CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of LA
Hearing dates:	15 August 2023
Date of findings:	15 August 2023
Place of findings:	Lidcombe
Findings of:	Magistrate Kennedy Deputy State Coroner
Catchwords:	CORONIAL LAW – child death, methadone toxicity, referral to unsolved homicide, lethal levels of methadone
File number:	2017/00022779
Representation:	Sgt Karissa Mackay, Advocate Assisting the Coroner

Findings:	***The identity of the deceased*** *The deceased person was LA* ***Date of death*** *22 January 2017* ***Place of death*** *Westmead children's Hospital, Westmead, New South Wales* ***Cause of death*** *Encephalopathy due to methadone toxicity* ***Manner of death*** *Unnatural death through misadventure*
Recommendations	Nil
Non-Publication Orders	Non-publication orders prohibiting publication of certain evidence pursuant to the *Coroners Act 2009* have been made in this Inquest. A copy of these orders, and corresponding orders pursuant to section 65 of the Act, can be found on the Registry file.

Table of Contents

Introduction:

1. This is the subsequent coronial inquest into the death of LA, a five year old girl who died as a result of methadone toxicity. A coronial inquest was held before Her Honour Truscott between the 11 and 14 November 2019, here at the NSW State Coroners Court. This inquest heard evidence from several witnesses including the police officer in charge, Detective Linda Bernadi and Forensic pharmacologist and toxicologist Professor Olaf Drummer. It was following this evidence that Her Honour Truscott made findings pursuant to S81 subsection 1 of the NSW Coroners Act that the person who died was LA, she died on the 22 January 2017 at Westmead Children's hospital, Westmead NSW. Her Honour Truscott did not enter findings in relation to LA's manner or cause of death, and suspended the inquest pursuant to S78 of the Act.

2. The transcript of the evidence heard between the 11 and 14 November 2019, along with the exhibits and brief of evidence were sent to the Director of the Office of Public Prosecutions for the consideration of whether indictable charges should be laid against a known person for causing LA's death.

3. On the 28 October 2022, the Director determined that having carefully considered the available evidence there was insufficient evidence to warrant the criminal prosecution of any person in relation to the death of LA.

4. Pursuant to S79(6) of the Coroners Act, the inquest is being resumed the inquest as outlined in S79(1) of the Coroners Act.

5. The coroner's primary function is set out in s. 81 of the *Coroners Act 2009*. It is to make findings as to the identity of the person who has died, the date and place of their death and the manner and cause of death. The inquest is not adversarial, but inquisitorial. The focus is to determine what happened without attributing blame, guilt or making findings of liability.

6. Her Honour Truscott has made findings pursuant to s81.1 of the Act regarding, who died, where she died and when she died. Therefore, the purpose of the continuation of this inquest is to satisfy the manner and cause of LA's death.

7. The notice of determination provided by the NSW Director of public prosecutions, and transcripts for the inquest into LA dated 11, 12, 13 and 14 November 2019 with all relevant exhibits formed part of the brief of evidence in this inquest.

Reflection on LA's life

8. It is important to reflect on who LA was. In an incredibly moving family statement her mother described that she was named after her grandmother, out of respect for her.

9. LA was the third of four children to her parents KF and NA. The family resided together with LA's siblings, J, S and C in Western Sydney. LA had completed kindergarten at Mount Druitt primary school in 2016.

10. She was remembered fondly as such a happy baby, she loved all the Elmo toys, her whole bedroom was filled with Elmo and Sesame Street toys. She loved dogs, cats and all animals.

11. She learned to walk very young, and quickly developed an independent personality. She liked to make decisions for herself, such as what television she would want to watch. She loved to wear her favourite gumboots which she never wanted to take off. She loved the water, particularly bath time, and her parents had purchased a blow up water slide and would take her fishing, boating and swimming. She was excited to get tall enough to go on all the slides at Wet n Wild.

12. She loved football, and wanted to be just like her big brother, and was eager to play in the under sixes. She was so multitalented and had such a wide range of interests, arts and crafts excited her with her creative imagination. She loved her family and would tell funny stories. Her favourite movie was Frozen. She loved being Koori and learning about dream time.

13. She loved her parents and her siblings. She brought them joy, happiness and friendship. It was clear that her family was so close and loving, and that she was an integral part of their lives. Her mother recounted beautiful memories about her, and this is just a small reflection to attempt to capture the essence of LA. She was a very special little girl.

Events leading up to her death

14. During the Christmas/New Year break, the family took a holiday together on the far north coast of NSW. Between the 12 and 15 January 2017, LA and her brother had suffered what is believed to be a minor virus which was treated with paracetamol. LA appeared to have recovered, however had some unknown spots on her bottom lip.

15. Late afternoon on the Monday 16 January 2017, LA's mother dropped LA and her brother to spend the night at her father's house, LA's grandfather.

16. The grandfather was a participant in the methadone program since 1997. He was a part of what is referred to as the takeaway program, in which he would collect his methadone doses from a dispensing pharmacy and return home where he would self-administer his doses. At the time of LA's death, he was prescribed daily doses of 24ml or 120mg. On this date he had taken his Monday dose at the pharmacy, while taking his Tuesday and Wednesday dose to his home for consumption.

17. The account by her grandfather was that when he returned home he took his shopping inside and began his routine of dividing one dose of his methadone into two halves. He gave the account that he drew the methadone from the bottle using a plastic 6 ml syringe and put the contents of the syringe into another empty bottle of methadone. He would then have one full bottle of 24 mL of methadone and two half doses. He indicated that he kept the bottles, including empty bottles in the top cupboard above the fridge in the kitchen, which is out of the reach of the children.

18. While he was doing this his account was that the children remained outside, but were banging on the door to let them in. He put all of the methadone in the cupboard space above the fridge.

19. Based on the grandfather's version of events, at around 7:30pm, he gave the children dinner of lamb and fried rice. About 9:30pm LA's brother was asleep on the lounge, however LA was awake watching the Disney channel on television.

20. Around 1am, when he walked from his bedroom through the loungeroom to the kitchen area, the TV was still on ,and the children were asleep head to toe on the lounge. He woke about 5am to use to toilet, however did not observe the children.

21. He did not take his methadone until 9.30 am the next morning, at which time on the grandfather's account, LA was asleep and did not wake again. He said that he took a bottle of methadone containing the 24 mL (or 120 milligrams) and consumed it all. He then later stated that he consumed some "extra" at that time.

22. About 9:30am both children appeared still asleep on the lounge. LA was laying on her back. He went to the kitchen, administered his medications including

24ml of methadone and went back to his bedroom to sleep. Hi grandson asked him for a glass of water at some point, which he got for him and went back to sleep, waking about 11:45am, LA's brother was awake, LA was not.

23. Shortly before 1.58pm LA was still asleep, the grandfather asked his grandson to wake LA up, but he could not. He walked over and noticed LA was breathing in manner he described as 'funny' and so he contacted 000.

24. Emergency services attended and LA was rushed to Westmead Hospital where preliminary tests indicated an amount of methadone was present in her urine. LA was placed in an induced coma and transferred to the paediatric intensive care unit. Her condition did not improve and on Sunday 22 January 2017, and at 7.17pm LA was pronounced deceased.

Autopsy findings

25. On Wednesday 25th January 2017 a limited postmortem examination was ordered by the coroner. The procedure was conducted by Pathologist Dr Du-Toit-Prinsloo at Glebe Morgue. Ante-mortem bloods taken from LA on the day she was admitted to Westmead Children's Hospital (the 17 January 2017) were analysed. A toxicology report indicated a blood Methadone level of 0.23mg/L. as well as the presence of Ketamine, Fentanyl, Midazolam and Naloxone.

26. Dr Du Toit Prinsloo concluded that LA's cause of death was Hypoxic-ischaemic Encephalopathy due to methadone toxicity.

The Expert Opinions:

27. Professor Olaf H Drummer AO noted the early antemortem specimen disclosing a concentration of .23 mg/L was not likely to change over few hours given its long half life. While he notes there is no specific concentration that can cause death, it remains a very toxic drug if the does for an opioid naïve person is too high. He further states that any among beyond a few milligrams will pose a significant health risk to an opioid-naïve child, as in this case. The blood concentrations was sufficient in this case to cause her death.

28. He could not determine the dose that she took as a result of the fact that there was likely to remain unabsorbed drug in her gastro-intestinal system. Methadone will retard the motility of the gastrointestinal system, and a coma does likewise. There is also huge variability in how much is absorbed orally

and when, he determines that other than opining that at least a few milligrams had been taken it was not possible to estimate a more accurate dose.

29. He could not advise on when the methadone was taken, although he suggests that the factual circumstances would suggest it was quite early and prior to her going to sleep on the couch with her brother, although conceivable that she woke after her grandfather went to bed and took the methadone later.

30. Importantly he opines that once a few milligrams were absorbed she is likely to have gone to sleep, since it is a narcotic. He notes that she appears to have been in a coma for some period prior to being discovered by her grandfather and already had sufficient brain injury from her hypoxia not to recover.

31. He noted that the ambulance did give her one dose of naloxone with little effect, but noted that if she was already suffering from hypoxia naloxone would have little effect. To have survived the ingestion she would have needed to have been revived much earlier prior to the development of the hypoxic brain damage.

32. He is of the opinion that the hypoxia would have been likely within a few hours of ingestions of the methadone.

33. He also noted that if the carer had consumed more methadone, such as an additional 12 mL or even 5.2 mL this would have likely made him drowsy and fall asleep, given this is a significant additional dose, particularly if he had not been a user of this dose on a regular basis.

34. Dr Paisley however noted that this amount of extra methadone would have had little effect on LA's grandfather, given he was such a regular user.

35. Mr Farrer gave evidence that aligned with Professor Drummer. He indicated that methadone is a synthetic drug, prescribed to assist with withdrawal or maintenance of withdrawal from opiate drugs such as heroin. The other is as an analgesic, which provides strong pain relief. It is classified as an opiate drug, and similar to opioid drugs cause sedation to an extent, they also cause respiratory depression, that is reduced breathing and have other side effects such as reduced blood pressure. They can also cause pinpointed pupils, dose dependant.

36. He agreed that at a blood level of .23m/L would fall within the fatal range.

Overview of the grandfather's methadone use

37. According to the evidence the grandfather began the opioid treatment program in 1993 at the age of 26 due to poly drug dependency. His most recent prescriber was Dr Keith Paisley. He prescribed the grandfather with a daily dose of Methadone of 24 mL (or 120 milligrams) in a liquid syrup. He was considered to be a stable participant on the program and was authorised to have two does at a time of methadone as take away doses. The grandfather also suffered from other ailments including type 1 diabetes, emphysema and cirrhosis.

38. On Wednesday 4 January 2017 Mr Paisley prescribed the grandfather 120 milligrams or 24 mL per day until Wednesday 18 January 2017. Dr Paisley specified the days during the two week period where he could have take away doses. Each prescription indicated which doses could be consumed at the pharmacy and what dates could be taken away for consumption at home.

39. In order to facilitate the take away process, the Grandfather would attend the pharmacy and on a day when the consumption was at the pharmacy, in front of the pharmacist and then would be given takeaway doses.

40. At the relevant time the methadone was prescribed as follows: Thursday 5 January 2017, he consumed at the pharmacy, Friday 6 January he also consumed at the pharmacy, and was given Saturday and Sunday as take away. On Monday he consumed at the pharmacy, with takeaway for Tuesday and Wednesday, on Thursday 12 January he consumed at the pharmacy and was given takeaway dose for Friday 13, 14 and 15. He returned on 16 January . He was given doses for Tuesday and Wednesday and was given two bottles of 120 milligrams each.

How was the methadone ingested by LA

41. The evidence is silent as to how LA ingested methadone. What the evidence shows is that the grandfather had received two 24ml doses on the 16 January. When police attended and lawfully searched his house on 17 January, they located multiple empty methadone bottles and only one methadone bottle containing 6.8ml (34mg/L) of methadone in the kitchen cupboard. Presuming that bottle was one of the 12 ml "little bit extra bottles" it is "missing" 5.2 ml. The other "missing" 12 ml bottle is unaccounted for. The grandfather told police that when he took his 24 ml dose at 9.30 am that morning he had taken a "little extra". Whether that was the full 12 ml or the other 5.2 ml is unknown.

42. LA's fingerprints were not located on any of the bottles but her DNA was located on the mouth of a syringe barrel found in the cupboard.

43. On an analysis of the evidence it appears unlikely that LA at her age could have accessed and ingested the drug herself. This would have required that she locate the drug, take off the safety lid, draw up the methadone in a syringe and ingest the same.

44. The evidence of the grandfather was that he stored the methadone safely and up high, too high for LA to have reached. During the walkthrough this position had changed somewhat.

45. After much evidence at inquest, many questions remained. The grandfather remained adamant in various accounts that LA could not and did not take the methadone. The only possible time frame on his account was when he was splitting the methadone. In summary his account was that he had his usual dose and "a little bit extra" in the morning, when LA was already asleep.

46. Another possibility was that LA accessed the cupboard. During the initial interview the grandfather considered that this was not possible, he indicated that it may have fallen out of the cupboard or that he had been distracted possibly and left it on the bench himself. However, he did not indicate at any time that he saw the methadone bottle or syringe that had been left out in the kitchen area.

47. Detective Munro investigated and considered this highly unlikely for a number of important reasons. She remained firmly of that view in evidence. She considered the ability to access the cupboard using the surrounding tools. The chairs were noted to be extremely difficult for a child of her size and age to move. There were no marks on the tile or carpet to suggest any chair had been dragged over to allow access. Importantly the evidence given on this point was that after careful investigation there was residue and dust coating the floor, and if a chair or table had been dragged across the floor evidence of the movement of a heavy object would have been apparent, and it was not.

48. There were other inconsistencies in the grandfather's account. There were inconsistencies noted by Detective Munroe about his reports of the sleeping patterns of the grandchildren, at times suggesting normally they would be awake much earlier in the morning.

49. A further piece of evidence was the presence of vomit on the floor, which had not been noticed or identified by the grandfather.

50. Detective Munroe also determined from the interviews with the grandfather that on his account there should have been two half bottles of methadone from when he split it on 16 January. When investigated there was only one bottle located with 6.8 m/L. 5.2M/L was therefore missing from that bottle. That left a further half bottle unaccounted for.

51. This raises another area which remains unexplained. If LA could not access the cupboard and the substance had been left on the bench, there is no explanation of why the grandfather put that empty bottle away, when he had purposively halved it for his own use.

52. The evidence proffered gives no explanation or possible explanation of how LA came to have access to, or consume the methadone. On balance, the available evidence suggests it was not possible for her to access the methadone herself.

53. The forensic evidence was also inconclusive, in that there were no fingerprints or DNA on cups in the sink. The only DNA of assistance was found on the mouth of a syringe. There were a number of inconsistencies in The grandfathers account.

54. LA's parents remain unsure of how LA came to ingest methadone, and the evidence before the inquest cannot conclusively determine the manner of ingestion. On the account of the only adult present, she did not have any access to the drug.

55. The evidence was that the drug was inaccessible to LA. The only link found with possible method of consumption was DNA on the mouth of a syringe. There was an amount of methadone unaccounted for as determined in the police investigation. It is clear on the evidence that LA consumed the drug by some means at the house.

56. LA was not checked upon by her grandfather until shortly before 2 pm. The day was hot and the house was extremely hot inside. She had been slightly unwell when she first arrived. Dr Marks noted that it seemed very unusual that she had not been woken by her grandfather in those circumstances, or at least checked.

57. Dr Susan Marks gave evidence, as the leading paediatrician of the child protection unit. She gave evidence of concern for supervision of LA, in particular leaving a child seemingly asleep for such a long period of time.

58. Dr Marks did consider that a child of her age could pick up a syringe with fluid and administer it, particularly given at that age that is how most paracetamol would be administered.

59. Dr Paisley as the grandfather's treating psychiatrist gave evidence that the grandfather is not usually a "fantastic historian" and when he spoke with him on 18 January 2017 he indicated it was even more difficult to get the complete picture of what had occurred given the grandfather was in a highly emotional state. He gave evidence that one account the grandfather gave him was that the children may have climbed up to the cupboard, or that he might have inadvertently left the substance out while he brought in the shopping, although this version was not later adhered to by the grandfather.

60. Dr Paisley also indicated that the methadone itself is a very bitter substance, and would be very unpalatable to children.

61. Paramedics that attended formed the view that she was in a serious clinical state well before they arrived. It took some time for the grandfather to offer that methadone was in the house. The evidence was that the paramedic Mr Thompson was surprised that no mention was immediately made of the methadone.

Concluding Remarks:

LA's parents remain unsure of how LA came to ingest the methadone. It is clear that she ingested it at the home of her grandfather. On the account of the only adult present she did not have any access to that drug.

The only link found with possible method of consumption was DNA located on the mouth of a syringe. There was an amount of methadone unaccounted for as determined in the police investigation.

There are a large number of inconsistencies and discrepancies in the various accounts given by her grandfather.

Given the manner of death remains unknown, and the evidence does not proffer an explanation consistent with LA consuming the drug independently, I direct these findings to be provided to unsolved homicide.

Recommendations

There are no recommendations that are required to be made as a result of this inquest.

Acknowledgments

1. To the Officer in Charge for careful preparation of the brief and the gathering of relevant evidence.

Formal Findings

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

1. The findings pursuant to s81(1) of the Act:

i. The person who died is LA.
ii. She died on the 22 January 2017 at Westmead Children's Hospital, Westmead NSW.
iii. The cause of LAs death is Hypoxic-ischaemic Encephalopathy due to methadone toxicity.
iv. That the Manner of Death was an unnatural death through misadventure

I again extend my most sincere condolences to LA's family and particularly her parents and siblings for t such a tragic loss of such significant little person from their lives.

I close this inquest.

Magistrate E Kennedy

Deputy State Coroner

15 August 2023