Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref No: 3/ 19

I, Barry Paul King, Coroner, having investigated the death of ***Ellie Marlene Hare*** *with an inquest held at the* ***Perth Coroner's Court*** *on* ***31 January 2019****, find that the identity of the deceased person was* ***Ellie Marlene Hare*** *and that death occurred on* ***23 January 2015*** *at* ***13 Salen Court, Ardross,*** *from* ***complications of opioid toxicity*** *in the following circumstances:*

Counsel Appearing:

Sgt L Housiaux assisted the Coroner

Mr J Hammond (Hammond Legal) appeared for the deceased's mother,

Ms J Owens

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SUPPRESSION ORDER

That no report may be published of any part of the proceedings or of the evidence given at this inquest by Matthew Miles Drake.

INTRODUCTION

1. On the evening of 21 January 2015, Ellie Marlene Hare (the deceased) used methadone intravenously with her friend, Matthew Drake, at his mother's home, where he lived. He drove her home in the early hours of 22 January 2015, and that day she went to work.[1]

2. On the evening of 22 January 2015, the deceased again went to Mr Drake's home and again used methadone. After her second injection of methadone that evening, she went to sleep and was still asleep or comatose when Mr Drake awoke on the morning of 23 January 2015. Mr Drake was concerned that she had received too much methadone, so he placed her in the recovery position and placed part of a wafer of Suboxone under her tongue in an attempt to counteract the effect of the methadone.[2]

3. Mr Drake had to leave the house at about 10.40 am that morning, so he asked his mother's friend who was staying there, Demitrios Alifrangis, to check on the deceased from time to time. At about 11.30 am, Mr Alifrangis checked on the deceased and found that she was unresponsive. Ambulance officers attended, but she had no signs of life and she could not be revived.[3]

4. Toxicological analysis later revealed that the deceased had very high levels of methadone and buprenorphine in her blood. Naloxone was also detected.[4] A forensic

[1] Exhibit 1, Tab 9
[2] Exhibit 1, Tab 9
[3] Exhibit 1, Tab 2
[4] Exhibit 1, Tab 6B

pathologist concluded that the cause of death was complications of opioid toxicity.[5]

5. Mr Drake was charged with four counts under s6(1)(c) of the *Misuse of Drugs Act 1981* of supplying a prohibited drug, and on 15 May 2015 he was sentenced to a total of two years imprisonment with parole. The sentencing magistrate took into account the circumstances of the death, especially the information that Mr Drake had been aware that the deceased's condition was worsening on the morning of 23 January 2015 but did not contact emergency services.[6]

6. Information obtained for a pre-sentence report caused investigators to re-open the investigation into Mr Drake's possible culpability for the deceased's death, but they concluded that there was insufficient evidence to charge him and that a successful prosecution was highly unlikely.[7]

7. On 9 March 2016, the deceased's mother, Julie Owens, contacted the State Coroner's Office by email and requested that an inquest be held. Ms Owens had many unanswered questions about the circumstances of the deceased's death, and she was concerned that Mr Drake had not been charged with a homicide offence. On 4 April 2017 lawyers acting on behalf of Ms Owens and the deceased's siblings renewed the request for an inquest.

8. Further investigations were undertaken, and a report was obtained from Professor David Joyce, physician in clinical toxicology and pharmacology, in relation to the roles of methadone and buprenorphine in the death.

9. On 20 October 2017, the State Coroner approved the holding of an inquest. The inquest was placed on the call-over list for 6 July 2018, and an inquest was listed for 31 January 2019.

[5] Exhibit 1, Tab 6A
[6] Exhibit 1, Tab 18
[7] Exhibit 1, Tab2

10. On 31 January 2019 I held an inquest at the Perth Coroner's Court. The primary issues for inquiry were Mr Drake's involvement in the deceased's death and, interconnected with that issue, the role of buprenorphine in the cause of death.

11. The documentary evidence adduced at the inquest comprised a brief of evidence,[8] including a report completed on 16 October 2015 by Detective First Class Constable Tegan Mills of the Coronial Investigation Unit of the Western Australia Police[9] and Professor Joyce's report.[10]

12. Oral evidence was provided by (in order of appearance):

    a. Professor Joyce;[11]

    b. Mr Paul Dessauer, from Peer Based Harm Reduction WA;[12]

    c. Mr Peter Fraunschiel, the deceased's partner leading up to the few days before her death;[13]

    d. Ms Owens, the deceased's mother;[14]

    e. Ms Marion Drake, Mr Drake's mother;[15] and

    f. Mr Drake.[16]

13. As Mr Drake was un-represented, I was concerned that, in his unfamiliarity with the relevant law, he might unintentionally incriminate himself in relation to the deceased's death. At the same time, however, his evidence of the events leading up to the deceased's death was crucial to the investigation.

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[8] Exhibit 1
[9] Exhibit 1, Tab 2
[10] Exhibit 1, Tab 7
[11] ts 9 – 23 per Joyce, D
[12] ts 23 – 35 per Dessauer, P J
[13] ts 36 – 55 per Fraunschiel, P
[14] ts 57 – 66 per Owens, J
[15] ts 66 – 88 per Drake, M
[16] ts 88 – 124 per Drake, M

14. When Mr Drake was called to give evidence, I explained the operation of s47 of the *Coroners Act 1996* (the Act) and, after giving him an opportunity to consider his options, came to the view that it was expedient for the ends of justice to compel him to answer questions. I then offered him a certificate under s47(2) of the Act.[17] After he gave oral evidence, I was satisfied that he had answered the questions put to him, so I gave him a certificate in accordance with that provision.[18]

15. Before Mr Drake gave evidence, I made an order under s49 of the Act that no report or publication of his evidence be published. In hindsight, that order was probably misconceived because it could have prohibited me from canvassing his evidence in this report. As it turned out, I was satisfied that his oral evidence was consistent with information that he had previously given to police investigators, so I have been able to rely on that earlier evidence.

16. Following the inquest, I received notes and submissions from Ms Owens. The notes included the results of her research into provisions of the Criminal Code which may have been relevant to Mr Drake's acts or omissions with respect to the deceased's death. She also provided a list of possible points of interest that she said may not have been already noted. Those points called into question much of Mr Drake's evidence and suggested that he was aware that he should have done more for the deceased. Ms Owens also provided a list of suggestions that she believed should be implemented to reduce the number of deaths from drug overdose.

17. Mr Hammond also provided helpful submissions on behalf of Ms Owens. Those submissions included a recommendation that the matter be referred to the Office of the Director of Public Prosecutions, and arguments supporting Ms Owens' suggestions.

[17] ts 89-93
[18] ts 124

THE DECEASED

18. The deceased was born in Osborne Park on 9 September 1989, so she was 25 years old at the time of her death.[19]

19. The deceased had a reasonably normal childhood. She had two sisters and one brother, and she had a close relationship with them. She was also close to her mother and her step-mother.[20]

20. When the deceased was almost 18 years old, her father passed away suddenly, which affected her profoundly.[21]

21. Sometime in 2008, the deceased came home in a panic attack after being out with her then boyfriend. She appeared to be experiencing anxiety related to her father's death, to her relationship with an abusive boyfriend and to her stressful job.[22] Her GP in Mt Lawley noted that she had been treated for anxiety, panic attacks and depression.[23]

22. The deceased broke up with her boyfriend and sought counselling. In late 2008 or early 2009, she began to recover from the anxiety and depression after seeing a psychologist and being treated with cognitive behavioural therapy and escitalopram.[24] She met Ryan La Rue, an American man who was travelling in Australia, and began a relationship with him. He returned to Oregon, and she followed him there when she had saved enough money.[25]

23. In August 2009, the deceased and Mr La Rue travelled to Las Vegas, where they were married. She returned to Perth after about five weeks, and he joined her in December 2009 on a 12 month visa.[26]

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[19] Exhibit 1, Tab 1
[20] Exhibit 1, Tab 12; ts 65 per Owens, J A
[21] Exhibit 1, Tab 12
[22] Exhibit 1, Tab 12
[23] Exhibit 1, Tab 15
[24] Exhibit 1, Tab 14
[25] Exhibit 1, Tab 12; ts 37 per Fraunschiel, P
[26] Exhibit 1, Tab 12

24. The deceased's relationship with Mr La Rue deteriorated. He assaulted her on several occasions, and it seems that he was convicted of aggravated assault. The deceased separated from him in August 2010.[27]

PEDRO

25. In about May 2010, the deceased had met a man called Peter Fraunschiel, also known as Pedro, through a group of friends who were concerned about her abuse at the hands of Mr La Rue. When they met, Mr Fraunschiel thought that she was a strong person and a funny, friendly and affable character.[28]

26. One night in August 2010, the deceased appeared at Mr Fraunschiel's apartment door covered in bruises and blood after being assaulted by Mr La Rue. He told her that she could stay there, and she moved in. At some stage around then, Mr Fraunschiel started using oxycodone analgesics for chronic pain.[29]

27. According to Ms Owens, on 9 September 2010, the deceased's birthday, Mr Fraunschiel gave the deceased oxycodone for the first time.[30] It is clear that, from about that time, they both used drugs fairly consistently for the next 18 months to two years. They would generally use oxycodone or heroin, depending on whatever was easier to find at the time, but they would also use benzodiazepines such as diazepam and alprazolam.[31]

28. When the deceased and Mr Fraunschiel used drugs intravenously, he always administered her the drugs. He said in oral evidence that she was physically incapable of using a syringe on herself because her hands were so small. He stressed that it was physically impossible for her to do it.[32]

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[27] Exhibit 1, Tab 12
[28] ts 37 per Fraunschiel, P
[29] Exhibit 1, Tab 13
[30] Exhibit 1, Tab 12
[31] Exhibit 1, Tab 13; ts 37 per Fraunschiel, P
[32] ts 42-44, 49 per Fraunschiel, P

29. Mr Fraunschiel said that, when he dosed the deceased with drugs, she would occasionally demand more and could get quite agitated about it. If they were unable to obtain any, she 'would start throwing mugs around the house.'[33]

30. In late 2011 or early 2012, the deceased contacted Ms Owens to ask for help because she was withdrawing from oxycodone. Ms Owens took her to Sir Charles Gairdner Hospital, where she was admitted for three days. After being discharged, she moved back in with Ms Owens.[34]

31. By January 2012 the deceased was in contact with an alcohol and drug treatment service, Cyrenian House, to seek assistance in addressing her addiction to opiates, primarily heroin and oxycodone.[35]

32. Late in the evening of 25 March 2012, the deceased went to Mr Fraunschiel's apartment after a night out with her sister and brother-in-law. She told Mr Fraunschiel that she had only had two drinks when she had actually had several more. He dosed her with heroin and she collapsed immediately from an overdose. He called for an ambulance, induced vomiting and administered CPR until ambulance paramedics attended and revived her with naloxone.[36]

33. From 17 July 2012 to 10 January 2013 the deceased resided at the Rick Hammersley Therapeutic Community, a drug rehabilitation service provided by Cyrenian House.[37]

34. While she was in the Rick Hammersley Therapeutic Community, the deceased met Mr Drake, who was also undergoing rehabilitation. They were attracted to each other and became close friends.[38]

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[33] Exhibit 1, Tab 13; ts 53 per Fraunschiel, P
[34] Exhibit 1, Tab 12
[35] Exhibit 1, Tab 14
[36] ts 40-41 per Fraunschiel, P; Exhibit 1, Tab 26A
[37] Exhibit 1, Tab 14
[38] Exhibit 1, Tab 9

35. Following her stay at the Rick Hammersley Therapeutic Community, the deceased moved back to Ms Owens' home and eventually obtained a full-time job with the Perth Wildcats, a professional sports team.[39]

36. The evidence of the chronology of that period is somewhat vague, but it seems that Mr Fraunschiel also went through drug rehabilitation in late 2012 and commenced a Suboxone program.[40] He then lived at his parents' home in Claremont. When the deceased got out of the Rick Hammersley Therapeutic Community, she stayed with him on weekends and lived at Ms Owens' home during the week.[41] During that time, Mr Drake occasionally called or texted her to keep in touch.[42]

MR DRAKE

37. Mr Fraunschiel and the deceased continued in their relationship during 2014, and occasionally they would use drugs. Mr Fraunschiel believed that the deceased also used drugs a few times with other people after September 2014 while he was having medical problems.

38. Mr Fraunschiel felt that, in the months leading up to the deceased's death, she was unwell due to stress from work and domestic issues. She seemed to be sleeping a lot, and he noticed that she was becoming distant from him.[43]

39. Around 14 January 2015, Mr Drake called the deceased with information about Mr Fraunschiel, and she suggested that they catch up. On 20 January 2015, Mr Drake picked up the deceased from Ms Owen's house and drove her to the beach. They spent the day together without using any drugs, and at about 1.00 am on 21 January 2015, he dropped her back home.[44]

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[39] Exhibit 1, Tabs 12 and 14
[40] ts 39 per Fraunschiel, P
[41] Exhibit 1, Tab 13
[42] Exhibit 1, Tab 9
[43] Exhibit 1, Tab 13
[44] Exhibit 1, Tab 9

40. During the day on 21 January 2015, the deceased worked at Perth Arena till 10.00 pm. She exchanged text messages with Mr Fraunschiel in the morning and in the late afternoon. She told him that her sciatica was playing up and that she was looking forward to resting after work.[45]

41. At about 11.00 pm on 21 January 2015, Mr Drake picked up the deceased from Perth Arena and drove her to Ms Drake's house in Ardross. They went into Mr Drake's bedroom, where he crushed five 10 mg methadone tablets, mixed them in water, and placed the solution in a syringe. He then filtered that solution in cotton buds to remove the talc from it and placed the filtered solution into a fresh syringe. According to Mr Drake, the deceased then injected about 2-3 ml of the solution in her left arm and he used a butterfly needle to inject himself with the remaining 7 ml.[46]

42. The deceased and Mr Drake remained in the bedroom and later went for a swim in the back yard pool. After the swim, they returned to the bedroom. Mr Drake prepared another five methadone tablets and they each injected similar amounts to the first time. They did not sleep. At about 3.30 am on 22 January 2015, Mr Drake took the deceased home to Ms Owen's house.[47]

43. The deceased went to work a bit late that morning. At about 11.00 am, Mr Drake sent her a text message, thanking her for the previous night and discussing one of his friends. He included a message which he had sent to his friend, alluding to the fact that he was going into detox the next day.[48]

44. At 12.24 pm, the deceased responded to Mr Drake's email by congratulating him on going into detox and asking if he was going to have a 'go away part'. She sent another message at 3.54 pm correcting the previous message to

[45] Exhibit 1, Tab 17
[46] Exhibit 1, Tabs 8 and 9
[47] Exhibit 1, Tabs 8 and 9
[48] Exhibit 1, Tab 17

'are you having a going away party', and then, by mistake, sent him a message that she had intended to send to a girlfriend. She sent him another message one minute later, explaining her mistake and, when he did not respond, sent him messages at 4.58 pm and 5.18 pm asking, 'Everything alright', and 'Or ignore us…'[49]

45. Mr Drake responded to the last of the deceased's messages with a message apologising and explaining that he had been helping a disabled lady. He mentioned that he had an 11.00 admission to detox the next morning, and the deceased indicated that she would not mind saying bon voyage. They agreed that she would go to his place by taxi and would stay the night.[50]

EVENTS LEADING UP TO DEATH

46. Unless otherwise indicated in the footnotes, the following account is based on information provided voluntarily by Mr Drake to police investigators on the evening of 23 January 2015.[51]

47. The deceased arrived at Mr Drake's home in Ardross at about 10.00 pm on 22 January 2015.[52]

48. Mr Drake introduced the deceased to Ms Drake and to Mr Alifrangis. He and she then went into his bedroom and he prepared six methadone tablets in a solution which they injected. Again, according to Mr Drake, the deceased injected herself into her left arm.[53]

49. After that injection, the deceased became extremely itchy. She and Mr Drake went to the back yard pool in order to ease the itching, but the water was cold this time, so they only stayed there for ten minutes. They went back to the bedroom and, at about midnight, Mr Drake got ice packs

[49] Exhibit 1, Tab 17
[50] Exhibit 1, Tab 17
[51] Exhibit 1, Tabs 8 and 9
[52] Exhibit 1, Tab 25
[53] Exhibit 1, Tab 9

to soothe the places that the deceased had scratched raw.[54]

50. When the deceased and Mr Drake went back to the bedroom, the deceased asked if there was any more methadone. He mixed four more tablets in water, together with the cotton buds he had used to filter the methadone previously. They then each used half of the solution. At some stage before doing so, the deceased told Mr Drake that she would snore when she fell asleep.[55]

51. Within a short time after they had injected the second dose of methadone, the deceased passed out on the bed and started snoring. Mr Drake went to sleep beside her.[56]

52. At about 4.00 am on 23 January 2015, Mr Drake awoke and noticed that the deceased was still snoring. He became concerned about her because he could not rouse her. He thought that he had given her too much methadone, and he felt semi-responsible despite the fact that she wanted it and injected it herself. He injected himself with a solution made from another methadone tablet and then, at about 5.00 am, he placed her in the recovery position and went back to sleep.[57]

53. At about 8.45 am, Ms Drake knocked on Mr Drake's bedroom door and told Mr Drake to get ready for his admission to Perth Clinic for detox. She said that she was going to an appointment at 9.30 am and that she would pick him up after that.[58]

54. After being awoken by Ms Drake, Mr Drake was aware that it was likely that something was wrong with the deceased. She was still snoring and was unresponsive. He found part of a Suboxone wafer in his room and three filters that he had used in the past to prepare Suboxone injections. (Suboxone is the brand name of a medication

[54] Exhibit 1, Tab 9
[55] Exhibit 1, Tab 9
[56] Exhibit 1, Tab 9
[57] Exhibit 1, Tab 9
[58] Exhibit 1, Tab 10

containing the opioid buprenorphine and the receptor-blocker naloxone.)[59] Mr Drake placed the wafer and the filters under the deceased's tongue, hoping that the naloxone component of the Suboxone would act as an antagonist to the methadone and would wake her up. He had previously injected a person with Suboxone when the person had overdosed, and it was effective to bring the person around.[60]

55. After placing the Suboxone wafer and filters under the deceased's tongue, Mr Drake spoke to Mr Alifrangis. He told him that the deceased was unconscious and asked him to check on her regularly.[61]

56. Mr Drake did not call for an ambulance, though it crossed his mind. He decided not to call for one because he was concerned that Mr Fraunschiel and the deceased's mother would be upset to learn that she had been with him. He was also concerned that Ms Drake would learn that the deceased was a drug user, and he took into account that the deceased was breathing and that Mr Alifrangis was there to check on her. He told police investigators that all these things came into his head, but they should not have been important given that the deceased's life was in the balance.[62]

57. At about 10.15 am, Ms Drake returned home to pick up Mr Drake. They were in a hurry to leave for the Perth Clinic. He told her that he could not wake up the deceased and that he did not consider that he knew her well enough to wake her, in case it alarmed her. He told Ms Drake that he had kissed the deceased goodbye and that she was definitely breathing at the time.[63] Ms Drake's evidence accorded with the information that Mr Drake had given to police.[64]

[59] ts 19 per Joyce, D
[60] Exhibit 1, Tab 9
[61] Exhibit 1, Tab 9 and 11
[62] Exhibit 1, Tab 9
[63] Exhibit 1, Tab 10.
[64] Exhibit 1, Tab 9

58. Ms Drake dropped Mr Drake off at the Perth Clinic at 11.20 am. She then went to Sir Charles Gairdner Hospital, where she worked as a switchboard operator.[65]

59. At 11.24, Mr Drake left text messages on the deceased's phone, apologising for giving her too much methadone and asking her to call him as soon as she read the message.[66]

60. At around 12.10 pm, Mr Alifrangis checked on the deceased and found her unresponsive. Shortly after that, he heard the land-line phone ring and heard Mr Drake on the answering machine. He called Mr Drake and said that the deceased was completely unresponsive.[67]

61. At 12.21, Mr Alifrangis called Ms Drake and told her that she must come home because he could not wake the deceased and he did not want to touch her. He asked Ms Drake to call for an ambulance. She transferred him to St John Ambulance and the call-taker instructed him to administer CPR.[68]

62. At 12.35 pm, ambulance paramedics arrived at Ms Drake's house and took over the CPR from Mr Alifrangis. The deceased was not breathing and had no palpable pulse. The ECG showed that she was in asystole. The paramedics administered advanced life support, but they were unable to revive the deceased. At 1.00 pm a paramedic certified that the deceased's life was extinct.[69]

CAUSE OF DEATH

63. On 30 January 2015, forensic pathologist Dr D M Moss performed a post mortem examination of the deceased and found needle puncture marks to the arms with underlying haemorrhage and congested lungs. There was

[65] ts 78 per Drake, M
[66] Exhibit 1, Tab 17
[67] Exhibit 1, Tabs 2 and 11
[68] Exhibit 1, Tab 11
[69] Exhibit 1, Tab 16

no evidence of injury or natural disease. Microscopic investigation showed patchy severe bronchopneumonia.[70] Microbiology showed hepatitis C antibody.[71]

64. Toxicological analysis showed a blood methadone level of 0.26 mg/L and a liver methadone level of 2.2 mg/L. The liver methadone level was within reported fatal levels. Buprenorphine was within the fatal range. Naloxone was detected at less than 1 ug/L.[72]

65. Dr Moss felt that death was due to complications, predominantly bronchopneumonia, which had developed following the toxic effects of two opioid medications. His formal opinion, which I adopt as my finding as to cause of death, was that the cause of death was 'complications of opioid toxicity'.[73]

66. In his report dated 27 July 2017, Professor Joyce described the circumstances leading up to the deceased's death and the results of the toxicological analysis. He noted that the evidence of witnesses implied that the deceased had not resumed regular opioid drug use before her encounters with Mr Drake, so she would not have had a regular user's tolerance to opioid drugs at the time of the doses on 21 to 23 January 2015. The deceased's blood concentration of methadone was in the range that can be lethal for a person who was effectively opioid naïve, as the deceased was. The deceased's liver concentration of methadone was also in the range associated with lethality for persons who were not highly tolerant.[74]

67. Professor Joyce also noted that methadone is a potent opioid drug which is cleared relatively slowly from the body. Around half of the body load is removed each 15 to 55 hours. He considered that the relative contributions of the doses on 21 January 2015 cannot be accurately estimated, but they were insufficient to cause her to sleep

[70] Exhibit 1, Tab 5A
[71] Exhibit 1, Tab 6
[72] Exhibit 1, Tab 5B
[73] Exhibit 1, Tab 5A
[74] Exhibit 1, Tab 7

that night, so were presumably less important contributors to her final body drug load.[75] He said in oral evidence that he would anticipate that around half of the doses on 21 January 2015 would have still been there at the beginning of the night on 22 January 2015.[76]

68. As to the buprenorphine quantified in the toxicological analysis, Professor Joyce considered that it was within the range that has been associated with lethal poisoning. He said that buprenorphine takes even longer to clear from the body than methadone.[77] The naloxone had largely been eliminated between the time when Mr Drake administered the deceased the Suboxone and when she died.[78]

69. Professor Joyce said that he was unsure whether the deceased would have died had she had not had the last injection and had not received the Suboxone. He was likewise unsure whether she would have died had she not had the last injection but had received the Suboxone.[79]

70. Professor Joyce concluded that the clinical course, the toxicology and the post mortem findings were typical for delayed death from opioid intoxication, and both the methadone and the buprenorphine contributed to the death.[80]

HOW DEATH OCCURRED

71. The issue of how the deceased's death occurred relates primarily to the circumstances of her using methadone on the night of 22 January 2015, when she would still have had in her body about half of the methadone she used on the night of 21 January 2015. Professor Joyce provided the following account of the deceased's pathway to death.

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[75] Exhibit 1, Tab 7
[76] ts 15 per Joyce, D
[77] ts 15 per Joyce, D
[78] Exhibit 1, Tab 7
[79] ts 15-16 per Joyce, D
[80] Exhibit 1, Tab 7

72. At 4.00 am and 5.00 am on 23 January 2015, the deceased was clearly overdosed and was in threat of her life but, had an ambulance attended at those times, she would very likely have recovered. By 8.30 am, she was already in threat of her life and the bronchopneumonia would have been in train. She may have simply metabolised the methadone or recovered with hospital care, but a proportion of people who pass through that situation do not recover. The exposure to buprenorphine at that stage may have accelerated or made inevitable the death, or was a neutral contributor, or possibly was a futile means of attempting to reverse things.[81]

73. Professor Joyce said that the post mortem examination, the toxicological assessment and the history together add up unambiguously to an opioid-caused death. The most likely attribution is that both the methadone and the buprenorphine shared responsibility for it, with the buprenorphine perhaps only bringing forward an already inevitable death. Less likely is that that buprenorphine had a neutral or even some protective effect.[82]

74. One issue for consideration was whether the deceased injected herself as stated by Mr Drake, or she was injected by Mr Drake, as implied by Mr Fraunschiel and suspected by Ms Owens. The importance of that issue was, as I understand it, that if Mr Drake had injected the deceased, it is arguable that he was criminally liable for causing her death.

75. It is important to note that s25(5) of the *Coroners Act 1996* prohibits a coroner from framing a finding or a comment in such a way as to suggest that any person is guilty of an offence. This does not mean that I am restricted from inquiring into and finding the circumstances surrounding the deceased's death;[83] however, in my view, a finding that a person's act or omission caused a person's death when that act or

[81] ts 13- 14 per Joyce, D
[82] ts 13- 14 per Joyce, D
[83] *Re The State Coroner; ex parte Loohuys* [2019] WASC 147 [34]-[36]; *Perre v Chivell* [2000] SASC 279

omission could constitute a serious criminal offence would require evidence establishing that finding at a standard of proof approaching 'beyond reasonable doubt' in accordance with the well-known 'Briginshaw' principle.[84]

76. The evidence establishing that Mr Drake supplied the methadone and the buprenorphine to the deceased is clear. However, he denied having injected her with the methadone on any of the four occasions and said that, on the last occasion they used it, she took it out of his hand and injected it herself. The notion that she would take it from Mr Drake's hand is consistent with Mr Fraunschiel's evidence that she could be greedy and demanding for more drugs.[85]

77. Mr Drake's evidence that the deceased injected herself on each of the occasions is inconsistent with Mr Fraunschiel's evidence that she was unable to inject herself and Ms Owens' submissions to the same effect.

78. Objective evidence which supports the notion that the deceased did not inject herself is found in the St John Ambulance patient care record for the ambulance paramedics' attendance on 23 January 2015, together with Dr Moss' post mortem report of 30 January 2015.

79. The patient care record indicates that the paramedics unsuccessfully attempted to insert an intravenous cannula in each of the deceased's elbow creases.[86] Professor Joyce confirmed that each of those attempts would have left a puncture mark from a relatively large needle.[87]

80. In his post mortem report, Dr Moss records that he found multiple needle puncture marks to the right elbow crease with a small amount of associated bruising, and a single needle puncture mark to the left elbow crease.

[84] *Anderson v Blashki* [1993] 2 VR 89; *Briginshaw v Briginshaw* [1938] HCA 34; (1938) 60 CLR 366 at 362 to 363 per Dixon J
[85] ts 53 per Fraunschiel, P
[86] Exhibit 1, Tab 16
[87] ts 21 per Joyce, D

The needle puncture marks on the right arm were covered with a cotton wool and tape dressing. There was haemorrhaging around the median cubital veins on both sides, with more marked haemorrhage on the right.[88]

81. Those findings by Dr Moss appear to be inconsistent with Mr Drake's statements to police that the deceased injected herself to the left arm on each of four occasions. Professor Joyce agreed that the single needle puncture mark on the left arm may have been the paramedics' attempt to cannulate that arm.[89]

82. It may be possible that the puncture mark left by the paramedics on the left elbow crease covered puncture marks that the deceased had made on, effectively, one site on the left arm. But, even if that were the case, the fact that there were several puncture marks to the right arm remains inconsistent with the deceased having injected only her left arm.

83. I note, however, the evidence from Mr Fraunschiel that the deceased may have used drugs with other people after November 2014 and before she spent time with Mr Drake.[90] It may be unlikely that she had injected herself then and caused puncture marks on her right arm, but I could not find that it was impossible that she had done so unless I accept Mr Fraunschiel's uncorroborated evidence.

84. On balance, the evidence establishes a likelihood that Mr Drake injected the deceased on each occasion on the nights of 21 January 2015 and 22 January 2015, but I am not able to find, at a standard of proof approaching 'beyond a reasonable doubt', that he had done so.

85. In any event, it seems to me that the issue of whether the deceased injected herself or whether Mr Drake injected her is, on one view, an artificial distinction. Even if the deceased had injected herself, it is clear that, when

[88] Exhibit 1, Tab 5A
[89] ts 22 per Joyce, D
[90] Exhibit 1, Tab 13; ts 43 – 44 and 52 per Fraunschiel, P

Mr Drake gave her the quantities of methadone, he knew she would inject them and he knew that she expected that he would provide appropriate doses.

86. At the same time, there seems no doubt that the deceased desired to use the methadone and that, if Mr Drake injected her, he did so at her behest. She sought and possibly demanded methadone from him, either without apparent concern about the doses or, as I infer from Mr Fraunschiel's evidence that he always dosed the deceased, because she also assumed that Mr Drake could likewise be trusted not to give her too much. It is also possible that such an assumption was supported by her benign experience of the night of 21 January 2015 and by the fact that she had not used methadone before.

87. The evidence establishes that the fundamental connection between the injections of methadone, the ingestion of buprenorphine, and the deceased's death lay in the quantities used within a short time frame and the deceased's relative opioid naivety. Mr Drake gave her substantially less methadone than he used himself, but he did not know of the extent of her tolerance and did not ask her.

88. In hindsight, it can be seen that Mr Drake's failure to call for an ambulance when he awoke and was unable to wake the deceased was a missed opportunity to save her life. As he admitted to police officers, his jumbled reasoning for that failure had no place in the context of the risk of her dying.

89. Mr Drake told police that he had attended a Save-a-Mate course while at the Rick Hammersley Therapeutic Community, but he said that he had only witnessed one case of a person overdosing previously.[91] Ms Drake said that she had called for ambulances for Mr Drake on probably four occasions when she could not rouse him due to his use of drugs.[92] That evidence indicates that Mr Drake was aware of the benefits of calling an

[91] Exhibit 1, Tab 9
[92] ts 81 per Drake, M

ambulance in the case of an overdose, but the timing of those occasions was somewhat vague, so some of them could have occurred after the deceased's death.

90. Mr Dessauer told the inquest of his understanding that in 50 to 60 percent of fatal overdoses there is someone else present, but they do not recognise that the overdosed person is experiencing an emergency. They think that the person is very stoned and they leave them to sleep it off. This, he said, occurs because people who are used to being around other people using opioids are used to seeing people in respiratory difficulty since the vast majority of overdoses are non-fatal.[93]

91. Mr Dessauer told the inquest about the peer education program run by Peer Based Harm Reduction WA, called Overdose Prevention and Management, in which people are taught to recognise the signs and symptoms of overdose, such as snoring and gurgling breathing, and to call '000' if the overdosed person cannot be awoken.[94] The fact that such a program even exists says much about the ignorance of a significant proportion of drug users about the signs of overdose.

92. Mr Dessauer's evidence suggests that, though Mr Drake's failure to call an ambulance was inexcusable, it was not unusual among other drug users in similar circumstances.

93. As to Mr Drake's misguided use of Suboxone as an antidote for methadone overdose, I am satisfied that he mistakenly believed that he was acting in her best interests at the time. There is evidence that the practice was perceived by some drug users to be effective.[95] I note, too, Professor Joyce's evidence that it was possible though unlikely that the buprenorphine 'had some neutral or even protective effect'.[96]

[93] ts 24-25 per Dessauer, P J
[94] ts 24 per Dessauer, P J
[95] ts 26 per Dessauer, P J
[96] ts 14 per Joyce, D

94. In the foregoing circumstances, I find that death occurred by way of accident.

MS OWENS' SUBMISSIONS

95. In addition to comments on the provisions of the Criminal Code and on the potentially relevant evidence, Ms Owens also made several suggestions that her research led her to believe could reduce the number of deaths from drug overdose. I assume that she presented those comments to me in order to encourage me to make recommendations in accordance with them.

96. It is important to note that a coroner's power to make comments or recommendations in relation to matters of public health is limited by the requirement that the matters are connected to the death in question.[97] In my view, that requirement relates to a causal connection between the matter in issue and the death.

97. Ms Owens' first suggestion is that WA should have medically-supervised injecting centres as have been provided in Victoria. The benefits she identifies appear irrefutable, but it is difficult to assume that the deceased and Mr Drake would have used such a centre. In those circumstances, there is no causal connection to the death.

98. Ms Owens' second suggestion was for state-funded emergency ambulances or assisted ambulance cover for private health insurance to remove the fear of the high cost of calling for an ambulance in the case of an overdose. She reports that Tasmania and Queensland both have free ambulance services. This also appears to be a useful suggestion, but it was not raised during the inquest and no evidence was adduced in relation to any relevant considerations. I do not consider that I am in a position to recommend that the WA government fund ambulances. I also note that the cost of an ambulance

[97] s25(2) *Coroners Act 1996*

did not appear to play a part in Mr Drake's failure to call for an ambulance, so again a causal connection is lacking.

99. Ms Owens third suggestion was evidence-based drug policies rather than what she calls 'legal enforcement of drug abstinence'. She points to Switzerland and Portugal as having models that have been far more successful in reducing the harm and the prevalence of drug use.

100. My brief research has revealed the following from an article on the Australian Bureau of Statistics (ABS) website:

> Drug use and drug mortality is an issue which affects the whole of the Australian community. The approach to addressing drug use is multi-dimensional, and includes the scheduling of pharmaceuticals, law enforcement practices, support and intervention services and positive public health messaging.
>
> Australia has implemented the seventh iteration of the National Drug Strategy, with the framework in place from 2017-2026. The strategy aims to minimise the harms associated with alcohol, tobacco and other drugs through demand reduction (delaying or preventing uptake of drug use), supply reduction (e.g. preventing supply of illegal drugs) and harm reduction (e.g. reducing adverse health consequences for drug users). The strategy cites the importance of collaboration and partnerships both nationally and by jurisdiction to address drug harm in Australia.[98]

101. The Commonwealth Department of Health describes the National Drug Strategy 2017-2026 as Australia's first long-term framework for reducing and preventing the harms associated with alcohol and other drugs through the agreement of a ten-year National Drug Strategy. The framework is said to be built on the four principles of partnership, coordination and collaboration, national

[98] https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2016~Main%20Features~Drug%20Induced%20Deaths%20in%20Australia~6

direction and jurisdictional implementation, and *evidence-informed responses*.[99]

102. The Strategy identifies 'enhancing access to *evidence-informed* effective and affordable treatment' as a priority action in the pillar of demand reduction.[100]

103. On the basis of the foregoing information, it seems that steps are currently being taken to incorporate evidence-based policies in addressing drug use.

104. Ms Owens' fourth suggestion is for greater funding for take-home naloxone and for further public education programs to see that it gets into the hands of those who need it most. This suggestion also appears sensible but, apart from Mr Dessauer's evidence, was not the subject of evidence at the inquest, so I am not in a position to make a recommendation as to what might be done. However, once again, it appears on its face to be a sensible suggestion which warrants consideration by the Health Department if it has not done so already.

105. Ms Owens' fifth suggestion is that relevant agencies and the general public should be educated to reduce the demonization of drug users and the resulting stigma. I note that Ms Drake agreed with Ms Owens' evidence about the unfairly negative public perception of drug users.[101]

106. This suggestion appears to me to relate to a complex area. For example, the Coroner's Court and the criminal justice system in general see a great deal of serious criminality and anti-social behaviour associated with drug abuse, so there appear to be justifiable reasons why some members of the public may fear and demonise drug users. I do not consider that the evidence at the inquest provides me with any basis to comment further.

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[99] https://campaigns.health.gov.au/drughelp/resources/publications/report/national-drug-strategy-2017-2026

[100] https://beta.health.gov.au/resources/publications/national-drug-strategy-2017-2026

[101] ts 76 per Drake, M; ts 64 per Owens, J A

107. Ms Owens' last suggestion was for law reform by way of: an extension of Good Samaritan laws to protect those who call for assistance in the case of an overdose, a review of duty-of-care laws, and the creation of a duty-to-rescue law.

108. In relation to Good Samaritan laws, Mr Dessauer said that he was unaware of anyone ever being successfully prosecuted in Australia for responding as a first aider to an emergency in the community or for calling for an ambulance in relation to an overdose. He also noted that police do not routinely attend overdoses.[102] He was, in effect, suggesting that such a law was not necessary.

109. In relation to the creation of a duty-to-rescue law, Mr Dessauer said that he would not like to see a law that created a criminal offence for failing to call for an ambulance because he could see all sorts of unintended negative consequences. He said that he was concerned about legislative responses that are not carefully thought-out and evidence-based, and he noted that things that feel intuitively like they would work well actually make things more complicated.[103]

110. I accept Mr Dessauer's warning, and I make no further comment in relation to Ms Owens' last suggestion.

111. Mr Hammond submitted that the matter be referred to the DPP for reconsideration of whether an indictable offence has been committed or whether a manslaughter charge should be brought. Section 27(5) of the *Coroners Act 1996* empowers a coroner to report to the DPP if the coroner believes that an indictable offence has been committed in connection with a death which the coroner investigated.

112. As I have not reached a positive belief that an indictable offence was committed, I do not intend to report to the DPP. To be clear, I have not reached a positive belief that an indictable offence was not committed, either. I simply

[102] ts 30 – 31 per Dessauer, P J
[103] ts 31 per Dessauer, P J

do not know. However, it does not appear to me that the inquest revealed pertinent information that was unavailable to investigators when they made an informed decision not to proffer a charge following the original investigation.

113. Mr Hammond also provided further arguments in support of Ms Owens' suggestions mentioned above. To a large extent, I have already addressed those. However, Mr Hammond extended Ms Owen's suggestion in relation to the need to reduce the stigma and demonization of drug users by pointing out that a drug addict is also someone's family member or loved one.

114. In that regard, Ms Owens provided touching evidence about the profound, on-going effects of the deceased's death on her family. She gave the example of the deceased's seven year old niece who adored her Auntie Ellie and who, following the death, would be found in the foetal position in her bed in the morning, unable to get up.[104] Ms Drake also spoke of how drugs addicts have a sadness about them.[105]

115. Lastly, Mr Hammond stated that the deceased's family strongly believed that Mr Drake should be held accountable for failing to contact emergency services when it would have saved the deceased's life and that his being held accountable would send a message that his failure was unacceptable. He submitted that, if the law does not deem this behaviour as unacceptable, then the law should be reformed. I have dealt with those submissions already.

116. I should also point out that, while it is clear as I have noted, that in unreasonably failing to call an ambulance, Mr Drake missed an opportunity to save the deceased's life, the evidence did not suggest that his failure was malicious or callous.

[104] ts 66 per Owens, J A
[105] ts 99 per Drake, M

117. Moreover, I note that the learned sentencing magistrate took that failure into account in arriving at what was a substantial penalty for offences which, I understand, would not normally attract a prison sentence.[106]

118. While I readily accept that there is much to do with respect to addictive drugs in our community, I do not consider that the evidence adduced at the inquest allows me to comment or to make recommendations confidently about any further steps that should be taken.

CONCLUSION

119. The inquest into the deceased's tragic and avoidable death provided the court with an insight into the lives of people involved in the Perth drug scene and the effect of their addictions on their respective families.

120. A striking characteristic of the evidence is that people in that scene spend much of their lives either feeding or trying to beat their addictions. The evidence in relation to the deceased and Mr Drake was that, even after having experienced life-threatening overdoses, and having had the benefit of comprehensive rehabilitation programs with the love and support of their respective family members, they were unable to stop risking their lives by taking drugs.

121. Addictive drugs are, by definition, difficult to quit, but the tenacious nature of addiction is sometimes difficult for people outside the drug scene to comprehend fully. Ms Drake said, 'Unless you've dealt with a druggie and know them to be a genuine person, well it's very difficult to relate to it. You say, 'Just get off it', and it's not so easy to just get off it. And they – obviously they would want to, but just can't …'[107]

122. That harmful drug use continues to be a serious public health issue in Australia is well-known, as is the fact that

[106] Exhibit 1, Tab 18
[107] ts 76 per Drake, M

the most common class of drugs in relation to drug-induced deaths is opioids.

123. It may not be so widely known that, according to the ABS, the region with the highest rate of drug-induced deaths in 2016 was WA.[108] That should be a sobering thought for opioid users and those attempting to protect them.

B P King
Deputy State Coroner
12 June 2019

[108] https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2016~Main%20Features~Drug%20Induced%20Deaths%20in%20Australia~6