra. These include outreach to injecting drug users, naloxone provision and overdose education, pharmacotherapy, NSPs, and other interventions universally supported as reducing the risk of drug-related harm and death. In reflecting upon these services, Ms Abbott also outlined in general terms what I understand were some future directions for the DHHS:

> *There's more that can be done in terms of creating pathways for injecting drug users into a wider range of support, treatment and response. There's more than can be done with peers and people with lived experience and that's certainly a focus for us at the moment...*[68]

95. Ms Abbott also stated, in response to the concerns expressed about access to services:

---

65 Exhibit 9 - Coronial brief, submissions of FLS dated 6 November 2017, p120

66 Exhibit 9 - Coronial brief, submissions of FLS dated 6 November 2017, p120

67 Exhibit 9 - Coronial brief, undated submissions of UnitingCare ReGen, p76

68 Transcript of evidence, p134

> *So there's been an independent review done of the recommission ... and that has a set of recommendations the government is acting on at the moment. One of the issues identified was that of how we best support people who may have very complex circumstances for whom waiting for the next available appointment just may be a missed opportunity, and that's something that's being considered further.*[69]

96. I was heartened by this indication that the DHHS is examining identified issues with service access and delivery, and actively seeking opportunities to refine services to meet the needs of drug addicted people. I have also made a recommendation to support this process.

FINDINGS

97. Having investigated the death of Ms A and having held an Inquest in relation to her death on 14 December 2016, at Melbourne, I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Ms A born 10 May 1982; and

    (b) that Ms A died on 30 May 2016, at St Vincent's Hospital, East Melbourne from 1a) GLOBAL CEREBRAL ISCHAEMIA SECONDARY TO MIXED DRUG TOXICITY INCLUDING A SUBSTANCE CONSISTENT WITH HEROIN;

    (c) in the circumstances described above.

98. Ms A had a long history of drug taking and addiction to heroin. Her dependence on drugs had brought her into contact with a range of organisations and services such as Victoria Police, DHHS, the criminal justice system and NRCH.

99. Weeks before her death she expressed a desire to improve her life and her family had committed to fund her for a naltrexone implant. According to NRCH outreach workers, Ms A genuinely wanted to make positive changes to her life and cease using heroin.

100. Unfortunately, her addiction and compulsion to use overwhelmed her and on 30 May 2016, after suffering an overdose in a public toilet at a fast food restaurant, she was taken to the Emergency Department of St Vincent's Hospital and later died.

101. I find that Ms A's death was due to the unintentional consequences of her use of illicit drugs and prescription medication.

102. I convey my sincerest sympathy to Ms A's family and friends.

---

69 Transcript of evidence, pp131-132

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

103. I attended North Richmond Community Health to see their service in operation. Staff took me on a guided walk around the North Richmond area on both sides of Victoria Street, where I witnessed injecting drug use and its aftermath. Personally, I found the experience to be very confronting, and I understand why shock and disengagement are instinctive reactions of many people in the community when they first encounter public injecting related activity. With the assistance of the North Richmond Community Health staff, as well as the other organisations and individuals who provided submissions and evidence, I developed an appreciation that a whole range of complex issues underpin what I witnessed.

104. My experience at North Richmond Community Health had a profound influence on my consideration of what could be done to prevent death and reduce heroin-related harms in the City of Yarra. There are people addicted to heroin in our community, who are compelled to illegally obtain and use the drug. Heroin is blatantly sold and used on the streets of North Richmond daily. The fact that 70,000 needles per month are distributed to drug users in the North Richmond area by North Richmond Community Health, reflects this uncomfortable truth.

105. This investigation has highlighted that heroin addiction is a public health issue. Heroin users face a daily battle against their compulsion to use and are at risk of death. They include some of the most marginalised and disadvantaged people in our society, who may suffer from physical and mental ill health, unemployment and homelessness, and come into contact with the criminal justice system as a result of their addiction. When we accept that addiction is a health issue, we are able to consider more clearly what can and must be done to support heroin users and reduce their risk of death.

106. Despite all best endeavours to date by police, health and community services to address drug use in North Richmond, the area consistently has the highest level of heroin overdose deaths in Victoria. Sadly, 20 people died in 2015 from a heroin overdose in the City of Yarra, with Ms A being one of those deceased.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

- I RECOMMEND THAT the Honourable Martin Foley MP as Minister for Mental Health take the necessary steps to establish a safe injecting facility trial in North Richmond.

- I RECOMMEND THAT Ms Kym Peake, Secretary, Department of Health and Human Services Victoria, take the necessary steps to expand the availability of naloxone to people who are in a position to intervene and reverse opioid drug overdoses in the City of Yarra.

- I RECOMMEND THAT Ms Kym Peake, Secretary, Department of Health and Human Services Victoria, review current DHHS-funded services that support the health and wellbeing of injecting drug users in the City of Yarra, and consult with relevant service providers and other stakeholders, to identify opportunities to improve injecting drug users' access to and engagement with these life-saving services.

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

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

(a) Senior next of kin.
(b) The Honourable Daniel Andrews MP, Premier of Victoria
(c) The Honourable Martin Foley MP, Minister for Mental Health
(d) The Honourable Martin Pakula, Attorney General
(e) Ms Kym Peake, Secretary, Department of Health and Human Services Victoria
(f) Interested parties
(g) Registrar of Births, Deaths and Marriages.

Signature:

JACQUI HAWKINS
CORONER
Date: 20 February 2017